November/December 1997 Medicare Part B Update! Publication
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HCFA
Health Care Financing Administration
****
FIRST COAST SERVICE OPTIONS, INC.
A HCFA Contracted Carrier and Intermediary
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PLEASE NOTE: THE BBS VERSION OF THIS ISSUE OF THE MEDICARE PART B OF FLORIDA UPDATE DOES NOT CONTAIN GRAPHIC EXAMPLES (I.E., HCFA-1500 EXAMPLES.THEREFORE,GRAPHIC EXAMPLES THAT MAY BE REFERRED TO BY THE FOLLOWING ARTICLES WILL NOT APPEAR HERE. MEDICARE PART B OF FLORIDA IS CURRENTLY WORKING TO INCLUDE GRAPHIC EXAMPLES ON THIS APPLICATION FOR FUTURE UPDATES.

THE PAGE NUMBERS LISTED HERE COINCIDE WITH THE PAGE NUMBERS OF THE ACTUAL PUBLICATION.

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Participate in 1998!

It s time again for all Medicare providers to choose whether to participate in the Medicare program for the upcoming calendar year. Medicare Part B of Florida offers the following benefits to participating providers:

Access to Patient Eligibility Data: Participating providers who file their claims electronically using a national standard format can obtain information about a patient s benefit eligibility. Contact Provider Electronic Services Marketing at (904) 791-8767 for more information.

Claim Filing Advantages: Participating providers are offered toll-free telephone lines for submitting electronic claims. Participating providers who file paper claims use a separate post office box established specifically for these claims.

Higher Payment Rates: Participating providers are reimbursed directly by Medicare Part B at rates five percent higher than those paid to non-participating providers.

Automatic Medigap Claim Filing: In most cases, Medicare Part B will automatically file claims to a patient s Medigap insurer (responsible for

the 20 percent not covered by Medicare), eliminating the need to submit separate claims to both Medicare Part B and the insurer.

Inclusion in Participating Provider Directory: All independently participating providers and groups are eligible for inclusion in a directory of participating providers distributed to Medicare beneficiaries. To be included in this directory, independently practicing physicians and groups must elect to participate during the upcoming year, actively file claims to Medicare Part B, and provide us with their physical office address (where the office is located) and telephone number for patients to use when scheduling appointments.

Enrollment materials for 1998 will be released in mid-November. We encourage you to register as a participating Medicare provider and to take advantage of these benefits. If you are undecided, see page 7 for additional information that will change your mind! But don t wait too long to decide: your decision must be received by December 31, 1997, and will apply to services provided from January 1, 1998, through December 31, 1998.

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What's New

Random Review of Evaluation and Management Services
Beginning in November 1997, all Medicare Part B carriers will conduct random prepayment reviews on certain Evaluation and Management (E&M) services for a particular date. The Health Care Financing Administration will designate which E&M service or services will be reviewed each month. The purpose of this review is to ensure the correct use of E&M procedure codes among all providers who bill for those services. E&M documentation guidelines were published in the September 1997 Medicare B Update! Special Issue: Documentation Guidelines for Evaluation and Management Services. For more information, refer to page 46.

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CLIA Compliance

Beginning October 1, 1997, the CLIA number must be included on all claims for laboratory services including purchased tests. This information applies not only to clinical diagnostic laboratory services, but also surgical anatomical pathology services. For paper claims, this information must be entered in Item 23 of the HCFA-1500 claim form (see page 8). Electronic claim filers must enter this information in the FA0 record, field 34, positions 164-178 of the National Standard Format (see page 41).

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New Phone Number for EMC Billing Guidelines

There is a new telephone number for EMC billing guidelines or problems. The new number is (904) 354-5977. Be sure to note this change!

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The Medicare B Update! is published by the Medicare Part B Provider Education Department to provide timely and useful information to Medicare Part B providers in Florida. Questions concerning this publication or its contents may be directed in writing to:
Medicare Part B
Provider Education
P.O. Box 2078
Jacksonville, FL 32231-0048

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A Physician s Focus

Influenza and Pneumococcal Campaigns

The flu season is here! Every year patients put themselves at unnecessary risk for serious illness and even death by failing to get their flu shots. The flu shots work and no one can catch the flu from them. Medicare has made it as easy as possible for everyone to get their flu shots by paying 100 percent of the allowable cost, allowing the shots without a doctor s order, and by allowing roster billing. The shots are allowed every flu season; they don t have to be 12 months apart.

Experience shows that the advice of a patient s physician is the single most important factor in the decision to get the flu shot. I personally have had one every year for over 20 years without any adverse reactions. All physicians are urged to remind their patients of the value of the flu shots at every opportunity during the flu season. Posters, pamplets and standing orders are effective in increasing the number of patients getting protected.

Getting patients protected from pneumococcal illness should be easier since one shot usually protects for life, yet we still have over 40,000 deaths a year from pneumococcal pneumonia. I would hate to have one of my patients go unimmunized and become one of those statistics. As always, the patient is most likely to take the shot if the doctor takes a few seconds to emphasize the importance of doing so. Although a doctor s order is needed, standing orders are acceptable and Medicare still pays 100 percent of the allowable charges.

For more information on Medicare s influenza and pneumococcal campaigns, including the instructions for patient specific or roster billing, please refer to the article beginning on page 14 of this issue (please note the new place of service used for mass immunizations). If you have any questions about the influenza or pneumococcal benefits, or if you would like flu posters or brochures for display in your office, please contact our Provider Customer Service representatives at (904) 634-4994.

Thank you for your help in bringing this important preventive health care benefit to the attention of Medicare patients.

Sincerely,

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Advance Notice Requirement

Note: The following information applies to all articles in this publication referencing services which must meet medical necessity requirements (e.g., services with specific diagnosis requirements). Providers should refer to this information for those articles which indicate that advance notice applies.

Medicare Part B allows coverage for services and items which are medically reasonable and necessary for the treatment/diagnosis of the patient. For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this is not an inclusive list):

Coverage for a service or item may be allowed only for specific diagnoses/conditions.
Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (utilization screen - i.e., there is a specified number of services within a specified timeframe for which the service may be covered).

In cases where the provider believes that the service or item may not be covered as medically reasonable and necessary, an acceptable advance notice of Medicare s possible denial of payment must be given to the patient if the provider does not want to accept financial responsibility for the service or item. The advance notice must meet the following requirements:

The notice must be given in writing, in advance of furnishing the service or item.
The notice must include the patient s name, date(s) and description of the service or item, and the reason(s) why the service or item may not be considered medically reasonable and necessary (e.g., service is not covered based on the diagnosis of the patient, the frequency of the service was furnished in excess of the utilization screen, etc.).
The notice must be signed and dated by the patient indicating that the patient assumes financial responsibility for the service if it is denied payment as not medically reasonable and necessary for the reason(s) indicated on the advance notice. The signature of the provider of service is not required.

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting procedure code modifier GA with the service or item. The advance notice form should be maintained with the patient s medical record.
Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.
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General Information About the Medicare B Update!

Articles included in each Update! represent formal notice that specific coverage policies either have or will take effect on the date given. Providers who receive each issue are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines. Medicare Part B of Florida maintains copies of the mailing lists for each issue, and inclusion on these mailing lists implies that the issue was received by the provider in the event there is a dispute over whether a provider received advance notice regarding coverage of a specific service and the financial liability for it.
The Coverage/Reimbursement section includes information on general and specific Part B coverage guidelines. A General Information section includes the latest information on topics which apply to all providers such as limiting charge, correct coding initiative, etc. The remainder of this section includes information for specific procedure codes and is structured in the same format as the Physician s CPT book (i.e., in

procedure code order) using the following categories: HCPCS Codes (A0000-Z9999), Anesthesia/Surgery (00100 *1-69999 *1), Diagnostic Tests (70000 *1-89999 *1), and Medicine (90000 *1-99999 *1).
Distribution of the Update! is limited to individual providers and PA groups who bill at least one claim to Medicare Part B of Florida for processing during the six months prior to the release of each issue. Providers who meet this criteria are sent one complimentary copy of that issue. Production, distribution, and postage costs prohibit us from distributing a copy of each issue to each provider s practice settings. This primarily affects members of PA groups; one copy of each issue is sent to the group. The group is responsible for dissemination of each copy to its members. If additional copies are needed, there are two options: purchase a separate annual subscription for $75, or download the text version from our on-line service, the B LINE BBS.
Medicare Part B of Florida uses the same mailing address for all correspondence, and cannot designate that each issue of the Update! be sent to a specific person/department within a provider s office. To ensure continued receipt of all Medicare correspondence, a HCFA 855-C form must be completed in the event of relocation. See page 48 for additional information.
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1998 ICD-9-CM Coding Changes
As outlined in the September/October 1997 Medicare B Update! (page 46), the latest update to the ICD-9-CM diagnosis coding structure became effective October 1, 1997. For claims processed on or after January 1, 1998, claims which include missing or invalid ICD-9-CM diagnosis codes will either be returned by Medicare Part B of Florida as unprocessable (assigned) or developed for a complete diagnosis code (unassigned). Medicare Part B of Florida has reviewed the latest ICD-9-CM coding changes to determine which procedure codes with specific diagnosis criteria were affected by this update. The table below lists the procedure codes affected and the specific conditions revised as part of the latest ICD-9-CM update.

Procedure Codes J9213-J9216
Publication Listing Covered Conditions: March/April 1996, p. 21
ICD-9-CM Changes: 078.10-078.19 Viral warts due to human papillomavirus

Procedure Codes 70450 *1, 70460 *1, 70470 *1
Publication Listing Covered Conditions: March/April 1997, p. 54
ICD-9-CM Changes: 430-438.9 Cerebrovascular disease 780.31-780.39 Convulsions

Procedure Codes 70551 *1-70553 *1
Publication Listing Covered Conditions: March/April 1997, p. 55May/June 1997, p. 13
ICD-9-CM Changes: 482.81-482.89 Pneumonia due to other specified bacteria518.0-518.6 Other diseases of the lung756.6-756.79 Anomalies of diaphragm; abdominal wall

Procedure Codes 71010 *1-71035 *1
Publication Listing Covered Conditions: October 1996 Special Issue, p. 15
ICD-9-CM Changes: 482.81-482.89 Pneumonia due to other specified bacteria518.0-518.6 Other diseases of the lung756.6-756.79 Anomalies of diaphragm; abdominal wall

Procedure Codes 80061 *1, 82172 *1, 82465 *1, 83715 *1, 83717 *1-83719 *1, 83721 *1, 84478 *1
Publication Listing Covered Conditions: July/August 1997, p. 27
ICD-9-CM Changes: 438.0-438.9 Late effects of cerebrovascular disease

Procedure Codes 80091 *1,80092 *1, 84436 *1, 84437 *1, 84439 *1, 84443 *1, 84479 *1-84482 *1
Publication Listing Covered Conditions: July/August 1997, p. 28
ICD-9-CM Changes: 275.40-275.49 Disorders of calcium metabolism

Procedure Codes 83735 *1
Publication Listing Covered Conditions: July/August 1997, p. 35
ICD-9-CM Changes: 275.40-275.49 Disorders of calcium metabolism458.0-458.8 Hypotension780.31-780.39 Convulsions

Procedure Codes 85007 *1-85009 *1, 85013 *1, 85014 *1, 85018 *1, 85021 *1-85025 *1, 85027 *1, 85031 *1
Publication Listing Covered Conditions: July/August 1997, p. 35
ICD-9-CM Changes: (From non-covered diagnosis list)V64.0-V64.4 Persons encountering health services for specific procedures, not carried out780.31-780.39 Convulsions

Procedure Codes 87086 *1-87088 *1
Publication Listing Covered Conditions: July/August 1997, p. 37
ICD-9-CM Changes: 038.10-038.19 Staphylococcal septicemia

Procedure Codes 88150, 88151, 88155 *1-88157 *1
Publication Listing Covered Conditions: July/August 1997, p. 37
ICD-9-CM Changes: 078.10-078.19 Viral warts due to human papillomavirus

Procedure Codes 93000 *1, 93005 *1, 93010 *1
Publication Listing Covered Conditions: October 1996 Special Issue, p. 42July/August 1997, p. 63
ICD-9-CM Changes: 780.31-780.39 Convulsions

Procedure Codes 99183 *1
Publication Listing Covered Conditions: October 1996 Special Issue, p. 46
ICD-9-CM Changes: 686.01 Pyoderma gangrenosum (Meleney s ulcer)

The latest versions of the ICD-9-CM manuals (as well as a variety of other 1998 coding materials) can be obtained from:

HealthCare Consultants of America
1-800-253-4945

Medicode Publications
1-800-99-4600

St. Anthony s Publishing
1-800-632-0123

ICD-9-CM and other coding materials may also be available from medical publishing and consulting firms in your area.

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Ordering a National Correct Coding Policy Manual

The National Technical Information Service (NTIS) in the Department of Commerce has developed a correct coding manual to promote correct coding nationwide and to assist physicians in correctly coding their services for reimbursement.

To order HCFA s National Correct Coding Policy Manual for Part B Medicare Carriers by mail, please call the National Technical Information Service (NTIS) sales desk at (703) 487-4650.

- If requesting a paper copy of the manual for each quarter, use order # SUB-9576 ($65.00 plus handling fee). A subscription may be purchased for $260.00.
- If you are requesting the CD-ROM version, use order # SUB-5407 ($80.00 plus handling fee).
- If you are requesting the ASCII version (raw data), use order # SUB-5408 ($140.00 plus handling fee).

Individual Chapters of the Correct Coding Manual

A one-time individual chapter of the correct coding manual may be purchased at $40.00 plus handling for each chapter or a one year subscription (updated quarterly) for one chapter may be purchased for $160.00. Listed below are the individual chapters that are available for purchase.

Chapter: 2
Description: Anesthesia Services (00000 *1-09999 *1)
Order#: SUB-9902

Chapter: 3
Description: Surgery: Integumentary System (10000 *1-19999 *1)
Order#: SUB-9903

Chapter: 4
Description: Surgery: Musculoskeletal System (20000 *1-29999 *1)
Order#: SUB-9904

Chapter: 5
Description: Surgery: Respiratory, Cardiovascular, Hemic, and Lymphatic System (30000 *1-39999 *1)
Order#: SUB-9905

Chapter: 6
Description: Surgery: Digestive System (40000 *1-49999 *1)
Order#: SUB-9906

Chapter: 7
Description: Surgery: Urinary, Male & Female Genital, Maternity Care, and Delivery System (50000 *1-59999 *1)
Order#: SUB-9907

Chapter: 8
Description: Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, Auditory System (60000 *1-69999 *1)

Order#: SUB-9908

Chapter: 9
Description: Radiology Services (70000 *1-79999 *1)
Order#: SUB-9909
Chapter: 10
Description: Pathology and Laboratory Services (80000 *1-89999 *1)
Order#: SUB-9910

Chapter: 11
Description: Medicine, Evaluation, and Management Services (90000 *1-99999 *1)
Order#: SUB9911

Additional Ordering Information
- To receive ordering information via NTIS FAX Direct , call (703) 487-4140 and enter code 8657.
- To receive ordering information by mail, call (703) 487-4630.
- To order a single copy, call (703) 487-4650.
- Ordering and product information is also available via the World Wide Web at www.ntis.gov/cci.

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Having dificulty getting your claims paid ??? See page 40.

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Information About the 1998 Medicare Participation Program

Physicians, suppliers, nonphysician practitioners, or any other organization authorized to accept assignment of Medicare benefits for covered services may enter into a participation agreement for calendar year 1998. Providers who participate in the Medicare program agree to accept Medicare's allowance as payment in full for covered services.

During November 1997, all active providers will receive a package outlining the 1998 Medicare participation program which includes an enrollment form and 1998 fee schedule payment rates. The mailing label on that package will indicate your current specialty designation (twoŽdigit numeric code) and participation status (PAR Žparticipating, NONPAR Ž nonparticipating). If you are now a participating provider or group and wish to maintain this participation status, simply do nothing; your status will automatically be carried over for 1998. However, if you decide to form a group during 1998, a separate agreement will need to be completed. If you are not a participating provider or group, you may enroll in the Medicare Participation Program until December 31, 1997. Please fill out the participation agreement forms completely, including your Medicare provider number, name, physical address, and telephone number; this information is used to produce the annual directories of participating providers. Simply signing the agreement without completing this information causes delays in the processing of your agreement.

Although a participation agreement will be furnished to providers upon request, the annual open enrollment period (midŽNovember through December 31 each year) is the only time established entities may enroll as

participants for the upcoming calendar year or terminate their existing participation agreement. However, a provider who is either newly licensed to practice medicine or first opens an office for professional practice in a different locality or service area may request a participation agreement from Medicare Part B of Florida to make their participation decision. The provider has 90 days to make this decision, and if they decide to participate, the agreement takes effect on the date it was postmarked. Retroactive requests will not be honored. The agreement remains in force until the end of that year's participation period.

If you have further questions about the participation program, would like to verify your current participation status, or wish to request a 1998 participation agreement, either call the Provider Customer Service department at (904) 634Ž4994, or write to:

Medicare Registration
P.O. Box 44021
Jacksonville, FL 32231Ž4021

Commonly Asked Questions About the Medicare Participation Program

Q

I am a clinical psychologist who was automatically designated as a participating provider in 1995. Will I need to make a participation decision for 1998?

A

No. The law which designated certain practitioners as participating providers in 1995 remains in effect until further notice. As a reminder, the practitioners affected by this policy are physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, and clinical psychologists.

Q
I have multiple practice settings. Can I choose whether to participate in the Medicare program at each setting?

A

No. The participation decision made on your independently practicing provider number will also apply to each of your satellite settings (excluding group affiliations).

Q

My partner and I are currently participating providers and we have decided to form a group. Will our group participation status automatically reflect participating?

A

No. A separate agreement must be filed on behalf of the group. The agreement binds all group members when performing and billing services

performed on behalf of the group and billed under the group's provider number.

Q

I was practicing with a group that was participating. However, I have decided to open an individual practice. Will I be considered participating or nonŽparticipating?

A

Your status will depend on the participation decision made when you first received your Medicare provider number. The participation status of the group has no effect on the status of your individual practice. If you have never been in independent practice and choose to participate, an agreement must be filed for your individual practice. If you need to check the participation status of your individual provider number, call the Provider Customer Service department at (904) 634Ž4994.

Q

My P.A. group had decided to join the Medicare Part B participation program. Is it necessary to complete an agreement for each group member?

ogram?

A

No. Participation agreements will only be accepted from providers who are newly licensed to practice medicine or when they open their first office for professional practice in a different locality or service area.

Q

How often can I change my participation status?

A

Your participation status can only be changed during the open enrollment period. Specific instructions are given each year regarding the dates the enrollment period is in effect. For 1998, participation agreements are effective from January 1, 1998, to December 31, 1998.

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CLIA Compliance for Part B Laboratory Claims

The Clinical Laboratory Improvements Amendments of 1988 (CLIA), Public Law 100Ž578, amended 353 of the Public Health Service Act (PHSA) to extend jurisdiction of the Department of Health and Human Services to regulate all laboratories that examine human specimens to provide information to assess, diagnose, prevent, or treat any disease or impairment. CLIA mandates that virtually all laboratories, including physician office laboratories (POLs), meet applicable Federal requirements and have a CLIA certificate in order to receive

reimbursement from Federal programs. CLIA also lists requirements for laboratories performing only certain tests to be eligible for a certificate of waiver or a certificate for Physician Performed Microscopy Procedures (PPMP). In 1992, carriers were instructed to deny clinical laboratory services billed by independent laboratories which did not meet the CLIA requirements. POLs were excluded from the 1992 instruction. However, that is being changed.

HCFA has undertaken an initiative to monitor CLIA compliance for all laboratories. Several tasks have already begun in HCFA and others are to be phased in through January 1, 1998 by HCFA and Medicare Part B carriers. These are the instructions to implement changes bringing POLs into compliance with CLIA.

The major change is a requirement for the CLIA number to be included on each Form HCFAŽ1500 claim for laboratory services by any laboratory performing tests covered by CLIA. While this number will be required in October 1997, claims without the CLIA number will not be denied until January 1, 1998. Medicare Part B will continue processing independent laboratories' claims as they currently do except that remittance advice notices will warn that claims will not be paid beginning January 1, 1998, where no CLIA number appears on the claim. Beginning in January 1998, the CLIA number must be on all claims for laboratory services or the service(s) will be returned as unprocessable.

Tests performed at more than one CLIA lab for the same beneficiary on the same day must be submitted on separate claims. Claims submitted with more than one CLIA number will be rejected (electronic) or returned as unprocessable (paper).

For reference laboratory services, the CLIA number of the referring/billing laboratory must be used when such services are submitted on the same claim as the referring/billing laboratory's services.

For paper claims, this information must be entered in Item 23 of the HCFAŽ1500 claim form. Electronic claim filers must enter this information in the FA0 record, field 34, positions 164Ž178, of the National Standard Format. This information applies to both independent laboratories and physician office laboratories. Page 42 of the September/October 1997 Medicare B Update! incorrectly stated that this information does not apply to independent clinical laboratories.

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HCPCS Codes

E1700-E1702: Jurisdiction Change

On March 19, 1997, local carriers and Durable Medical Equipment Regional Carriers (DMERCs) were informed that claims processing jurisdiction for HCPCS codes E1700, E1701 and E1702 (Jaw motion rehabilitation system; replacement cushions and replacement measuring scales) was being changed from DMERC jurisdiction to local carrier jurisdiction, effective for claims received on or after June 30, 1997. Effective for claims received

on or after October 20, 1997, jurisdiction for these codes is changed back to the DMERCs.

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Revisions to Injectible Drug Fees

The allowances for injectible drugs are based on the median of the average wholesale prices (AWPs) from the Drug Topics Red Book. The median of the AWPs has changed for the following injectible drugs. These revised fees are effective for claims processed on or after September 29, 1997.

Code:	Participating:	Nonpar:	Limiting Charge:
J0150:	$26.97:	$25.62:	$29.46
J0170:	$1.12:	$1.06:	$1.22
J0210:	$9.45:	$8.98:	$10.33
J0280:	$1.15:	$1.09:	$1.25
J0350:	$2511.93:	$2386.33:	$2744.28
J0530:	$6.94:	$6.59:	$7.58
J0540:	$13.88:	$13.19:	$15.17
J0550:	$27.76:	$26.37:	$30.33
J0560:	$6.92:	$6.57:	$7.56
J0570:	$10.52:	$9.99:	$11.49
J0580:	$30.19:	$28.68:	$32.98
J0690:	$3.55:	$3.37:	$3.88
J0697:	$8.00:	$7.60:	$ 8.74
J0704:	$2.68:	$2.55:	$2.93
J0713:	$7.52:	$7.14 :	$8.21
J0743:	$15.77:	$14.98:	$17.23
J0780:	$2.85:	$2.71:	$3.12
J0850:	$424.67:	$403.44:	$463.96
J0895:	$11.19:	$10.63:	$12.22
J0945:	$1.08:	$1.03:	$1.18
J0970:	$1.59:	$1.51:	$1.74
J1040:	$3.12:	$2.96:	$3.40
J1070:	$1.48:	$1.41:	$1.62
J1160:	$2.60:	$2.47:	$2.84
J1200:	$1.27:	$1.21:	$1.39
J1250:	$49.54:	$47.06:	$54.12
J1580:	$3.90:	$3.71:	$4.27
J1625:	$177.40:	$168.53:	$193.81
J1840:	$6.75:	$6.41:	$7.37
J1950:	$440.63:	$418.60:	$481.39
J1980:	$4.61:	$4.38:	$5.04
J2060:	$10.34:	$9.82:	$11.29
J2320:	$7.21:	$6.85:	$7.88
J2321:	$7.23:	$6.87:	$7.90
J2322:	$14.46:	$13.74:	$15.80
J2430:	$207.26:	$196.90:	$226.44
J2675:	$1.80:	$1.71:	$1.97
J2690:	$13.31:	$12.64:	$14.54
J2810:	$1.45:	$1.38:	$1.59
J3105:	$2.48:	$2.36:	$2.71
J3130:	$1.80:	$1.71:	$1.97
J3230:	$2.25:	$2.14:	$2.46
J3250:	$2.61:	$2.48:	$2.85
J3260:	$6.83:	$6.49:	$7.46
J3350:	$77.46:	$73.59:	$84.63

J3365:	$450.21:	$427.70:	$491.86
J3370:	$12.48:	$11.86:	$13.64
J3430:	$2.74:	$2.60:	$2.99
J7030:	$11.79:	$11.20:	$12.88
J7040:	$11.02:	$10.47:	$12.04
J7042:	$11.32:	$10.75:	$12.36
J7070:	$12.23:	$11.62:	$13.36
J9100:	$6.94:	$6.59:	$7.58
J9110:	$31.00:	$29.45:	$33.87
J9217:	$540.63:	$513.60:	$590.64
J9218:	$64.25:	$61.04:	$70.20
J9245:	$325.03:	$308.78:	$355.10
J9293:	$189.01:	$179.56:	$206.49
J9360:	$3.92:	$3.72:	$4.28

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L8610: Coverage Revisions

Effective for claims processed on or after September 8, 1997, ocular implants (procedure code L8610) are covered when performed in an Ambulatory Surgical Center (ASC). Additionally, the service is also covered when performed by an ophthalmologist.
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Correction: Third Quarter Revisions to the 1997 Fee Schedule for DMEPOS

Page 23 of the September/October 1997 Medicare B Update! featured the fees for certain DMEPOS (Durable Medical Equipment Prosthetics Orthotics and Supplies) procedure codes. These fees were incorrect. The following are the corrected fees:

Codes	Fees
L8600	$459.03
L8610	$470.84
L8612	$496.59
L8613	$222.33
L8630	$247.66
L8641	$268.79
L8642	$220.63
L8658	$230.59
L8670	$263.36

These revisions are effective for claims processed October 20, 1997, and after.

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Q9920ŽQ9940: Calculating EPO Payments

Erythropoietin (EPO) coverage requirements are based on a 90Žday rolling average hematocrit measurement for End Stage Renal Disease (ESRD) patients whose hematocrit levels are greater than 36 percent. This method of calculation, referred to as the Hematocrit Measurement Audit (HMA), will safeguard against overutilization. There will be no change in processing instructions for nonŽESRD patients on EPO.

Specifically, a claim containing a hematocrit level exceeding 36 percent will be averaged with the hematocrit levels posted on all claims for services furnished within the previous 90 days.

Medicare policy indicates that ESRD patients with symptomatic anemia who are considered for EPO therapy should be treated until the hematocrit reaches a target range of 30Ž60 percent. As the hematocrit approaches 36 percent, administration of EPO should be reduced temporarily. The dosage of EPO required to maintain target hematocrit levels is subject to individual patient variation and should be calculated, according to patient response, with a goal not exceeding a hematocrit level of 36 percent.

If the average of the 90Žday hematocrit level reading are 36.5 percent or less, Medicare Part B will pay for the EPO. If the level exceeds 36.5 percent, Medicare will deny the EPO. Previously, Medicare policy provided for EPO hematocrit levels exceeding 36 percent if there was supporting medical documentation.
****

Anesthesia/Surgery
****
00142 *1: Cataract Anesthesia Time

For personally performed anesthesia services, including Monitored Anesthesia Care (MAC), provided to a patient undergoing cataract surgery, there must be a continuous actual presence of the anesthesiologist or anesthesist. In addition, the anesthesia services should be medically necessary in order to obtain reimbursement from Medicare for these services.

For personally performed services, anesthesia time starts when the anesthesiologist or anesthetist begins to prepare the patient for anesthesia care in the operating room or equivalent area and ends when the anesthesiologist or anesthetist is no longer in personal attendance, i.e., when the patient may be safely placed under postŽoperative supervision. Anesthesia time units involve the continuous, actual presence of the anesthesiologist or anesthetist. Blocks of interrupted time should not be added together to report anesthesia time for personally performed anesthesia services.

Again, the provider must be in continuous, actual presence to report personally performed anesthesia time. We hope this clarifies any questions regarding how anesthesia time should be reported for procedure code 00142 *1.

****

was present during all critical (or key) portions of the procedure including induction and emergence. The anesthesia teaching physician should use both modifiers AA and GC. The teaching physician presence is not required during the preŽoperative or postŽoperative visits with the patient. Of course, a claim would not be submitted to Medicare Part B for the resident's service. If the anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a

nonphysician anesthetist, Medicare will pay for the anesthesiologist's services as medical direction.

Situation:

More than one resident or resident/CRNA combination.

Guideline:

If the teaching physician directs more than one resident or any combination of residents/CRNAs, these services continue to fall under the normal medical direction rules. Only use of the QX modifier (Medical direction of two, three, or four concurrent procedures) is required. The teaching physician modifier GC should never be used with the medical direction modifier QK.
****

Revision to ASC Facility Rates

The Ambulatory Surgical Center (ASC) facility payment rates have been updated to reflect an inflation adjustment effective for services furnished October 1, 1997, and after. The following information lists the new ASC facility payment rates for each of the payment groups; they are listed by cities and surrounding counties.

Daytona Beach, Flagler, Volusia
Group 1: 301.43
Group 2: 405.11
Group 3 462.70
Group 4 571.18
Group 5 650.86
Group 6 763.42
Group 7 903.33
Group 8 896.86

Ft. Lauderdale, Broward
Group 1 319.27
Group 2 429.08
Group 3 490.09
Group 4 604.98
Group 5 689.37
Group 6 799.72
Group 7 956.79
Group 8 941.05

Ft. Myers, Cape Coral, Lee
Group 1 301.43
Group 2 405.11
Group 3 462.70
Group 4 571.18
Group 5 650.86
Group 6 763.42
Group 7 903.33
Group 8 896.86

Ft. Pierce , Port St. ˜Lucie, Martin, St. Lucie
Group 1 316.78
Group 2 425.74
Group 3 486.27
Group 4 600.27
Group 5 684.00
Group 6 794.66
Group 7 949.33
Group 8 934.89

Ft. Walton Bch., Okaloosa
Group 1 301.43
Group 2 405.11
Group 3 462.70
Group 4 571.18
Group 5 650.86
Group 6 763.42
Group 7 903.33
Group 8 896.86

Gainesville
Group 1 309.85
Group 2 416.42
Group 3 475.62
Group 4 587.13
Group 5 669.03
Group 6 780.55
Group 7 928.55
Group 8 917.71

Jacksonville , Clay, Duval, Nassau, St. Johns
Group 1 302.85
Group 2 407.01
Group 3 464.88
Group 4 573.87
Group 5 653.92
Group 6 766.30
Group 7 907.58
Group 8 900.37

Lakeland , Winter Haven , Polk
Group 1 301.43
Group 2 405.11
Group 3 462.70
Group 4 571.18
Group 5 650.86
Group 6 763.42
Group 7 903.33
Group 8 896.86

Melbourne , Titusville , Palm ˜Bay, Brevard
Group 1 301.43
Group 2 405.11
Group 3 462.70
Group 4 571.18
Group 5 650.86

Group 6   763.42
Group 7   903.33
Group 8   896.86

Miami , Dade
Group 1   312.47
Group 2   419.95
Group 3   479.66
Group 4   592.11
Group 5   674.71
Group 6   785.90
Group 7   936.43
Group 8   924.22

Naples , Collier
Group 1   315.18
Group 2   423.58
Group 3   483.81
Group 4   597.23
Group 5   680.55
Group 6   791.40
Group 7   944.53
Group 8   930.92

Ocala, Marion
Group 1   303.53
Group 2   407.93
Group 3   465.93
Group 4   575.16
Group 5   655.39
Group 6   767.69
Group 7   909.62
Group 8   902.06

Orlando, Lake, Orange, Osceola, Seminole
Group 1   307.48
Group 2   413.23
Group 3   471.99
Group 4   582.64
Group 5   663.92
Group 6   775.73
Group 7   921.45
Group 8   911.84

Panama ˜City , Bay
Group 1   301.43
Group 2   405.11
Group 3   462.70
Group 4   571.18
Group 5   650.86
Group 6   763.42
Group 7   903.33
Group 8   896.86

Pensacola, Escambia, Santa Rosa
Group 1   301.43
Group 2   405.11

Group 3 462.70
Group 4 571.18
Group 5 650.86
Group 6 763.42
Group 7 903.33
Group 8 896.86

Punta Gorda , Charlotte
Group 1 301.43
Group 2 405.11
Group 3 462.70
Group 4 571.18
Group 5 650.86
Group 6 763.42
Group 7 903.33
Group 8 896.86

Sarasota , Bradenton, Manatee, Sarasota
Group 1 311.37
Group 2 418.47
Group 3 477.96
Group 4 590.02
Group 5 672.32
Group 6 783.65
Group 7 933.12
Group 8 921.49

Tallahassee, Gadsden, Leon
Group 1 301.43
Group 2 405.11
Group 3 462.70
Group 4 571.18
Group 5 650.86
Group 6 763.42
Group 7 903.33
Group 8 896.86

Tampa , St. Pete , Clearwater, Hernando, Hillsborough, Pasco,
Pinellas

Group 1 305.30
Group 2 410.31
Group 3 468.65
Group 4 578.52
Group 5 659.22
Group 6 771.30
Group 7 914.94
Group 8 906.45

West Palm Bch, Boca Raton, Palm Beach
Group 1 317.34
Group 2 426.49
Group 3 487.13
Group 4 601.33
Group 5 685.22
Group 6 795.80
Group 7 951.02

Group 8 936.28

****

Fiscal Year 1998 ASC Facility Rates for Rural Counties Where Hospitals Are Deemed Urban

County/Urban Area
Indian River/, Ft. Pierce
Group 1 314.09
Group 2 422.12
Group 3 482.13
Group 4 595.16
Group 5 678.19
Group 6 789.18
Group 7 941.26
Group 8 928.21

****

Fiscal Year 1998 ASC Facility Rates for Rural Areas /Non-Urban Areas

County/Urban Area
Rest of state
Group 1 301.43
Group 2 405.11
Group 3 462.70
Group 4 571.18
Group 5 650.86
Group 6 763.42
Group 7 903.33
Group 8 896.86

****

Diagnostic Tests

Which Mammography Centers are Certified by the FDA?

As of October 1, 1994, the Mammography Quality Standards Act (MQSA) requires that all mammography centers that bill Medicare get certification from the Food and Drug Administration (FDA). Medicare Part B carriers receive this certification information, and can reimburse only FDA-certified mammography centers.
To find out if a particular center is FDA-certified, call the Medicare Part B Provider Customer Service department at (904) 634-4994.

****

76092 *1: Release of Screening Mammography X-Rays

Screening mammography X-ray interpretations may be performed only by physicians who are associated with the certified mammography facility. Screening mammography X-rays cannot be released for interpretation to physicians who are not approved to perform interpretations under the facility's certification number, except in one of the following cases:
- The patient has requested a transfer of the films from one facility to another for a second opinion; or

- The patient has moved to another part of the country where the next screening mammography will be performed.

****

76092 *1: Diagnosis Coding for Screening Mammography

As a result of section 4101 of the Balanced Budget Act of 1997, Medicare Part B will pay for annual screening mammogaphies for women age 40 and over and the Part B deductible is waived. Since Medicare no longer pays for mammographies based on risk criteria, always bill for screening mammographies (procedure code 76092 *1) with diagnosis code V76.12 (other screening mammography).
As a reminder, effective for claims processed on or after January 1, 1998, diagnosis code V76.1 is no longer valid. Claims submitted with V76.1 will be returned as unprocessable (assigned) or developed for a complete diagnosis code (nonassigned).

****

85651 *1, 85652 *1: Erythrocyte Sedimentation Rate

Page 40 of the January/February 1997 Medicare B Update! featured a list of diagnoses for which erythrocyte sedimentation rate (procedure codes 85651 *1 and 85652 *1) is covered. Due to an oversight, the following diagnoses were inadvertently omitted from that list:

240.0-240.9
241.0-241.9
242.00-242.91
245.0-245.9
246.8

Advance Notice Requirement
Applies to diagnosis requirement (see page 4).

****

88342 *1: Billing Guidelines

The description for procedure code 88342 *1 (Immunocytochemistry [including tissue immunoperoxidase], each antibody) indicates "each antibody." When more than one antibody is tested for, the number billed should reflect the total number of antibodies tested for (e.g., five antibodies would be reported with a number billed of "5").

If the procedure is being performed as a repeat procedure, bill with a 76 *1 modifier to indicate this.

****

Medicine

90724 *1, 90732 *1: Roster Billing Guidelines for Influenza and Pneumococcal Pneumonia Vaccines
Overview
The Social Security Act, Section 1848 (g)(4) requires that providers bill Medicare for covered Part B services rendered to eligible beneficiaries. Public health clinics, community health clinics, and other entities which have not provided Medicare-covered services to their clients in the past must bill Medicare for the influenza virus vaccine, the pneumococcal

pneumonia vaccine (PPV), and the administration of either/both vaccine when the services are provided to Medicare beneficiaries.
To encourage mass immunization of the influenza vaccine and the pneumococcal pneumonia vaccine (PPV), Medicare has:

- Established the roster billing method for mass immunizers who agree to accept assignment,
- Expanded use of the roster billing method to all providers licensed to render the vaccines and/or their administrations,
- Defined mass immunizers as individuals/entities immunizing five or more beneficiaries on the same day,
- Allowed physicians who administer the vaccine in the office setting to use the roster billing method regardless of the number of beneficiaries immunized, provided no other services were rendered to these beneficiaries, and
- Now accepts "signature on file" on the roster in lieu of the actual patient's signature where the provider has a signed authorization on file to bill Medicare for services rendered.

Public health clinics and other entities that do not have a provider number and qualify for simplified billing procedures for influenza vaccine or PPV claims should call (904) 634-4994 to obtain the provider/supplier enrollment application form HCFA-855. See page 48 for additonal information on the HCFA-855.

What's New for 1997

A new place of service code has been developed for providers to use when they are performing mass immunizations, no matter what the actual location is. Providers should use place of service 60 (mass immunization center) when performing mass immunizations. This can include public health centers, pharmacies, malls, and physician offices. Remember: use place of service 60 when using the roster billing method.

Pneumococcal Pneumonia Vaccine

Effective November 1, 1996, PPV can be billed to Medicare Part B using the simplified roster billing method. Typically, the vaccine is administered once in a lifetime to persons at high risk of pneumococcal disease. Considered at risk are persons age 65 or older; immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks), and individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, HIV infection, nephrotic syndrome, sickle cell disease, or organ transplantation).

Medicare requires for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. However, a physician does not have to be present to meet the physician order requirement if a previously written physician order (standing order) is on hand and it specifies that for any person receiving the vaccine:

- The person's age, health, and vaccination status must be determined;
- A signed consent must be obtained;
- The vaccine may be administered only to persons at high risk of pneumococcal disease who have not been previously vaccinated; and
- A record of vaccination must be provided.

Because PPV must be ordered by a physician, the ordering physician's name must be noted in box 17, and the Unique Physician Identification Number (UPIN) must be noted in box 17a of the HCFA-1500 form. If the ordering physician's name or UPIN is missing, the claim will not be processed for payment.

PPV Vaccine Codes

The following HCPCS codes should be used when billing for PPV and its administration. Please note that neither deductible nor coinsurance apply to these codes, and no money may be collected from the beneficiary if the provider is accepting assignment and/or roster billing.

Procedure Code: 90732 *1
Description: Pneumococcal vaccine, polyvalent

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Procedure Code: G0009
Description: Administration of pneumococcal vaccine

PPV claims should be submitted using diagnosis code V03.82 (Other specified vaccinations against single bacterial diseases, other specified vaccination). See page 15 for claim completion instructions, page 19 for a PPV claim form, and page 20 for the PPV roster.

Influenza Virus Vaccine

The influenza virus vaccine and its administration are covered by Medicare Part B and may be billed to Medicare Part B using the simplified roster billing method.

Influenza Virus Vaccine Codes

The following HCPCS codes should be used when billing for the influenza virus vaccine and its administration. Please note that neither deductible nor coinsurance apply to these codes, and no money may be collected from the beneficiary if the provider is accepting assignment and/or roster billing.

Procedure Code: 90724 *1
Description: Immunization, active; influenza virus vaccine
Procedure Code: G0008
Description: Administration of influenza virus vaccine.

Influenza virus vaccine claims should be submitted using diagnosis code V04.8 (need for prophylactic vaccination and inoculation against certain viral diseases). See page 16 for claim completion instructions, page 17 for the flu claim form, and page 18 for the flu roster.

Advance Notice Requirement for Influenza Services

The influenza virus vaccine is covered by Medicare Part B when it is furnished within the accepted standards of medical practice. For services which exceed the accepted standards of medical practice, an acceptable advance notice of Medicare's denial of payment must be provided to the patient when the provider does not want to accept financial responsibility for the service.

Benefits of Accepting Assignment

Providers who accept assignment agree to accept the Medicare-approved charge as payment in full for the services rendered. For flu and PPV shots, providers who accept assignment (including those who roster bill for these services) may not collect any money from the beneficiary, as the Medicare-approved charge is paid at 100 percent by Medicare.

Nonparticipating providers who submit claims to Medicare for the flu shot or PPV do not have to accept assignment. However, we encourage providers to accept assignment as the out-of-pocket expense burdens some patients to the extent that they will not have these necessary preventative

services. Plus, providers who do accept assignment are eligible to submit claims under the simplified billing method for mass immunizations.

Reimbursement for Flu and PPV Claims

The fees for the influenza vaccine, PPV, and their administration are not based on the Physician Fee Schedule; therefore, the limiting charge rules do not apply. Part B reimburses for the influenza vaccine and its administration, and for PPV and its administration, at 100 percent of the Medicare allowed amount. Deductible and coinsurance do not apply, and reimbursement is the same for both participating and nonparticipating providers.

When the claim is nonassigned, the provider may collect payment for the full charges from the beneficiary on the spot. Though the provider cannot roster bill, he/she must complete and submit a claim to Medicare Part B on the patient's behalf.

The Medicare allowed amounts for the influenza vaccine and its administration, and PPV and its administration are outlined below:

Code G0008 (Administration of influenza virus vaccine)
Locality 1/2: $3.67
Locality 3: $4.14
Locality 4: $4.51

Code 90724 *1 (Immunization, active; influenza virus vaccine)
Locality 1/2: $4.06
Locality 3: $4.06
Locality 4: $4.06

Code G0009 (Administration of pneumococcal vaccine)
Locality 1/2: $3.67
Locality 3: $4.14
Locality 4: $4.51

Code 90732 *1 (Pneumococcal vaccine, polyvalent)
Locality 1/2: $14.20
Locality 3: $14.20
Locality 4: $14.20

Both the administration of the vaccines and the vaccines themselves are covered separately when they are rendered with or without other covered physician services. If the sole purpose of the patient encounter is to provide the flu vaccine or PPV, only the administration and vaccine provided should be billed. If a patient receives other services constituting an office visit level of service, the physician may also bill for the visit. Medicare will pay for medically reasonable and necessary visits when rendered with the administration and vaccine. When other services are rendered to the beneficiary on the same day, claims must be submitted using the standard HCFA-1500 and related filing requirements.

How To Roster Bill for Influenza and PPV Claims

The following chart outlines the fields on the HCFA-1500 claim form that must be completed for the roster billing of flu and PPV claims. For roster billing of either or both services, use the preprinted HCFA-1500 forms on pages 17 and 19 as cover sheets to the preprinted rosters (pages 18 and 20). (Note: Information in the shaded blocks must be added to the HCFA-1500 form by the provider.)

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HCFA-1500 Block: Block 1
Influenza Virus Vaccine Claims: Check "Medicare"
Pneumococcal Pneumonia Vaccine Claims: Check "Medicare"

HCFA-1500 Block: Block 2
Influenza Virus Vaccine Claims: See attached roster
Pneumococcal Pneumonia Vaccine Claims: See attached roster

HCFA-1500 Block: Block 11
Influenza Virus Vaccine Claims: None
Pneumococcal Pneumonia Vaccine Claims: None

HCFA-1500 Block: Block 17
Influenza Virus Vaccine Claims: N/A
Pneumococcal Pneumonia Vaccine Claims: Name of ordering physician MUST be entered(One name per claim form)

HCFA-1500 Block: Block 17a
Influenza Virus Vaccine Claims: N/A
Pneumococcal Pneumonia Vaccine Claims: UPIN of ordering physician MUST be entered(One UPIN per claim form)

HCFA-1500 Block: Block 20
Influenza Virus Vaccine Claims: No
Pneumococcal Pneumonia Vaccine Claims: No

HCFA-1500 Block: Block 21
Influenza Virus Vaccine Claims: V04.8
Pneumococcal Pneumonia Vaccine Claims: V03.82

HCFA-1500 Block: Block 24B
Influenza Virus Vaccine Claims: 60-Mass Immunization Center
Pneumococcal Pneumonia Vaccine Claims: 60-Mass Immunization Center

HCFA-1500 Block: Block 24D (line 1)
Influenza Virus Vaccine Claims: 90724 *1
Pneumococcal Pneumonia Vaccine Claims: 90732 *1

HCFA-1500 Block: Block 24D (line 2)
Influenza Virus Vaccine Claims: G0008
Pneumococcal Pneumonia Vaccine Claims: G0009

HCFA-1500 Block: Block 24E (lines 1 AND 2)
Influenza Virus Vaccine Claims: 1
Pneumococcal Pneumonia Vaccine Claims: 1

HCFA-1500 Block: Block 24F
Influenza Virus Vaccine Claims: Enter the charge for each listed service.
Pneumococcal Pneumonia Vaccine Claims: Enter the charge for each listed service.

HCFA-1500 Block: Block 27
Influenza Virus Vaccine Claims: X in YES block
Pneumococcal Pneumonia Vaccine Claims: X in YES block

HCFA-1500 Block: Block 29

Influenza Virus Vaccine Claims: 0.00
Pneumococcal Pneumonia Vaccine Claims: 0.00

HCFA-1500 Block: Block 31
Influenza Virus Vaccine Claims: Entity's representative must sign
Pneumococcal Pneumonia Vaccine Claims: Entity's representative must sign

HCFA-1500 Block: Block 32
Influenza Virus Vaccine Claims: N/A
Pneumococcal Pneumonia Vaccine Claims: N/A

HCFA-1500 Block: Block 33
Influenza Virus Vaccine Claims: Enter the entity's billing name, address, ZIP code, and telephone number, and enter the carrier-assigned Provider Identification Number
Pneumococcal Pneumonia Vaccine Claims: Enter the entity's billing name, address, ZIP code, and telephone number, and enter the carrier-assigned Provider Identification Number.

IMPORTANT NOTE: .....Separate claim forms and rosters must be submitted for influenza vaccines and PPV claims.
All entities that use for the simplified billing process should be sure to use place of service 60 (mass immunization center) on any roster claim submitted to Medicare Part B.

How to Complete the Roster
When completing the roster for influenza virus vaccines or for PPV claims, the roster information for each beneficiary must include the following:
- Provider name and number
- Date of service
- Patient's health insurance claim number (copy directly from the patient's red, white, and blue Medicare card)
- Patient's name
- Patient's address
- Date of birth
- Sex
- Beneficiary's signature, or stamped "Signature on File"

This information must be printed clearly so that we can process these claims in a timely manner. Also, no more than 50 claims (i.e., five rosters per claim form) should be submitted with each claim form. Finally, if you are only rendering the vaccine or its administration, on the HCFA-1500 claim form mark out the service you are not providing.

Submitting Claims to Medicare Part B of Florida
Roster billings of the PPV and flu vaccine must be mailed to the following address:
Medicare Part B Claims
P.O. Box 45031
Jacksonville, FL 32232-5031
Be sure to include photocopies of the appropriate HCFA-1500 claim form, front and back (the back of the HCFA-1500 claim form is on page 21), and a copy of the appropriate vaccine roster.

Filing Electronically
If you are interested in billing influenza virus vaccine and/or PPV claims electronically, here are some steps to help you get started:

- If you currently have a computer vendor, contact them to find out if they offer electronic claim submission capability;
- If your vendor does not offer electronic claims submission capability, the Provider Electronic Services (PES) marketing staff will furnish you with a list of vendors;
- Another option is the claims submission software developed by Medicare Part B of Florida's PES department.

By filing claims electronically, providers can expect to receive payment from Medicare Part B in 14 days as opposed to 27 days for paper claims. Please note, however, the claims cannot be sent electronically in the roster format; each claim must be entered on a per-beneficiary basis. For more information, contact the PES marketing area at (904) 791-8767.

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Page 17

Influenza Virus Vaccine Claims Only
Roster Billing

Sample of 1500 Form
NOT VIEWABLE IN THIS FORMAT

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Page 18

Influenza Virus Vaccine Roster

NOT VIEWABLE IN THIS FORMAT

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Page 19

Pneumococcal Pneumonia Virus Claims Only
Roster Billing Only

Sample of 1500 Form
NOT VIEWABLE IN THIS FORMAT

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Page 20

Pneumococcal Pneumonia Virus Vaccine Roster

NOT VIEWABLE IN THIS FORMAT

****

Page 21

Reverse side of HCFA1500 form

NOT VIEWABLE IN THIS FORMAT

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Page 22

90846 *1-90847 *1: Coverage For Family Counseling Services

Family medical psychotherapy services procedure codes 90846 *1 [Patient is not present] and 90847 *1 [Patient is present] are commonly used to

describe family participation in the treatment process of the patient. These services are covered only when a family member is physically present and where the primary purpose of such psychotherapy is the treatment of the patient's condition as in the following situations:

There is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members (procedure code 90847 *1);

There is a need to assess conflicts or impediments within the family, and assist, through psychotherapy, the family members in the management of the patient (procedure code 90846 *1 or 90847 *1).

Multiple-family group medical psychotherapy (procedure code 90849 *1) is intended for group therapy sessions for multiple families when similar dynamics are occurring due to a commonality of problems and is directed to the effects of the patient's condition on the family. However, this procedure code generally has restrictions because it may not meet the standards of being part of the provider's personal services to the patient.

Counseling principally concerned with the effects of the patient's condition on the family member would not be reimbursable as part of the physician's personal services to the patient. These services do not relate primarily to the management of the patient's problems, but instead involve treatment of the family member's problems.

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93990 *1: Billing for Duplex Scan of Hemodialysis Access

Medicare pays for outpatient maintenance of dialysis services furnished by End Stage Renal Disease (ESRD) facilities based on a composite payment rate. The composite rate is a comprehensive payment for a complete dialysis treatment. It is payment for all services, equipment, and supplies, including dialysis related testing and drugs that are necessary in order to provide dialysis to ESRD patients.

ESRD facilities are responsible for monitoring hemodialysis access sites. Procedures associated with monitoring access, including duplex scanning of hemodialysis access (93990 *1) are covered under the composite rate. The technical component of non-invasive vascular diagnostic studies of hemodialysis access sites is not covered as a separately billable service, as it is included in the composite rate. The professional component of such procedures is not separately payable if it is performed by the physician billing the monthly capitation rate for the patient.

If an ESRD patient requires non-invasive vascular studies of hemodialysis access, an ESRD facility must furnish the service, either directly or under arrangements which make the ESRD facility financially responsible for the service. If the service is performed by an alternate source, such as an independent physiological laboratory, that source must look to the ESRD facility for payment. Separate payment for the technical component of non-invasive vascular diagnostic studies of access sites for ESRD patients, whether coded as the access site or coded more generally as a peripheral site, is not permitted to any entity.

The only CPT code for billing of non-invasive diagnostic testing of a hemodialysis access site is 93990 *1. Separate billing of the technical component of this code will be denied if it is performed on any patient for which the ESRD composite rate for dialysis is being paid. This policy is applicable not only to claims from ESRD facilities, but also to claims submitted by other sources, such as independent physiological

laboratories, independent diagnostic testing facilities, or hospital outpatient departments.
This policy is effective for services furnished on or after December 1, 1997.

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Local and Focused Medical Review Policies

This section of the Medicare B Update! features new and revised medical policies developed as a result of either the Local Medical Review (LMR) or Focused Medical Review (FMR) initiatives. Both the LMR and FMR initiatives are designed to ensure the appropriateness of medical care and that the Carrier's medical policies and review guidelines are consistent with the accepted standards of medical practice.

Effective Dates
The policies contained in this section are effective for claims processed December 15, 1997, and after, unless otherwise specified.

Sources of Information
The sources of information used in the development of these policies may be obtained by accessing the B LINE BBS.

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Table Of Contents

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Billing for Noncovered Services
Page 31 of the September/October 1997 Medicare B Update! featured an article on Medicare Part B of Florida's noncoverage policy. As a result of this policy, the following questions and answers have been developed to assist providers in properly coding claims for noncovered services.
Q
Is documentation required when billing for a noncovered service using an unlisted procedure code (e.g., 95999 *1 - Surface electromyography)?

A
No. When filing electronically, the description of service must be entered in the narrative record. If your system does not support the transmission of narrative field data, contact your electronic claims software support vendor. Paper claim filers must enter a concise description of the service in item 19 of the HCFA-1500 claim form.
Q
Are there any instances where documentation should be submitted for a noncovered service?

A
Yes. Providers may request that procedures designated as noncovered be reevaluated for coverage. Such requests must be submitted in writing to the following address:

Medical Policy Department
P.O. Box 2078
Jacksonville, FL 32231

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In addition, the following documentation must be submitted:
Peer reviewed articles from appropriate medical journals;
Statements from authorities within the field;
FDA approval; and
Appropriate CPT/HCPC code.
National noncovered services will not be covered by Medicare Part B of Florida under any circumstance.
Q

Is an advance notice statement required for all services included in the noncovered policy?
A

No. An advance notice of Medicare's denial of payment should only be provided to the patient when the provider does not want to accept financial responsibility for a service that falls into one of the following categories:
- is considered investigational/experimental;
- not approved by the FDA; or
- there is a lack of scientific and clinical evidence to support the procedure's safety and efficacy.

These services are denoted with an asterisk (*) in the noncoverage policy.
Q

Several procedures/services contained in the noncoverage policy are listed using procedure code A9270. Why?
A

Since no CPT-4 procedure codes exist to report these procedures, Medicare Part B asks that providers use procedure code A9270 (noncovered service or item) to report such services. No documentation is required when procedure code A9270 is billed.

Note: An advance notice of Medicare's denial of payment must be provided to the patient when the provider does not want to accept financial responsibility for all services denoted with an asterisk (*).

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A9270:Noncoverage Coding Guidelines Clarified
A working list of medical services and procedures which are not covered by the Medicare program was published in the September/October 1997 Medicare B Update! The following procedure codes have been deleted from the list of noncovered services, because under specified conditions, they are covered by Medicare:
J0270 Injection, Alprostadil, per 1.25 mcg

58750 *1 Tubo-tubal anastomosis
93650 *1 Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement
93278 *1 Signal-averaging EKG (formerly M0540)

90846 *1 Family medical psychotherapy (without patient present)

75978 *1 PTA, venous, supervision/interaction only

93797 *1 Physician services for outpatient cardiac rehab without continuous ECG monitoring (per session)

96910 *1 Photo chemotherapy, PCT treatment
95075 *1
Challenge ingestion food testing for diagnosis of RA, depression, respiratory disorders

20974 *1 Electrical stimulation to aid bone healing, noninvasive
E0782 Implantable infusion pumps

The following services are currently not covered by Medicare, and their procedure codes are being added to the working list of noncovered services:

95999 *1 Current Perception Threshold Testing (CPT)
A9270 Autologous Chondrocyte Transplantation
A9270 Meniscal Allograft Transplantation

A9270 Urea Breath Test for H-Pylori
56805 *1 Clitoroplasty for intersex state
57335 *1 Vaginoplasty for intersex state

58321 *1 Artificial insemination; intra-cervical

58322 *1 Artificial insemination; intra-uterine

58323 *1 Sperm washing for artificial insemination

80050 *1 General health panel
****

G0063: Central Bone Mineral Density Studies
Page 33 of the September/October 1997 Medicare B Update! featured a comprehensive article on Bone Mineral Density Studies. Since that publication, the following two indications have been added to the Indications and Limitations of Coverage and/or Medical Necessity for procedure code G0063:
- For a woman with primary ovarian failure or post-ablative ovarian failure before the age of 40, who is suspected of having osteoporosis, and for whom a decision to treat with estrogen or bone mineral enhancing drugs is being made. A letter describing the medical necessity may be required if the test is done more than once.

- For a woman who is estrogen deficient and has a personal history of breast and/or uterine cancer if diagnostic information is needed to determine appropriate "nonestrogen" treatment for osteoporosis.

ICD-9 Codes That Support Medical Necessity (procedure code G0063)
For the two indications listed above, use ICD-9 code 256.2 (postablative ovarian failure) for secondary estrogen or ICD-9 code 256.3 (other ovarian failure) for primary estrogen deficiency.
Also, the following ICD-9 diagnosis code was published incorrectly in the September/October 1997 Medicare B Update!:
ICD-9 diagnosis code E923.7 should read E932.7.

Advance Notice Requirement
Applies to diagnosis requirements (see page 4).

Additional Guidelines
To ensure reliability of bone mass measurements, the densitometry technologist must have proper training in performing this procedure. Malpositioning of a patient or analyzing a scan incorrectly can lead to great errors in bone mineral density studies.

Mobile Densitometer Now Covered
That article also stated that bone mineral density studies performed on mobile instruments were noncovered because of the lack of sufficient data to determine its accuracy and precision. Since that publication, Medicare Part B of Florida has determined that bone mineral density studies may be performed in a mobile setting (i.e., a full body DEXA system housed in a motor vehicle that is transported from site to site). However, a portable densitometer (i.e., one that can be picked up and moved from one site to another and is used to perform peripheral measurements) remains noncovered.

****

G0100: HIV-1 Viral Load Testing
Viral Load testing is the direct measurement of the amount of free virus ribonucleic acid (RNA) in the blood of Human Immunodeficiency Virus (HIV) infected individuals.
HIV-1 viral load testing has become a tool for use by clinicians to assess the status of patients known to have HIV-1, as well as to manage therapy. Coding practices, based on existing CPT codes in the molecular diagnostics and microbiology sections of the American Medical Association Current Procedural Terminology manual, do not specify whether a viral load test was performed for HIV-1 or another antigen such as hepatitis,

tuberculosis, or chlamydia. The Health Care Financing Administration (HCFA) has established a new code (G0100) which will both simplify the claims process and allow Medicare to track the utilization of this service within the context of HIV. Therefore, local medical review policy has been developed to indicate the appropriate coverage guidelines.
Currently, there are three types of viral load tests, measuring RNA:
- branched DNA (bDNA) (Chiron) - identification of HIV RNA, then signal amplification by DNA branched-chain technique (Quantiplex HIV RNA assay) - limit of sensitivity: 10,000 copies/ml; sensitivity of 2nd generation assay reported as 100-1000 copies/dl

- NASBA (nucleic acid sequence-based amplification) (Organon Technika) - amplification of RNA of HIV - limit of sensitivity: 100-1000 copies/ml
- PCR (polymerase chain reaction) (Hoffman-La Roche Amplicor HIV-1 Monitor) - couple reverse transcription to a DNA PCR amplification - limit of sensitivity: 500 copies/ml.
At present, only the Roche Diagnostic Amplicor Test (R+T-PCR) has been approved by the FDA.

Indications and Limitations of Coverage and/or Medical Necessity
Effective April 7, 1997, Medicare Part B of Florida will consider HIV-1 viral load testing (G0100) to be medically reasonable and necessary for:
- monitoring HIV-1 disease progression, and
- assessing response to antiretroviral therapy.
Additionally, only those viral load tests which are FDA approved, are covered by Medicare. Currently, the only FDA-approved viral load test is the Roche Diagnostic Amplicor Test (also known as R+T-PCR).
****

Diagnosis Requirements
HIV-1 Viral Load testing (G0100) is covered by Medicare Part B of Florida when it is performed for the following condition/diagnosis:
042 Human immunodeficiency virus [HIV] disease.....

Reasons for Denial
HIV-1 Viral load testing (G0100) used for predicting maternal-fetal transmission of HIV-1 is considered investigational, and therefore, noncovered by Medicare.
Viral load testing performed by investigational methods not approved by the Food and Drug Administration such as Chiron Quantiplex (bDNA), Nucleic Acid Sequence-Based Amplification (NASBA), and testing procedures developed in-house by individual laboratories and commonly referred to as "home brews" are not covered by Medicare.
Coding Guidelines
Only HIV-1 viral load testing should be billed using procedure code G0100. Other types of viral load testing should continue to be coded as before.
No other codes (i.e., 82397 *1, 83890 *1-83912 *1, 86313 *1, and 87178 *1-87179 *1) will be paid in connection with HIV-1 viral load testing.

Documentation Requirements
Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the test. This information is usually found in office/progress notes

Additionally, laboratory results and the type of viral load testing performed must be documented. Currently, only the Roche Diagnostic Amplicor (R+T-PCR) is FDA-approved, and therefore covered.
If the provider of the service is other than the ordering/referring physician, that provider must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies. The physician must state the clinical indication/medical necessity for the study in his order for the test.

Advance Notice Requirement
Applies to diagnosis requirements (see page 4).

Gap-Fill Allowance
HCFA has instructed carriers to gap-fill the allowance for G0100. Therefore, G0100 (HIV-1 viral load, quantitative), has been approved effective April 7, 1997, with the allowance of $64.78.
****

J9999: Docetaxel (Taxoterer)
Docetaxel is an antineoplastic agent belonging to the taxoid family that acts by disrupting cell replication. It is a derivative of 10-deacetylbaccatin III, a compound extracted from the needles of the European yew tree. Taxotere is indicated for the treatment of patients with locally advanced or metastatic breast cancer, and it is useful in the treatment of a number of other cancers. Taxotere is a front-line agent in the treatment of metastatic breast cancer when anthracycline based therapy and other agents have failed.
Taxoterer for Injection Concentrate is indicated for the treatment of patients with locally advanced or metastatic breast cancer who have progressed or relapsed during anthracycline based therapy. It has also been demonstrated to be useful in the treatment of lung cancer, squamous cell cancer of the head and neck, ovarian cancer, gastric cancer, and malignant melanoma.

Coding Guidelines
When billing for Taxoterer use HCPCS code J9999 and the ICD-9 diagnosis code which indicates the medical condition being treated. The name, strength and dosage of the drug must be listed in Item 19 of the HCFA-1500 claim form. EMC senders should report this information in HA0 field 05.0.
Chemotherapy administration codes 96400 *1 through 96450 *1, 96542 *1, and 96549 *1 are used only in reporting chemotherapy administration when the drug being administered is an antineoplastic agent and the diagnosis is cancer.

Reasons for Denial
Clinical scenarios deviating from those outlined in the indications for coverage. Lack of medical record documentation.

Documentation Requirements
Documentation supporting the medical necessity for this service must accompany the claim. Documentation could be found in the office/progress notes, the history and physical, laboratory reports, pathology reports, and/or radiology reports.
****

L8603: Collagen Implants

A collagen implant, which is injected into the submucosal tissues of the urethra and/or the bladder neck and into tissues adjacent to the urethra, is a prosthetic device used in the treatment of stress urinary incontinence resulting from intrinsic sphincter deficiency (ISD). ISD is a cause of stress urinary incontinence in which the urethral sphincter is unable to contract and generate sufficient resistance in the bladder, especially during stress maneuvers.

Indications and Limitations of Coverage and/or Medical Necessity
Coverage of a collagen implant and the procedure to inject it, is limited to the following types of patients with stress urinary incontinence due to ISD:

Criteria for male patients, following an evaluation which must include a complete history and physical examination with a simple cystometrogram:
- stress incontinence of urine (788.32)
- following trauma, including prostatectomy and/or radiation
- congenital sphincter weakness secondary to conditions such as myelomeningocele, or epispadias
- acquired sphincter weakness secondary to spinal cord lesions
Criteria for female patients, following an evaluation which must include a complete history and physical examination (including a pelvic exam) and a simple cystometrogram to rule out abnormalities of bladder compliance and abnormalities of urethral support:
- documented type III stress urinary incontinence (625.6) with urodynamic evidence of intrinsic sphincter deficiency:
- urodynamically demonstrated low leak pressure of 100 cm H2O or less
- congenital sphincter weakness secondary to conditions such as myelomeningocele, or epispadias
- acquired sphincter weakness secondary to spinal cord lesions
Patients must be evaluated by a qualified health care professional to objectively diagnose stress incontinence. The workup should include a thorough history, physical and urodynamic evaluation. Urodynamic testing may include a provocative stress test, cystometrogram with leak point pressure and a cystourethrogram or videourodynamic study. The physician performing the injection procedure must have urology training in the use of cystoscope and be credentialed in collagen implant through an appropriate CME training course.
Prior to initiation of collagen implant therapy, a skin test for collagen sensitivity (95028 *1) must be administered and evaluated over a 4-week period.
Procedure code G0025 should be used to report collagen skin test kits. Coverage for the skin test kit is not dependent on a positive skin test indicative of an allergic reaction. The skin test kit may be billed in addition to the collagen implant.
Patients whose incontinence does not improve within 5 injection procedures (5 separate treatment sessions) are considered treatment failures and no further treatment of urinary incontinence by collagen implant is covered. HCFA is amending the lifetime limitation of five treatment sessions for patients who have received successful treatments in the past to allow latitude for the treating physician to decide whether additional sessions of collagen injection may be beneficial for these patients. Medical documentation must accompany claims for additional treatments beyond five.

HCPCS Code

L8603: Collagen implant, urinary tract, per 2.5 cc syringe, includes shipping and necessary supplies

Coding Guidelines
Collagen implant (L8603) claims will be processed by the Carrier. Endoscopic Injection Procedure (51715 *1) with collagen implant is indicated for use in the treatment of urinary incontinence resulting from intrinsic sphincter deficiency.

Documentation Requirements
Medical record documentation, supporting the medical necessity for this procedure must be maintained by the performing physician This documentation could be found in the office/progress notes, history and physical, and test results.

Advance Notice Requirement
Applies to medical necessity guidelines (see page 4).
****

45355 *1-45385 *1: Coverage for Colonoscopies
Colonoscopy allows direct visual examination of the intestinal tract with a flexible tube containing light transmitting glass fibers that return a magnified image. Colonoscopy can act as both a diagnostic and therapeutic tool in the same procedure. Therapeutic indications include removal of polyps or foreign bodies, hemostasis by coagulation, and removal of tumors.
This policy was reviewed as part of the Carrier's process of periodically evaluating all finalized policies. The review of the covered diagnosis list, revealed that a deletion to the list was needed to ensure that all services covered are medically necessary and reasonable. The policy is being published in its entirety.
Medicare Part B will consider a colonoscopy (procedure codes 45355 *1-45385 *1) to be medically necessary under any of the following circumstances:

- Evaluation of an abnormality on barium enema which is likely to be clinically significant, such as a filling defect or stricture.
- Evaluation and excision of polyps detected by barium enema or flexible sigmoidoscopy.
- Evaluation of unexplained gastrointestinal bleeding; hematochezia not thought to be from rectum or perianal source, melena of unknown origin, or presence of fecal occult blood.
- Unexplained iron deficiency anemia.
- Examination to evaluate the entire colon for simultaneous cancer or neoplastic polyps in a patient with a treatable cancer or neoplastic polyp.
- Evaluation of a patient with carcinoma of the colon before bowel resection. Post surgical follow up should be conducted annually for 2 years and every 2 years thereafter.
- Yearly evaluation with multiple biopsies for detection of cancer and dysplasia for patients with chronic ulcerative colitis who have had pancolitis of greater than seven years duration.

- Yearly evaluation with multiple biopsies for detection of cancer and dysplasia for patients with chronic ulcerative colitis who have had left-

sided colitis of over 15 years duration (not indicated for disease limited to rectosigmoid).

- Chronic inflammatory bowel disease of the colon when more precise diagnosis or determination of the extent of activity of disease will influence immediate management.

- Clinically significant diarrhea of unexplained origin.

- Treatment of bleeding from such lesions as vascular anomalies, ulceration, neoplasia, and polypectomy site (e.g., electrocoagulation, heater probe, laser or injection therapy).

- Foreign body removal.
- Decompression of acute non-toxic megacolon.

- Balloon dilation of stenotic lesions (i.e., anastomotic strictures)

- Decompression of colonic volvulus.

- Examination and evaluation when a change in management is probable or is being suspected based on results of the colonoscopy.

- Evaluation within 6 months of the removal of sessile polyps to determine and document total excision. If evaluation indicates that residual polyp is present, excision should be done with repeat colonoscopy within 6 months. After evidence of total excision without return of the polyp, repeat colonoscopy yearly.

- If a total colonoscopy is unsuccessful preoperatively due to obstructive cancer, repeat colonoscopy 3-6 months post-operatively unless unresectable metastases are found at surgery.

- Evaluation to differentiate between ulcerative and Crohn's colitis.

- Evaluation 3 years after resection of newly diagnosed small (œ 5mm diameter) adenomatous polyps when only a single polyp was detected. After 1 negative 3-year follow up examination subsequent surveillance intervals may be increased to 5 years.

- Evaluation at 1 and 4 year intervals after resection of multiple or large (3 10mm) adenomalous polyps. Subsequent surveillance intervals may then be increased to every 5 years.

- Evaluation of low to high grade dysplasia in flat mucosa by colonoscopy 6 months after undergoing aggressive medical therapy, especially when inflammatory changes were present.

- Evaluation in 1 year after the removal of multiple adenomas. If examination proves negative then repeat in 3 years. After 1 negative 3-year follow up examination, repeat exam every 5 years.

To ensure that payment is made only for medically necessary services, these procedures are covered only for the following diagnoses:

009.0-009.1

009.3
038.9
152.2
153.0-153.9
154.0-154.8
155.2
176.3
195.2
197.0
197.5
197.6
197.7
198.3
198.89
199.0
199.1
201.90
211.2
211.3
211.4
211.8
230.3
230.4
230.5
230.6
230.9
235.2
235.5
239.0
280.0
280.9
281.9
448.0
555.0-555.9
556.0-556.9
557.0-557.9
558.1-558.9
560.0
560.1
560.2
560.30-560.39
560.81-560.89
560.9
562.11
562.12
562.13
564.0
564.1
564.4
564.5
****

564.7
564.8
569.0
569.3

569.41
569.49
569.5
569.60-569.69
569.81-569.89
578.1
578.9
783.2
787.3
787.6
787.91-787.99
789.00-789.09
789.30-789.39
789.60-789.69
792.1
793.4
936
V10.05
V10.06
V12.72

Prior to January 1, 1997, a failed colonoscopy, e.g., the inability to extend beyond the splenic flexure, should be billed and paid as a sigmoidoscopy, (CPT code 45330 *1) rather than a colonoscopy, since this is the procedure that was actually performed. Procedure code modifier 22 *1 should be used and extra payment allowed only when supporting documentation indicates that significantly more time and effort is involved than is required in the typical sigmoidoscopy. The fact that a particular sigmoidoscopy was intended to be a colonoscopy does not in itself automatically justify the use of modifier 22 *1.
Effective January 1, 1997, incomplete colonoscopies should be billed as procedure code 45378-53 *1 beginning with services provided on or after January 1, 1997. Procedure code 45378-53 *1 is included in the 1997 Medicare Physician Fee Schedule Database (MPFSDB). The relative value units (RVU) will be the same as procedure code 45330 *1 (sigmoidoscopy). There will be no site-of-service reduction. Providers will be able to file claims for failed colonoscopies electronically.

Reasons for Denial
Medicare Part B cannot provide coverage for colonoscopy done as a screening test (including instances of high risk based on a family history of colon cancer).

Documentation Requirements
Medical record documentation (office/progress notes) maintained by the ordering/referring physician must indicate the medical necessity of the colonoscopy procedure covered by the Medicare program. The procedure results/report and any associated pathology report must be included in the patient's medical record.
If the provider of the colonoscopy is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of procedure results/report and pathology report along with copies of the ordering/referring physician's order for the procedure.

Advance Notice Requirement
Applies to diagnosis requirements (see page 4).
****

70450 *1-70470 *1: Computerized Tomography Scans
Page 54 of the March/April 1997 Medicare B Update! featured a list of diagnoses for which procedure codes 70450 *1-70470 *1 (computerized tomography scans) may be covered. Due to an oversight, the following diagnoses were not coded to the highest level of specificity:
Incorrect: 250.2, 250.3
Correct : 250.20-250.23, 250.30-250.33
Advance Notice Requirement
Applies to diagnosis requirement (see page 4).
****
72198 *1: MRA of the Pelvis
Page 27 of the September/October 1997 Medicare B Update! featured an article on Magnetic Resonance Angiography (MRA). Due to an oversight, procedure code 72198 *1 (MRA of the pelvis) was inadvertently left off of the list of investigational MRA procedures which are not covered by Medicare Part B.

Advance Notice Requirement
Applies to the investigation status of this procedure (see page 4).

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76090 *1, 76091 *1: Coverage for Diagnostic Mammography
As part of the Carrier's process to evaluate existing medical policy, it was determined that a revision in this policy was needed to ensure that this carrier was in compliance with Medicare regulations.
A diagnostic mammography involves obtaining exposures of the breast to provide specific analytical information to be used in problem solving for a suspected breast disease. A radiologist is available at the time of the study to review the images and request immediate additional evaluation if necessary.
As of January 1, 1996, the definition of diagnostic mammography has been expanded to include as candidates for this service men or women with signs or symptoms of breast disease, a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease. Previously, only symptomatic men or women were candidates for diagnostic mammography.
Medicare Part B covers diagnostic mammograms (procedure codes 76090 *1 and 76091 *1) when the beneficiary:
- presents signs, symptoms or physical findings suggestive of breast disease (e.g., lump, pain, nipple discharge or retraction, or skin changes such as dimpling, skin thickening or orange peel skin)
- has been or is being treated for breast cancer
- has a personal history of biopsy-proven benign breast disease.
Asymptomatic women without medical record documentation to support a personal history of breast cancer or biopsy-proven benign breast disease are candidates for screening mammography.
To ensure that medical necessity requirements are met, diagnostic mammography is covered for the following diagnosis:

174.0-174.8
175.0-175.9
198.2
198.81
217
233.0
238.3

610.0-610.8
611.0-611.8
793.8
879.0
879.1
996.54
V10.3
V15.89
V71.1

Coding Guidelines

All mammography facilities (both diagnostic and screening) require a certification number. The certification number should be placed in FAO record, field 31, field positions 142-151 (electronic claim submissions - National Standard Format) or Block 32 of the HCFA 1500 form (paper claim submissions).

If you perform these services and are not certified, please call the American College of Radiology at 1-800-227-5463 to begin the certification process. Please call the FDA Hotline at 1-800-838-7715 for other questions regarding certification numbers. Services performed by a non-certified center or by a facility whose certificate is suspended or revoked will be denied.

Documentation Requirements

If you refer a patient for mammography, include the following information in your order:

- the ICD-9 diagnosis code that reflects the reason for the test;
- the type of test (diagnostic);

The provider should maintain on file records which support medical necessity. This information is usually found in the history and physical and progress notes.

If you perform the mammography test, obtain the following information:

- a physician's order that specifically prescribes diagnostic mammogram as well as the medical reason for the test; and
- the radiology report must be maintained on file.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

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Certification and Accreditation Requirements for Diagnostic Ultrasound, Echocardiography and Noninvasive Vascular Studies

The accuracy of diagnostic ultrasound, echocardiography and noninvasive vascular studies depends on the knowledge, skill, and experience of the technologist and interpreter. Inaccurate tests can lead to erroneous medical decisions resulting in major negative consequences to the beneficiary. Consequently, the providers of interpretations must be capable of demonstrating documented training and experience and maintain documentation for postpayment audit.

Diagnostic Ultrasound and Echocardiography (HCPCS codes 76506 *1 - 76999 *1 and 93303 *1 - 93350 *1)

Medicare reimburses for diagnostic ultrasound and echocardiography procedures under the following conditions:

All procedures must be either (1) performed by, or under the direct supervision of, a physician, (2) performed by persons that have demonstrated

minimum**********

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level competency by being credentialed in the specific type of procedure being performed, or (3) performed in laboratories accredited in the specific type of evaluation. Direct supervision requires the physician's physical presence in the facility during the examination.
Appropriate Personnel Certification includes but is not limited to:
- The Registered Diagnostic Medical Sonographer (RDMS) credential
- The Registered Diagnostic Cardiac Sonographer (RDCS) credential
- The Registered Cardiovascular Technologist (RCVT) credential
- The Certified Ophthalmic Medical Technologist (COMT) credential
Each credential must include the specialty area for the examination to be performed. Some examples of appropriate specialty areas for specific Current Procedural Terminology (CPT) Codes are listed below.

CPT Code: 76506 *1 and 76800 *1
Certification: RDMS: Neurosonology

CPT Code: 76511 *1 - 76529 *1
Certification: RDMS: Ophthalmology, or COMT

CPT Code: 76536 *1, 76645 *1 - 76775 *1, and 76870 *1 - 76880 *1
Certification: RDMS: Abdomen

CPT Code: 76805 *1 - 76857 *1, 76941 *1, and 76945 *1 - 76948 *1
Certification: RDMS: Obstetrics & Gynecology

CPT Code: 93303 *1 - 93350 *1
Certification: RDCS: Adult or Pediatric Echocardiography, or RCVT: Noninvasive Cardiac

Appropriate Laboratory Accreditation includes but is not limited to:
-The Ultrasound Practice Accreditation Commission (UPAC) of the American Institute of Ultrasound in Medicine (AIUM)
- The Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL)
- The American College of Radiology (ACR)

Each accreditation must include the specialty area for the examination being performed.
For indications and limitations of coverage for individual CPT codes, refer to the specific local medical review policy for that code.

Noninvasive Vascular Studies (HCPCS codes 93875 *1 - 93991 *1 and 76936 *1)
Medicare reimburses for noninvasive vascular studies under the following conditions:
All noninvasive vascular studies must be either (1) performed by, or under the direct supervision of, a physician, (2) performed by persons that have demonstrated minimum entry level competency by being credentialed in vascular technology, or (3) performed in laboratories accredited in vascular technology. Direct supervision requires the physician's physical presence in the facility during the examination.
Appropriate Personnel Certification includes but is not limited to:
- The Registered Vascular Technologist (RVT) credential
- The Registered Cardiovascular Technologist (RCVT) credential in Vascular Technology

** In addition to the appropriate certification, providers of Transcranial Doppler (TCD) studies must show evidence of attendance at a formal TCD training program that includes hands on experience and results in a certificate of proficiency and a minimum experience of 100 TCD examinations.

Appropriate Laboratory Accreditation includes but is not limited to:

- The Ultrasound Practice Accreditation Commission (UPAC) of the American Institute of Ultrasound in Medicine (AIUM)
- The Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL)
- The American College of Radiology (ACR)

For indications and limitations of coverage for individual CPT codes, refer to the specific local medical review policy for that code.

Reasons for Denial
Services will be denied when performed by a person and/or laboratory that is not properly certified or accredited to do so. Services will also be denied if documentation does not support the medical necessity of the services performed.

Documentation Requirements
The providers of interpretations must maintain documentation that supports that the services were performed by those properly credentialed or accredited to do so. Documentation must also support that the services performed were medically necessary.

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82172 *1: Apolipoprotein Considered Routine Screening
The July/August 1997 Medicare B Update! featured an article on Coverage for Lipid Profile/Cholesterol Testing which included the medical necessity guidelines for procedure codes 80061 *1, 82172 *1, 82465 *1, 83715 *1, 83717 *1, 83718 *1, 83719 *1, 83721 *1 and 84478 *1. To clarify this policy, procedure code 82172 *1 is always considered a screening test, and is never covered by Medicare Part B of Florida regardless of the diagnosis submitted.
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82784 *1: Gammaglobulin (Immunoglobins); IgA, IgD, IgG, IgM, Each
Page 31 of the July/August 1997 Medicare B Update! featured a comprehensive article on Gammaglobulin (Immunoglobins); IgA, IgD, IgG, IgM, each (procedure code 82784 *1). Since that publication, the list of conditions which may require monitoring therapy has been expanded. After a diagnosis has been made, performing serum gammaglobulin tests may not be medically necessary or reasonable, except in cases of monitoring a patient's propensity to infection; monitoring therapy such as is done with myelomas (particularly IgG or IgA myeloma), IgM disorders (Waldenstrom's macroglobulinemia and lymphoma), or Immune Globulin Therapy; and/or monitoring the advancement of a disease.
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80162 *1: Digoxin Assay
On page 26 of the July/August 1997 Medicare B Update!, the coverage criteria for Digoxin Assay (procedure code 80162 *1) were published.

Since the publication of that article, the following diagnosis has been added: E942.1 (digoxin toxicity).

Advance Notice Requirement
Applies to diagnosis requirements (see page 4).
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86430 *1: Rheumatoid Factor
The blood of many individuals with rheumatoid arthritis (RA) contains a macroglobulin-type antibody called rheumatoid factor (RF). Evidence indicates that rheumatoid factors are antigammaglobulin antibodies; however, a specific antigen that produces RF has not been discovered. It is believed that a genetically susceptible individual develops abnormal or altered immunoglobulin G (IgG) antibodies when exposed to an antigen. This altered IgG antibody isn't recognized as "self," and the individual forms an antibody against it, known as RF, which is directed against the Fc fragment of IgG. Most rheumatoid factors are the IgM type. Less commonly, rheumatoid factors are the IgG or IgA variety. By aggregating into complexes, RF generates inflammation.
Medicare will consider rheumatoid factor testing to be medically necessary when it is performed on those patients whose clinical diagnosis is highly suspicious for rheumatoid arthritis and the test is needed to help confirm the diagnosis. Rheumatoid factor testing would be medically indicated after it has been demonstrated that the clinical examination is unable to distinguish between rheumatoid arthritis and the following conditions:
- Chronic interstitial fibrosis
- Chronic hepatitis disease
- Fibromyalgia
- Infectious mononucleosis
- Polymyositis
- Psoriatic arthritis
- Reiter's syndrome
- Sarcoidosis
- Scleroderma
- Syphilis
- Systemic lupus erythematosus
- Tuberculosis

Diagnosis Requirements
To ensure that payment is made only for medically necessary services, rheumatoid factor testing is covered only when it is performed for the following diagnoses:

015.0-015.9
075
095.8
099.3
135
273.2
274.0
446.5
516.3
571.9
695.4
701.0
710.0-710.4
710.9

711.10-711.39
712.10-712.99
713.0-713.6
714.0-714.2
714.30-714.33
714.4
714.49
714.81
714.89
714.9
725
729.1

Documentation Requirements

Medical records maintained by the physician must substantiate the medical necessity for this test by documenting the condition for which the test was ordered. This documentation could be found in the history and physical or in the office/progress notes.

Reasons for Denial

Rheumatoid factor testing will not be covered by Medicare Part B when performed on a routine screening basis in the absence of abnormal signs and symptoms.

Advance Notice Requirements

Applies to diagnosis requirements (see page 4).

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95857 *1, 95858 *1: Tensilon Test

Analysis of January through June 1996 claims data indicated that tensilon test for myasthenia gravis; with electromyographic recording (CPT code 95858 *1) has been billed substantially more in Florida than at the national level for specialty 01 (General Practice). This procedure code was selected for 1997 Focus Medical Review (FMR). Further analysis of the data indicated that this procedure code was being billed with diagnoses that do not support medical necessity, and the procedure was being billed at frequent intervals. Therefore, this policy was created to establish the condition/illnesses for which Medicare Part B of Florida will consider the service to be medically reasonable and necessary. The Tensilon Test medical policy includes procedure codes 95857 *1 (Tensilon test for myasthenia gravis) and 95858 *1 (Tensilon test for myasthenia gravis; with electromyographic recording).

The tensilon test involves careful observation of the patient following intravenous administration of tensilon (edrophonium chloride), a rapid, short-acting anticholinergic agent that improves muscle strength by increasing muscular response to nerve impulses. It is especially useful in diagnosing myasthenia gravis, an abnormality of the myoneural junction in which nerve impulses fail to induce normal muscular responses.

When tensilon testing is performed on a patient with myasthenia gravis there is a sudden, short-lasting improvement in muscle strength. When the test is performed to differentiate between myasthenic and cholinergic crisis, patients with myasthenic crisis improve, but those with cholinergic crisis worsen. Dangerous cardio-respiratory depression can occur, and facilities to maintain respiration and atropine (as an antidote) must be available during the test.

Electromyography testing may supplement tensilon testing in diagnosing myasthenia gravis. Electromyography is the recording of the electrical

activity of selected skeletal muscle groups at rest and during voluntary contraction. In this test, a needle electrode is inserted percutaneously into a muscle. The electrical discharge (or motor unit potential) of the muscle is then displayed and measured on an oscilloscope screen.

Indications and Limitations of Coverage and/or Medical Necessity
To ensure that payment is being made only for medically reasonable and necessary services, Tensilon Test is covered for the following conditions:

- To aid diagnosis of myasthenia gravis
- To help distinguish myasthenic from cholinergic crises
- To monitor oral anticholinesterase therapy.

Diagnosis Requirements
Medicare Part B will consider Tensilon Test to be medically reasonable and necessary when performed for the following conditions/diagnoses:

358.0
368.2
374.30
378.73
728.9
780.7
784.5
786.09
787.2

Coding Guidelines
Procedure code 95858 *1 includes electromyographic recording. You would not expect to see other EMG codes performed on the same day of service. There may be a rare circumstance when you may see a patient have EMG studies performed which were not conclusive, followed by tensilon testing with electromyographic recording to try to establish a diagnosis of myasthenia gravis.

Reasons for Denial
Services submitted with diagnoses other than those listed as covered ICD-9 codes will not be eligible for coverage. Screening services are not a benefit of Medicare.

Advance Notice Requirement
Applies to diagnosis requirements (see page 4).

Documentation Requirements
Medical record documentation maintained by the ordering/referring physician must include the medical necessity for performing this test (including a neurologic history, examination, and documentation of neurologic symptomatology), Tensilon Testing results, and if performing 95858 *1, a copy of the electrographic recording. This information is usually found in the office/progress notes and/or history and physical.
If the provider of the service is other than the ordering/referring physician, the provider must maintain hard copy documentation of test result(s) and interpretation, along with copies of the ordering/referring physician's order for the test(s). The physician must state the clinical indication/medical necessity for the study in his order for the test.
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95860 *1, 95861 *1, 95863 *1, 95864 *1: Electromyography
Analysis of January through June 1996 claims data indicated that needle electromyography, four extremities and related paraspinal areas (CPT code 95864 *1) has been billed substantially more in Florida than at the national level for specialty 01 (General Practice) and 13 (Neurology). This procedure code was selected for 1997 Focus Medical Review (FMR). Additional analysis of the data indicated that this procedure code was being billed at frequent intervals. Therefore, this policy was created to establish the conditions/illnesses for which Medicare Part B of Florida will consider the service to be medically and reasonable and to establish medical review guidelines. The Electromyography medical policy includes procedure codes 95860 *1 (Needle electromyography, one extremity and related paraspinal areas), 95861 *1 (Needle electromyography, two extremities and related paraspinal areas), 95863 *1 (Needle electromyography, three extremities and related paraspinal areas), and 95864 *1 (Needle electromyography, four extremities and related paraspinal areas).
Electromyography (EMG) includes the insertion of a needle electrode into skeletal muscle to measure electrical activity and assess physiologic function. In this procedure, percutaneous, extracellular needle electrodes are placed into a selected muscle group. Muscle action potentials are detected by these electrodes, amplified, and displayed on a cathode ray oscilloscope. In addition, fluctuations in voltage are heard over a loudspeaker, permitting both auditory and visual analysis of the muscle action potentials.
Testing is performed with the muscle at rest, with mild voluntary contraction, and with maximal muscle contraction. When a normal muscle is completely relaxed, no electrical activity can be detected in it. When a voluntary contraction is induced, the record shows the characteristic response of a motor unit which is usually biphasic, that is, shows a positive followed by a negative phase. As the contraction increases in strength, more and more motor unit contractions are added to the record . In various diseases of the motor system, typical electrical abnormalities may be present: increased insertional activity, abnormal motor unit potentials, fibrillations, fasciculations, positive sharp waves, decreased recruitment pattern, and others. EMG assesses the integrity of upper motor neurons, lower motor neurons, the neuromuscular junction, and the muscle itself.
EMG is seldom diagnostic of a particular disease entity. Its major use is differentiating between the following disease classes: primary myopathy, peripheral motor neuron disease, and disease of the neuromuscular junction.

Indications and Limitations of Coverage and/or Medical Necessity
Medicare Part B will consider Electromyography testing medically necessary and reasonable when performed under the following circumstances:

Evaluation of the patient with clinical features of primary muscle disease (symmetric and proximal weakness, muscle atrophy, intact sensory system, etc.) Examples include:
- muscular dystrophy
- glycogen storage disease
- myotonia

- inflammatory myopathies (systemic lupus, sarcoidosis, infectious myopathies)
- polydermatomyositis
- alcoholic myopathy
- endocrine myopathies

Evaluation of the patient with suspected lower motor neuron disease, including:
- suspected peripheral nerve lesions, such as diffuse peripheral neuropathies, spinal root lesions, and trauma
- suspected disease of the anterior horn cells (characterized by asymmetric weakness, muscle atrophy, fasciculations), as in amyotrophic lateral sclerosis or poliomyelities

Evaluation of a patient with suspected upper motor neuron disease, including:
- occult lesions of the corticospinal tract (syringomyelia, tumor)
- lesions of the cerebral tract (tumor, CVA)

Evaluation of patient with suspected neuromuscular junction disease, including:

- myasthenia gravis
- paraneoplastic Eaton-Lambert syndrome

This test may be used to monitor the response to therapy for known cases of myopathy or neuropathy.
For asymptomatic patients, EMGs would be considered screening in the absence of signs and symptoms. It is expected that this procedure should only be performed when medically reasonable and necessary for the patient's condition. This procedure should not be repeated unless there is a documented need to 1) evaluate the effectiveness of various treatments or 2) evaluate a worsening or modification in the patient's symptomatology.
Coding Guidelines
The number of limbs tested should be the minimum needed to differentiate between diseases.
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Reasons for Denial
Screening services are not a benefit of Medicare

Advance Notice Requirements
Applies to medical necessity guidelines (see page 4).

Documentation Requirements
Medical record documentation maintained by the ordering/referring physician must include the medical necessity for performing this test (including a neurologic history, examination, and documentation of neurologic symptomatology) and EMG test results. This information is usually found in the office/progress notes and/or history and physical. If the provider of the service is other than the ordering/referring physician, the provider must maintain hard copy documentation of test result(s) and interpretation, along with copies of the ordering/referring physician's order for the test(s). The physician must state the clinical indication/medical necessity for the study in his order for the test. The

physician must indicate which limb(s) or muscle group(s) are to be tested.
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95900 *1, 95903 *1, 95904 *1: Nerve Conduction Studies
On pages 30 and 31 of the May/June 1997 Medicare B Update!, the coverage criteria for Nerve Conduction Studies (procedure codes 95900 *1, 95903 *1, and 95904 *1) were published. Since the publication of that article, the following diagnosis range has been added:

337.20-337.29 (Reflex sympathetic dystrophy).

Advance Notice Requirement
Applies to diagnosis requirements (see page 4).
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95999 *1: Current Perception Threshold Testing
Current Perception Threshold testing (neurometer CPT) is a somatosensory test that measures peripheral nerve conduction function to diagnose the extent of certain neuropathies. Effective for services rendered June 16, 1997, and after (see pages 30 and 31 of the May/June 1997 Medicare B Update!), CPT testing (95999 *1) was covered by Medicare Part B of Florida. Effective for claims processed December 15, 1997, and after, CPT testing is considered part of the evaluation and management aspect of the physician's service and should not be billed separately. Additionally, it is inappropriate to report this service as nerve conduction studies (95900 *1, 95903 *1, 95904 *1).
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99183 *1: HBO Denials
Medicare's Coverage Issues Manual (CIM) houses Medicare's national coverage decisions. All decisions made are based upon 1862(a)(1) of the Social Security Act unless otherwise specified. 1862(a)(1) speaks to the preface that no program payment may be made for items and services not found to be reasonable and medically necessary. According to national coverage policy, Hyperbaric Oxygen therapy may not be covered for twenty two specific medical conditions outlined under Section 35-10 paragraph B (which can be found in Local Medical Review Policy 99183 *1). At a national level, Medicare has made the decision that it is not reasonable and necessary to receive HBO treatments for these conditions.

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CLOSER LOOK

In the Medicare B Update!, "A Closer Look" provides in-depth and comprehensive information on topics of interest to the provider community. In this issue, "A Closer Look" addresses the following topic:

The Audio Response Unit (ARU)
In this article, the following issues will be addressed:
- Benefits of the ARU;
- What you need to do to use the ARU;
- How to enter a Medicare number;

- Status requests; and

- Examples of ARU speed calling.

Also, as of October 1, 1997, eligibility and deductible information are available ONLY by using the Audio Response Unit (ARU).

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What's New
Eligibility and deductible information are now available only by using the Audio Response Unit (ARU). As of October 1, 1997, this information will no longer be given by the Customer Service Representatives on the telephone.

Benefits
The good news about this process is that you no longer need to have the patient available to speak to Medicare when you want this information. All you need is:
- The Express Line telephone number, which is (904) 353-3205;
- A touch-tone phone; and
- The patient's Medicare number.

What You Will Receive
Once the ARU accepts the Medicare number you keyed, it will tell you if the patient is currently eligible for Medicare benefits or if he/she is currently enrolled in a Health Maintenance Organization (HMO). It will also tell you if the patient has or has not met his/her deductible.
The information you will receive is the most current information available on the Medicare Part B of Florida processing system.
If Social Security's files have been recently changed, or if the patient has had services rendered out of state, the information you receive may not be the most current.
In this case, the Medicare system in Florida will be updated once a claim is processed for the patient.

What You Need to do to Use the ARU
- Call the Express Line at (904) 353-3205;
- Press 3 from the main menu;
- Enter the patient's Medicare number;
- Get the information_it's that easy!

How to Enter a Medicare Number
The following are the instructions the ARU will give you to enter a Medicare number.

ARU:
"I will need the patient's Medicare number in order to help you. If the number begins with a letter, the patient is normally covered by a Travelers insurance policy. You will need to verify this information with the patient and Social Security.
"For all other Medicare numbers, press one.
"The number consists of nine numbers followed by a letter. Please enter the first nine numbers.
"If there are two letters following the number, press 2; otherwise, press 1 now.
"There is a letter following the number you just entered. If the letter is:
A, press 1
B, press 2
C, press 3
D, press 4
M, press 5
T, press 6."
If any other letter, press 7.
"If you need instructions on entering alphabetical characters, press the pound sign.
"If you would like to enter the suffix and know how to key an alphabetical character, please key your letter or letters now followed by the # key."

How to Enter a Letter
To enter a letter, you must press three keys. First, press the star (*) key to indicate you are entering a letter. Second, press the key containing the letter you wish to enter. Third, press the number 1, 2, or 3, depending on the position of the letter on that key. For example: to enter the letter A, press *, 2, 1. To enter letter B, press *, 2, 2. The letters Q and Z do not appear on the telephone key pad. To enter the letter Q, press *, 1, 1. To enter the letter Z, press *, 1, 2.
After you have entered the alpha letter or letters, press the # key to complete the process.
If the Medicare number ends in two letters, follow the instructions you just heard. For example, to enter the suffix TA, you would press *, 8, 1, * 2, 1.
If there is a number after the letter or letters, press that number now.
If there is no number following the letter or letters, press the # key.
ARU:
"You entered
"If this is correct, press one.
"If this is not correct and you would like to reenter the Medicare number, press two."
Example: Medicare number is 123456789TA. Key 1- 2- 3- 4- 5- 6- 7- 8- 9- *- 8- 1- *- 2- 1-#.

Status Request
If you are currently calling our office to get status of claims you have submitted for payment, you will now have to use the ARU to receive this information. The Customer Service Representatives will no longer be able to provide this information on the phone line. To receive a claim status, you will need to call the Express Line at (904) 353-3205. This is the most efficient and cost-effective way to respond to this type of inquiry. To receive information from the system, callers will need to have the following information ready:

- A touch-tone phone;
- Your 5-digit Medicare provider number (12345)
- The patient's 9-digit Medicare number (123456789A)
- The date of service (MMDDYY format).

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The system will request that the caller enter his provider number using the telephone key pad. It will provide instructions on how to do this, if needed. When the provider number is entered, callers will hear the main menu. The main menu will list available information, and ask the caller to make a choice. Depending on the choice, the caller may be asked to enter the patient's Medicare number and the date of service. As the caller enters the requested data, the system will retrieve the information and repeat it back to you.
The services available through the system include:
A
Information about new legislation and other provider issues (press 1). This option gives the choice of listening to several informational messages. Callers can listen to as many of the messages as they would like.

B
Information about the status of a claim (press 2).

When this choice is made, the caller will be asked to enter the patient's Medicare number and the date of service of the claim for which the caller is requesting the status. The ARU will respond with the following information on an assigned claim:
- Amount allowed;
- Amount paid;
- Check number;
- The date the check was issued; and
- Date the check was cashed.

After this information is provided, callers will also be offered more specific details about their claims. With this option, the ARU will advise you if any procedures were denied payment on the claim. In many situations, the caller will be informed of the reason for the denial.

On a non-assigned claim, callers will be advised if we have begun processing the claim. If Medicare Part B of Florida has begun processing the claim, the caller will be informed if it has completed processing. (Medicare Part B can only release payment information regarding non-assigned claims to the patient or to someone else after obtaining the patient's permission.
C
Receive eligibility and deductible information currently on the Medicare processing system (press 3).

D.
Receive the number of pending and finalized claims that are currently on file in the Medicare processing system for the caller's provider number (press 4)

With this choice, the caller will be informed of the number of claims Medicare is currently processing for him/her, as well as the number of claims that have been completed to date.
D-1
To receive the year-to-date amount paid to them by Medicare (press 4).
Callers who choose this option will receive the year-to-date amount that Medicare has paid to their provider number.

E
To receive information about the most recent Medicare check on file for their provider number (press 5).
With this choice, callers will be informed the check number, the date it was issued, and the amount of the most recently issued check.
F
To repeat this menu (press 7).
The above is the current main menu. When calling, providers do not have to listen to the entire menu if they know which number to press for their choice. Callers can press that number at the beginning of the menu and will be immediately provided the information they need.

Benefits of the ARU
The ARU is available for extended hours. The hours of the ARU are:
7:30 a.m. until 5:30 p.m. on Monday
7:30 a.m. until 6:30 p.m. Tuesday through Friday.

When callers use the ARU, they have 15 minutes in which to get as much data as they can. Callers don't have to wait for the prompts to key their information. All they need to do is start keying the data as soon as the system answers, and it will provide them with the requested information in an instant.
Callers can change the provider number during the call, so that they can obtain information for multiple providers during a single call. Also, they are able to change the patient's Medicare numbers on the claim status option. This allows them to receive status information for several claims during the same call.

Examples of ARU Speed Calling
Example One: Provider number with numeric characters only.

Provider number: 12345
Patient's Medicare number: 123456789A
Date of service of the claim: January 1, 1997
You would enter: 12 12345 # 21 123456789 1 # 010197.....

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In sequential order, it would be:

Number/Character Entered: 1
Description: Access to the ARU

Number/Character Entered: 2
Description: You are telling the ARU that you are going to enter your provider number.

Number/Character Entered: 12345

Description: Your provider number.

Number/Character Entered: #
Description: You are telling the ARU that you are requesting the status of a claim

Number/Character Entered: 21
Description: You are telling the ARU that you are going to enter the patient's Medicare number

Number/Character Entered: 123456789
Description: The patient's nine-digit Medicare number.

Number/Character Entered: 1
Description: The alpha character "A" at the end of the Medicare number.

Number/Character Entered: #
Description: You are telling the ARU that you have completed entering the patient's Medicare number.

Number/Character Entered: 010197
Description: The date of service of the claim.

Example Two: Provider number that begins with a letter.

Number/Character Entered: Provider number
Description: A1234.....

Number/Character Entered: Patient's Medicare number
Description: 123456789T

Number/Character Entered: Date of service of the claim
Description: May 1, 1997

Number/Character Entered: You would enter
Description: 12*21 1234 #21 123456789 5 # 050197

Look at this in sequential order:

Number/Character Entered: 1
Description: Access to the ARU

Number/Character Entered: 2
Description: You are telling the ARU that you are going to enter your provider number

Number/Character Entered: *
Description: You are telling the ARU that your provider number begins with a letter.

Number/Character Entered: 2
Description: You are indicating the button on which the letter is located

Number/Character Entered: 1
Description: You are indicating the position of the letter on the button.

Number/Character Entered: 1234
Description: The remaining numbers of your provider number

Number/Character Entered: 3
Description: You are telling the ARU that you have completed entering your provider number.

Number/Character Entered: 2
Description: You are telling the ARU that you are requesting the status of a claim.

Number/Character Entered: 1
Description: You are telling the ARU that you are going to enter the patient's Medicare number.

Number/Character Entered: 123456789
Description: The patient's nine-digit Medicare number

Number/Character Entered: 5
Description: The alpha character "T" at the end of the Medicare number.

Number/Character Entered: #
Description: You are telling the ARU that you have completed entering the patient's Medicare number.

Number/Character Entered: 050197
Description: The date of service of the claim.

Example Three: Laboratory
Provider number: L8355
Patient's Medicare number: 123456789T
Date of service of the claim: May 1, 1997
You would enter: 12*53 8355 #21 123456789 5 # 050197.....

Look at this in sequential order:

Number/Character Entered: 1
Description: Access to the ARU

Number/Character Entered: 2
Description: You are telling the ARU that you are going to enter your provider number.

Number/Character Entered: *
Description: You are telling the ARU that your provider number begins with a letter.

Number/Character Entered: 5
Description: You are indicating the button on which the letter is located

Number/Character Entered: 3
Description: You are indicating the position of the letter on the button

Number/Character Entered: 8355
Description: The remaining numbers of your provider number.

Number/Character Entered: 3
Description: You are telling the ARU that you have completed entering your provider number.

Number/Character Entered: 2
Description: You are telling the ARU that you are requesting the status of a claim.

Number/Character Entered: 1
Description: You are telling the ARU that you are going to enter the patient's Medicare number

Number/Character Entered: 123456789
Description: The patient's nine-digit Medicare number.

Number/Character Entered: 5
Description: The alpha character "T" at the end of the Medicare number.

Number/Character Entered: #
Description: You are telling the ARU that you have completed entering the patient's Medicare number.

Number/Character Entered: 050197
Description: The date of service of the claim.

Medicare Part B is dedicated to ensuring customer satisfaction with our services, and is continually striving for enhancement. We greatly appreciate your feedback, comments, suggestions for improvement, or concerns. Please send them to the following address:
Medicare Part B
P.O. Box 2078
Jacksonville, FL 32231
Att'n: Rita Sheppard

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ELECTRONIC MEDIA CLAIMS

What's New for EMC?

Medicare's Free Gift: PC-ACE Software
Medicare has a Free Gift for your medical practice that will help you receive claim payments faster and reduce administrative costs - are you interested?
PC-ACE Electronic Claims Submission (EMC) software can save your medical practice time and money when filing insurance claims for payment. PC-ACE will:

- Reduce costs in purchasing HCFA-1500 forms;
- Reduce costs for postage, as claims are submitted without them (save your stamps for other uses);
- Reduce time spent completing insurance forms;

- Prevent payment delays because cleaner claims will be submitted; and
- Lessen payment floor delays, as clean electronic claims are paid on the 14th day versus 27 days for paper claims.

Receive your free gift from Medicare that will provide numerous benefits to your medical practice by contacting the Provider Electronic Services (PES) area at (904)791-8767.

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Why Use Electronic Media Claims?

Electronic Media Claims (EMC) filing was created to enable providers' and suppliers' claims to be received at Medicare the same day of transmission. Due to increasing volume of claims being filed to Medicare Part B, this is an ongoing effort to expedite payments and to maintain cost effectiveness to both Medicare carriers and Medicare providers. EMC is rapidly changing to improve services and enhance features to better serve all Medicare customers.

There are several ways to submit claims electronically:

System to System - The computer you currently have in your office can be used for this purpose. Upgrading your software and purchasing a modem (if necessary) is all it takes.

Leased Terminals - These are available through computer companies, clearinghouses and billing services.

Service Bureaus, Billing Services, and Clearinghouses - These are companies that specialize in sending claims electronically to Medicare. You can send your claims seven days a week, 24 hours a day. If you are a participating provider, you can use the toll-free WATS line; if you are non-participating, you only pay for any long-distance telephone charges that apply.

In the past, only a few kinds of claims could be submitted electronically, but in the last several years Medicare has expanded the claims to include:

- All physicians' claims
- Ambulance
- Ambulatory Surgical Center
- Anesthesia
- Chiropractic
- Dialysis
- Extended Care Facility/Skilled Nursing Facility
- Hospital (Inpatient & Outpatient)
- Independent Laboratory
- Nursing Home
- Ophthalmologists
- Optometrists
- Physical Therapy
- Podiatry
- Portable X-Ray
- Psychiatric
- Radiology
- Third Party Prescription Drug

Some surgical claims may be sent electronically. Call the Provider Customer Service department at (904) 634-4994 to find out if your specific claim can be submitted electronically.

If you are still filing claims on paper claim forms, consider this!

Disadvantages to Paper Claims

- Higher administrative costs (i.e., stamps, envelopes, claim forms). The cost is estimated to be about $1.50 per claim;
- 27 days processing time for clean claims;
- Additional Development letters;
- Manual posting of accounts receivable;
- No acknowledgment of receipt of claims; and
- Additional staff.

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Advantages to EMC Claims

- Less administrative cost. The cost is estimated to be about fifty cents per claim;
- 14 days processing time for clean claims;
- Fewer Additional Development letters;
- Electronic posting of accounts receivables (ERN) saving your office time and money;
- Confirmation report stating receipt of your claims;
- Eliminate possible keying errors - You key the claims, you're in control;
- Lines available 24 hours a day, seven days a week;
- Toll-free access to sending claims for participating providers;
- Electronic eligibility information;
- Electronic Rejects; and
- Certificate of Medical Necessity for Ambulance and Chiropractor.

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CLIA Number Requirements for Electronic Claims

The Health Care Financing Administration has mandated that effective for claims processed on or after January 1, 1998, claims for clinical diagnostic and physician office laboratory services must contain the 10-digit Clinical Laboratory Improvement Amendments (CLIA) number in the FA0 record, field 34, positions 164-178, of the National Standard Format. Providers will be given a grace period from October 1, 1997 through December 31, 1997. During this time frame, providers will receive an informational message on their remittance advice notices indicating the upcoming need for the CLIA number.

Tests performed at more than one CLIA lab for the same beneficiary on the same day must be submitted on separate claims. Claims submitted with more than one CLIA number will be rejected.

Beginning January 1, 1998, laboratory claims billed electronically with either no CLIA number or a CLIA number formatted incorrectly will be rejected with the message: INV/MISS CLIA1. This requirement applies to both physician office laboratories and independent clinical laboratories. Providers may start submitting this information as soon as the capability is developed in their software.

For additional information on CLIA compliance, see page 8.

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Dinosaurs are extinct and paper claims soon will be. Before you become an exhibit at the history museum, call (904) 791-8767 for more information on EMC.

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Billions of taxpayer dollars are lost annually to health care fraud and abuse, money which should be paid to legitimate providers and suppliers for actual services provided to keep our seniors in good health. The

Medicare Fraud Branch (MFB) is aggressively dealing with these issues. Please report the following activities, or any fraudulent and abusive practices, to the Medicare Fraud Branch by phone, fax, or by mail at the following:

Medicare Part B Provider lines: (904) 634-4994
Medicare Part A Provider lines: (904) 355-8899
MFB Fax Line: (904) 791-6716
Medicare Fraud Branch
P.O. Box 45087
Jacksonville, Florida 32231-0048
Please include as much detail as possible including the name of at least one beneficiary who has been victimized, or at least the provider's name, address and code(s) at issue. You may remain anonymous and the information will not be shared beyond law enforcement entities. All reports are held in the strictest confidence, and the concerned individual will not be exposed.

New Scheme
Medicare Part B of Florida has been alerted to a new program in which a company is offering Skilled Nursing Facilities and homes a program to deal with residents' urinary incontinence. The company offers a screening service that evaluates residents for Permanent Urinary Incontinence (PUI), and offers recommendations for pharmacologic and behavioral management of this disorder. This program involves the use of an evaluation form, performance of mental tests and record-keeping. The service provider evaluates patients, then requests that attending physicians approve the treatment plan and recommendations. Remember: screening services are not a covered benefit, psychological tests must be ordered by an attending physician and must be related to the diagnosis and management of mental disorders, and general hygiene services and supplies are part of the nursing care provided to residents which are paid under the SNF per-diem rate reimbursement. Do not participate in programs designed to circumvent the reimbursement rules and cause duplicate payment for services or payment for services which would not be considered medically necessary.

New Trends for Dealing With Health Care Fraud
A fraud and abuse control program, implemented by the Health and Human Services' Office of the Inspector General, that came as a result of the Health Insurance Portability and Accountability Act of 1996 netted significant results during its first six months in operation. From October 1, 1996, through March 31, 1997, a total of 1,353 OIG sanctions were imposed in the form of exclusions or civil recoveries on individuals and entities for engaging in fraud or abuse of the Medicare or Medicaid programs. Also, almost $937 million was recouped through both civil money penalties and False Claims Act civil settlements by the OIG. This program involves multiple special audits and investigations involving Medicare and Medicaid fraud and abuse.
Medicare & Medicaid Fraud Actions
- The owner of a set of Miami medical offices pleaded guilty to one count of conspiracy to commit health care fraud. He was sentenced to 18 months imprisonment and ordered to make restitution in the amount of $75,000. The owner was using individual physician provider numbers to file for services which were never rendered.
- Two Miami owners of a medical corporation signed a settlement agreement in which they agreed to pay $904,000 and to be permanently excluded from

participation in the Medicare program. The two utilized their company to submit claims for services which were never ordered by the indicated referring physicians.

- Two South Florida men who were un-licensed physicians were convicted in a jury trial in Ft. Lauderdale. The two were associated with multiple medical service providers and IPL's. They had also been previously indicted for submission of false claims, money laundering, and other charges.
- A home health care provider indictment in the Southern District led to the suspension of five Medicare Part B providers for their participation in this conspiracy and subsequent indictment.

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In The News/FYI
- Columbia-HCA Healthcare Corporation, the nation's largest health-care company, is under investigation by the FBI for possible violations of federal law. Questions raised relate to whether Columbia padded bills to the government, and to whether it violated physician self-referral laws.

- A Wisconsin psychiatrist has to make restitution in the amount of $2.4 million. The physician persuaded a patient that she suffered from multiple personality disorder and than billed her insurance carrier for group psychotherapy for the 126 separate personalities.

- A Texas psychiatrist and his office manager were convicted of multiple violations related to billing for services that were never rendered. The psychiatrist was sentenced to more than seven years in prison and ordered to make restitution in the amount of $3.9 million.

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Extension of the Limitation on Payment for Services to Individuals Entitled to Benefits on the Basis of End Stage Renal Disease (ESRD) Who Are Covered by Group Health Plans (GHP)
Prior to enactment to the Balanced Budget Act (BBA) of 1997, Medicare benefits were secondary to benefits payable under a GHP in the case of individuals entitled to benefits on the basis of ESRD during an 18-month coordination period. The coordination period begins with the first month the individual is eligible for Medicare, whether or not the individual is actually entitled or enrolled. Medicare is secondary during this period even though the employer policy or plan contains a provision stating that its benefits are secondary to Medicare, or otherwise excludes or limits its payments to Medicare beneficiaries.
Under this provision, the GHP must be billed first for services provided to a Medicare ESRD beneficiary. If the GHP does not pay for covered services in full, Medicare may pay secondary benefits in accordance with current billing instructions. This provision applies to all Medicare covered items and services (not just treatment of ESRD) furnished to beneficiaries who are in the coordination period.
Section 4631(b) of the BBA of 1997 permanently extends the coordination period to 30 months for any individual whose coordination period began on or after March 1, 1996. Therefore, individuals who have not completed an 18-month coordination period by July 31, 1997, will have a 30 month coordination period under the new law. Claims for primary payment that are submitted for applicable individuals during the 30-month coordination

period will be denied payment. This provision does not apply to individuals who would reach the 18-month point on or before July 31, 1997. These individuals would continue to have an 18-month coordination period.

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Find Sanctioned Provider Information on the Internet

The Office of Inspector General (OIG) keeps public records of individuals/entities that are excluded from reimbursement under Medicare (Title XVIII of the Social Security Act). This information is avilable on the internet. Providers should visit www.arnet.gov/epls/ for the list of debarred, excluded, and suspended providers and entities. The website will be updated daily.

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HCFA-1500: Special Signature Requirements (Item 12)

A provider or physician or other supplier submitting a claim for diagnostic tests or test interpretations need not attempt to obtain the patient's signature or sign the claim on behalf of the patient if the patient neither visits the provider or supplier nor is visited by a representative of the provider or supplier in connection with the services.

For example, when the patient's physician draws a blood sample at his office and sends the blood sample to an independent laboratory, the independent laboratory should indicate "patient not physically present for services" in Item 12 of the HCFA-1500 claim form. The date must also be indicated. For electronic claims submission, indicate a "P" in either the National Standard Format (DA0 record, field 16.0, position 154) or ANSI formats (Table 2, sequence-130, segment - clm, data element 10) which represents the same or similar verbiage. If you are not familiar with the appropriate field within your software, contact your software support vendor.

Note: This procedure does not apply to claims submitted by a physician or other supplier for services furnished in a medical facility which is visited by the beneficiary, or whose representative visits the beneficiary, in connection with the services.

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Providers Can Raise the Hispanic Mammography Utilization Rate

Consider these facts:

- Breast cancer is the most common cancer among women and the second leading cause of death among females, according to the American Cancer Society.

- The incidence of breast cancer among Hispanic women appears to be rising at a rate three times greater than for white women.

- Hispanic women with breast cancer have lower five-year survival rates than white women, mainly due to late detection.

In Florida, Dade county holds the second-largest Hispanic population in the United States. As a result, the facts noted above demonstrate a dire need for targeted outreach to educate beneficiaries of the importance of screening mammographies. Though screening mammographies have grown in

acceptance as a necessary preventive health measure, barriers continue to exist, particularly in the Hispanic community. Providers have the ability to increase the mammography screening rate and therefore reduce the incidence of breast cancer nationwide: studies have shown that a lack of physician recommendation is a significant barrier to mammography among women of all ethnic backgrounds. By recommending screening mammography to all female patients over age 50, providers, plans, and physicians can significantly impact this population.

Much work needs to be done. A 1995 report by Florida's Breast Cancer Screening Force indicated that in Florida, the fourth most populous state in the nation) approximately 945,000 women over 40 had never had a mammogram and more than a million women over 50 had not been screened within five years. Among the female Hispanic population, the mammography rate falls short of the Health People 2000 goal of 60 percent among women over age 50.

Studies have shown that in addition to a lack of physician recommendation, barriers preventing screening mammography among Hispanic women include:

- The misconception that without symptoms, there is no need to be screened;
- Cost and/or lack of health insurance;
- Lack of access to mammography facilities;
- Fear of cancer detection;
- Language barriers; and
- Cultural beliefs and values that do not emphasize preventative medical care.

Florida Medical Quality Assurance, Inc. (FMQAI), the Medicare Peer Review Organization in the State of Florida, the Medicare Beneficiary Education and Outreach area, and the American Cancer Society are conducting a state-wide project designed to increase the mammography rate among female Medicare beneficiaries. In addition, there will be a targeted campaign that identified opportunities that might influence preventative health behaviors of Hispanic female Medicare beneficiaries and seeks to identify key factors that might motivate such women to get a mammogram.

"It is vital that physicians encourage their patients to undergo screening mammography if we are to reduce the breast cancer rate in Florida," said FMQAI's Principal Clinical Coordinator Luis Miranda, M.D., M.P.H. "Among Hispanic patients, cultural barriers must be addressed."

FMQAI's state-wide mammography project will be in the intervention stage from October 13 to December 15, coinciding with October's designation as Breast Cancer Awareness Month. All providers are encouraged to stress the importance of screening mammography to their female patients. If you have questions, or if you would like any mammography promotional materials, please call FMQAI at (813)- 354-9111.

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How to Correctly Reassign Benefits

If you are an existing Medicare provider who is contracting with an entity and you want your benefits reassigned to the entity, you should obtain a HCFA 855 form and complete sections 1D, 2, 13, 14, 16, 18 and 19. If the entity does not have an existing Medicare provider number they must also obtain and complete the HCFA 855 form regardless of whether a provider number is being requested.

If you are an existing Medicare provider and are employed by an entity which has an existing Medicare number (e.g., a group), you should complete the HCFA 855G form to reassign your benefits to this entity. If the entity does not have an existing Medicare provider number they must

also obtain and complete the HCFA 855 form regardless of whether a provider number is being requested by the entity.
If you are a new provider who has never obtained a Florida Medicare provider number, you should obtain and complete the HCFA 855 form. If you would like to reassign your benefits, the guidelines listed above should be followed.
Applications, HCFA 855 forms, HCFA 855G forms and HCFA 855C forms (HCFA 855C form is for changes to an existing provider) may be obtained by calling the Medicare Part B Provider Customer Service department at (904) 634-4994.

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Reassignment of Benefits to Staffing/Billing Agencies
It has been brought to the Health Care Financing Administration's attention that entities which are not eligible to receive Medicare payment have been enrolled as providers or suppliers and have received billing numbers. In addition, certain physicians have been allowed to reassign their benefits to those entities that were not eligible to receive reassigned Medicare payments. This situation seems to be occurring primarily when the ineligible entity is entering contractual arrangements with a hospital to provide medical services.
The most clear example is one in which an organization, such as a staffing/billing agency, has a contract with a hospital to provide emergency room services. The agency subcontracts with physicians to service the emergency room. Since all the services furnished by the physicians are not rendered on the physical premises of the staffing organization, the staffing organization does not meet the definition of a health care delivery system, (see section 1842 (b) (6) of the Social Security Act, 42 U.S. Code Section 1395u(b)(6) and 42 C.F.R. Section 424.80(b). In such an arrangement, the staffing organization is not eligible to receive payment unless it meets one of the exceptions to the prohibition on reassignment of benefits as specified in Section 3060 of the Medicare Carrier Manual.
The Health Care Financing Administration's interest is not only to insure that proper payment is made but, that the physician, who is accountable to the Medicare program, is fully aware of the services billed and payments made on his or her behalf. For physicians who use a billing agent and wish to review his/her billing records, the billing agent must make this information available and accessible to the physician who rendered the services. For physicians who have reassigned their benefits, this information should be made available from the group who receives the reassigned benefits.
We wish to alert individual physicians, group practices, billing agencies and staffing organizations to this situation and the need to take action, where necessary, to come into compliance. The Health Care Financing Administration has been working with a number of the major staffing organizations in order to assist them in complying with the law and regulation while at the same time ensuring that Medicare beneficiaries continue to receive access to medical services.
Individual physicians, group practices, billing agents and staffing organizations should evaluate existing reassignment arrangements to determine if these types of non-compliant arrangements exist, and if so, contact the Medicare Part B Provider Customer Service department at (904) 634-4994 to determine what action needs to be taken.

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Deductible Information Available in New Flyer

The Beneficiary Education and Outreach Department has produced a flyer that answers the most common questions about Medicare deductibles. Some of the information in the brochure includes the following:

Q
What is the Medicare deductible?

A
The Medicare deductible is the amount you as the patient or beneficiary will pay before Medicare can begin paying for services covered under the program. The amount of the deductible for Medicare Part B is $100 per year.

Q
How do I pay my Medicare deductible?

A
Never mail a check to Medicare! For Medicare Part B, money is applied towards the deductible from the first claim(s) that finish processing after the beginning of each new year.

Q.
If I do not receive physicians' services or supplies during the year, do I still have to pay the Medicare deductible?

A.
No. You only pay towards the Medicare Part B deductible if you have received physicians' services or supplies during the year.

Q.
How do I know if my deductible has been met?

A.
Always read your Medicare Summary Notice.

For Medicare Part B, generally, your first few visits to a doctor or supplier during the new year will be applied to your deductible.

Q.
On January 15, I saw Dr. Smith and paid him $100 for my Part B deductible. On January 25th, I saw Dr. Jones. I told him I had already paid my deductible to Dr. Smith. Later, I got a bill from Dr. Jones that stated the deductible was taken from his claim. What happened?

A.
The claim from the second doctor you saw (Dr. Jones) finished processing before the claim from Dr. Smith. Your deductible was taken from the first claim that finished processing. Dr. Smith, the doctor you saw on January 15th, owes you a refund and you may owe that refund to Dr. Jones.

The brochure contains other information about Medicare deductibles. Copies can be ordered by calling the Provider Customer Service department at (904) 634-4994.

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Random Review of E&M Services Begins November 1997

Beginning in November 1997, all Medicare Part B carriers will conduct random prepayment reviews on certain Evaluation and Management (E&M) services for a particular date. The Health Care Financing Administration will designate which E&M service or services will be reviewed each month.

The purpose of this review is to ensure the correct use of E&M procedure codes among all providers who bill for those services and to ensure services rendered are medically necessary. Medicare Part B cannot release to any provider the dates or codes that will be affected by the review. One or more E&M procedure codes will be reviewed during each month. When a provider's service or services are randomly selected for prepayment review, Medicare Part B will send a letter to the provider to request supporting documentation. Please be sure to send this supporting documentation immediately; as usual claims will be denied payment if documentation is not received in a timely manner. At this time, do not send documentation for E&M claims unless it is requested!
E&M documentation guidelines were published in the September 1997 Medicare B Update Special Issue: Documentation Guidelines for Evaluation and Management Services.

Advance Notice Information
Advance notice and waiver of liability are applicable to E&M services. See "Advance Notice Requirement" on page 4 for complete information about advance notice and waiver of liability.

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UPIN Directory Available on CD-ROM
The CD-ROM version of the UPIN directory is available upon request. The directory is a complete national UPIN listing, current through August 1996. Updates will be issued at a later date. Since there is a limited amount (170 copies to be exact), they will be sold on a first come first serve basis. The cost will be $14.00.

System Requirements
The following configuration is needed to use this CD-ROM disc:
- An IBM PC/AT or PS/2 or compatible with 640 KB RAM ((520 KB base memory available after CD-ROM drive installed).
- MS-DOS version 3.1 or later and Windows 95.
- CD-ROM drive with Microsoft MS-DOS CD-ROM extensions. Version 2.0 or later capable of reading ISO 9660 format.

To order your complete CD ROM version, make checks payable to Blue Cross Blue Shield of Florida (Account # 754-250) and mail to the following address:
Medicare Registration
532 Riverside Ave
14 Tower
Jacksonville, Florida 32207
Attn: Tawny Stewart, UPIN Coordinator
The CD is available through the Government Printing Office(GPO) for $28.00. The contact person for GPO sales is Esther Edmonds at (202) 512-1530. Please refer to stock number 017-060-00601-3 when requesting your CD directory from GPO.

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Physician Coercion
Durable Medical Equipment Regional Carrier (DMERC) Certificates of Medical Necessity (CMNs) have two sections that require physician input. Section B has questions concerning the medical condition of the patient, the answers to which guide the DMERC as to the medical necessity of the item being ordered. The other section is for the signature of the physician, attesting to the accuracy of the answers in Section B. The

supplier is neither permitted to complete Section B nor tell the physician what answers to give. Suppliers have been known to engage in such activity and even coerce physicians into changing their answers in Section B. Incidentally, Section C of the CMN is supposed to be completed by the supplier before the physician signs the document, and is supposed to list the charges for the equipment being ordered.
If physicians become the target of coercive pressure or harassment by suppliers to justify through their orders or CMNs, medical equipment which is being directly marketed to their patients, they are encouraged not to betray their better medical judgment by acquiescing to such pressure, and reporting this behavior to the following DMERC contact:

DMERC Program Integrity Department Provider Hotline: (803) 788-5414.....
Physicians are also encouraged to request copies of the relevant DMERC medical policies directly from the supplier of the items in question, or they may contact the manager of the Professional Relations Department of the DMERC, Jean Gaddy, for this material at (803) 735-1034, ext. 35707. Physicians may always discuss aspects of medical policy concerning coverage of this equipment with the DMERC medical director, Paul D. Metzger, M.D., at (803) 735-1034, ext. 35706.

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IMPORTANT ADDRESSES:

CLAIMS SUBMISSIONS
Routine Paper Claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019
Participating Providers
Medicare Part BParticipating Providers
P.O. Box 44117
Jacksonville, FL 32231-4117
Chiropractic Claims
Medicare Part B Chiropractic Unit
P. O. Box 44067
Jacksonville, FL 32231-4067
Ambulance Claims
Medicare Part B Ambulance Dept.
P. O. Box 44099
Jacksonville, FL 32231-4099
Medicare Secondary Payer
Medicare Part B Secondary Payer Dept.
P. O. Box 44078
Jacksonville, FL 32231-4078
ESRD Claims
Medicare Part B ESRD Claims
P.O. Box 45236, Jacksonville, FL 32232-5236

COMMUNICATIONS
Review Requests
Medicare Part BClaims Review
P. O. Box 2360
Jacksonville, FL 32231-0018
Fair Hearing Requests

Medicare Part B Fair Hearings
P. O. Box 45156
Jacksonville, FL 32232-5156
Administrative Law Judge Hearing
Administrative Law Judge Hearing
P.O. Box 45001
Jacksonville, FL 32231-5001

Status/General Inquiries:
Medicare Part B Correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018
Overpayments
Medicare Part BFinancial Services
P.O. Box 44141
Jacksonville, FL 32231-0048
DURABLE MEDICAL EQUIPMENT (DME)
DME, Orthotic or Prosthetic Claims
Palmetto GBA
Medicare DMERC Operations
P.O. Box 100141
Columbia, SC 29202-3141

ELECTRONIC MEDIA CLAIMS (EMC)

EMC Claims, Agreements and Inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071
MEDICARE PART B ADDITIONAL DEVELOPMENT
Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-2537

Over 40 days of initial request:
Submit the charge(s) in question, including information requested, as you would a new claim to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

MISCELLANEOUS
Fraud and Abuse
Medicare Fraud Branch
P.O. Box 45087
Jacksonville, FL 32231

Medicare Claims for Railroad Retirees:
MetraHealthRRB Medicare
P. O. Box 10066
Augusta, GA 30999-0001
Provider Change of Address:
Provider Registration DepartmentBlue Cross Blue Shield of FloridaP. O. Box 41109Jacksonville, FL 32231-1109
and
Medicare Registration

P.O. Box 44021
Jacksonville, FL 32231-4021
Provider Education:
For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:Medicare Part BProvider Education DepartmentP. O. Box 2078Jacksonville, FL 32231-0048
For Seminar Registration:
Medicare Part BProvider Education Department
P. O. Box 45157
Jacksonville, FL 32231

Limiting Charge Issues:
For Processing Errors:
Medicare Part B
P.O. Box 2360
Jacksonville, FL 32231-0048

For Refund Verification:
Medicare Part B
Compliance Monitoring
P.O. Box 2078
Jacksonville, FL 32231-0048

Provider Participation and Group Membership Issues;

Written Requests for UPINs, Profiles & Fee Schedules:
Medicare Registration
P.O. Box 44021
Jacksonville, FL 32231

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Medicare Registration Applications
The Health Care Financing Administration (HCFA) has issued three new types of enrollment applications. Given below are the three types of applications and their appropriate use. Providers should obtain these applications and start using them immediately.

HCFA 855 General Enrollment
HCFA 855C Change of Enrollment Information
HCFA 855G Individual Group Member Enrollment

Copies of the HCFA 855C and 855G can be found on pages 53-65 of the September/October 1997 issue of the Medicare B Update! In addition, all three forms may be obtained by calling our Provider Customer Service department at (904) 634-4994, or downloaded from the Florida B-Line Bulletin Board System (BBS).

HCFA 855 General Enrollment
The HCFA 855 is a Medicare General Enrollment Application for providers to obtain a Medicare provider number or a satellite office for providers already enrolled. This application should also be used to update information. If the updates to a providers practice are items included on the HCFA 855C, that application may be used instead of the HCFA 855. This application should also be used for providers to inform Medicare of additional practice settings.

This application replaces one which is very similar and is currently in use. The new HCFA 855 shows HCFA (5/97) in the lower left corner. Where the one currently in use shows OMB Approval No 0938-0685 in the lower left corner. Providers should request, become familiar with and start using the new application. No other application is acceptable.

HCFA 855C Change of Enrollment Information
The new HCFA 855C should be utilized when providers need to make changes to their existing Medicare files. If providers need to update their name, specialty, E-Mail address, practice location address, billing agency address, pay to address, mailing address, pricing locality, telephone number, fax number, or deactivate (cancel) a Medicare billing number, they should complete the HCFA 855C. If information is being updated which is not listed above, the provider should complete the appropriate section(s) which contains the changed information) of the HCFA 855 (general enrollment application) and sign the certification statement. If a provider does not wish to complete the HCFA 855C and has one or more of the changes listed above, they may request the change(s) in writing. The letter requesting the change(s) must be on letterhead with the provider's (or authorized representative's) original signature. If requesting a change to a physical address, the request must include a copy of the city and/or county occupational license. The signature on the letter will be compared to the signature we have in the provider's file. If it does not match or if we do not have a signature on file, the request will be returned requesting that the HCFA 855C be completed prior to making the change.

HCFA 855G Individual Group Member Enrollment
The HCFA 855G should be used when an individual provider is joining a group practice. If an individual provider is joining a group and both the group and the individual are currently enrolled in the Medicare Program, the individual must complete only the HCFA 855G. If the individual is not currently enrolled in the Medicare Program and is joining an existing group practice, they must complete the HCFA 855 AND the HCFA 855G.

Important Note: Effective immediately Medicare Part B of Florida will no longer accept the Florida Reassignment of Benefits (the green and white form). Providers must complete the HCFA 855G.
Completed forms must be sent to the following address:
Medicare Registration Department
P.O. Box 44021
Jacksonville, FL 32231-4021

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Index to Publications by Topic
Not available in this format

See Main Index

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END OF FILE