Program Memorandum Intermediaries/Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1535

SUBJECT: Instructions for Coverage and Billing of Biofeedback Training for the Treatment of Urinary Incontinence

Coverage

This Program Memorandum (PM) revises the Coverage Issues Manual (CIM) by adding §35-27.1.

In §35-27.1, biofeedback for the treatment of urinary incontinence is covered for the treatment of stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training. A failed trial of PME training is defined as no clinically significant improvement in urinary continence after completing 4 weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength.

Home use of biofeedback therapy is not covered.

This revision to the CIM is a national coverage decision made under §1862 (a)(1) of the Social Security Act. National coverage determinations (NCDs) are binding on all Medicare carriers, intermediaries, peer review organizations, and other contractors. Under 42 CFR 422.256 (b) an NCD that expands coverage is also binding on a Medicare+Choice organization. In addition, an administrative law judge may not disregard, set aside, or otherwise review a national coverage decision issued under §1862 (a)(1), (see 42 CFR 405.732 and 405.860).

Billing and coding instructions are not included in the national coverage decision.

The following claim instructions apply for dates of service on or after July 1, 2001.

Intermediary Billing Instructions

Applicable HCPCS Codes

- 90901 - Biofeedback training by any modality; and
- 90911 - Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry.

Payment Requirements

Biofeedback for urinary incontinence is paid as follows when provided in a:

- Hospital outpatient department - payment is under the outpatient prospective payment system (OPPS);
- Skilled nursing facility or comprehensive outpatient rehabilitation facility - payment is under the Medicare physician fee schedule;

- A critical access hospital (CAH) - payment is made on a reasonable cost basis;
- Rural health clinics (RHCs)/federally qualified health centers (FQHCs) - payment is made on an all-inclusive rate for the professional component; or based on the provider's payment method for the technical component. (See below for RHC/FQHC instructions.)

Billing Requirements

The applicable bill types for biofeedback for treatment of urinary incontinence are 12X, 13X, 14X, 22X, 23X, 75X and 85X. The applicable revenue code is 917 (see below for RHCs and FQHCs).

The professional component of a urinary biofeedback service furnished within an RHC/FQHC by a physician or non-physician is considered an RHC/FQHC service. RHCs and FQHCs bill you under bill type 71X or 73X for the professional component along with revenue code 52X.

The technical component of a urinary biofeedback service is outside the scope of the RHC/FQHC benefit. If the technical component of this service is furnished within an independent RHC or freestanding FQHC, the provider of that technical service bills the carrier on Form HCFA-1500.

If the technical component of a urinary biofeedback service is furnished within a provider-based RHC/FQHC, the provider of that service bills you under bill type 13X, 14X, 22X, 23X, 75X or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since this service is not covered as an RHC/FQHC service). The appropriate revenue code is 917.

Carrier Billing Instructions

HCPCS Coding

The following existing HCPCS codes should be used when billing for biofeedback therapy:

- 90901 - Biofeedback training by any modality; and
- 90911 - Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry.

Claims Requirements for Carriers

Follow the general instructions in §2010, purpose of health insurance claim Form HCFA-1500, Medicare Carriers Manual (MCM) Part 4, chapter 2 for preparing claims. Claims for biofeedback training are to be submitted on health insurance claim Form HCFA-1500 or electronic equivalent.

Payment Requirements for Carriers

Pay for biofeedback training on the basis of the Medicare physician fee schedule. Deductible and coinsurance apply. Claims from physicians, other practitioners, or suppliers where assignment was not taken are subject to the Medicare limiting charge (refer to MCM Part 3, chapter VII, §7555 for more information).

Claims Editing

Nationwide claims processing edits for pre or post payment review of claim(s) for biofeedback therapy are not being required at this time. Carriers may develop local medical review policy and edits for such claim(s).

Denial Messages for Intermediaries and Carriers

Remittance Advice Notices

Contractors should use remittance advice messages, as follows, when denying coverage for biofeedback therapy:

- If the services are furnished before 7/1/2001, use Reason Code 26 - Expenses incurred prior to coverage.

- If coverage is denied as provided at home place of service, use Reason Code 58 - Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Also, send in the same remittance advice notice, new remark code, N87 "Home use of biofeedback therapy is not covered." As with any new remittance advice message, notify your providers of the code and its meaning prior to your initial use in a remittance advice.

- If coverage is denied due to the lack of a failed trial of PME training, use, as most appropriate, either Reason Code 107 - Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim or Reason Code B5 - Claim/service adjusted because coverage/program guidelines were not met or were exceeded. Also, send in the same remittance advice notice, new remark code N86, "A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treatment of urinary incontinence to be covered." As with any new remittance advice message, notify your providers of the code and its meaning prior to your initial use in a remittance advice.

Medicare Summary Notice (MSN) and Explanation of Medicare Benefits (EOMB) Message

If the claim for biofeedback therapy is being denied because the service was provided prior to July 1, 2001, then use the following new (March 2001) line MSN or EOMB message:

> "This service is not covered prior to July 1, 2001." (MSN Message 16.51, EOMB Message 20.1)

The Spanish version of this MSN or EOMB message should read:

> "Este servicio no se cubre antes del 1 de julio de 2001."

If the claim for biofeedback therapy is being denied because the service was provided at home place of service, then use the following new (March 2001) line MSN or EOMB message:

> "Medicare does not cover this service at home." (MSN Message 15.18, EOMB Message 15.39)

The Spanish version of this MSN or EOMB message should read:

> "Medicare no cubre este servicio en su casa."

If the claim for biofeedback therapy is being denied because of the lack of a documented failed trial of pelvic muscle exercise training, then use the following new (March 2001) line MSN or EOMB message:

> "This service was denied because coverage of this service is provided only after a documented failed trial of pelvic muscle exercise training." (MSN Message 16.52, EOMB Message 20.2)

The Spanish version of this MSN or EOMB message should read:

> Este servicio fue negado debido a que la cobertura para este servicio es proporcionada solamente después de una prueba documentada sin éxito del ejercicio de entrenamiento del músculo pélvico.

Prior to the systems implementation date, contractors should use an appropriate generic noncoverage message for claims that are being denied.

The *effective date* for this Program Memorandum (PM) is July 1, 2001.

The coverage *implementation date* for this PM is July 1, 2001.

The systems *implementation date* is October 1, 2001.

These instructions should be implemented within your current operating budget.

Carriers and intermediaries should notify providers of these changes in their next regularly scheduled bulletin, in their website, and in routinely scheduled training sessions.

This PM may be discarded after July 1, 2002.

If you have any questions, contact the appropriate regional office. Providers and other interested parties should contact the appropriate carrier or intermediary.