Medicare B Update!

A Newsletter for Florida Medicare Part B Providers

In This Issue...

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Routing Suggestions:

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HCFA Health Care Financing Administration

FIRST COAST SERVICE OPTIONS, INC.
A HCFA Contracted Carrier & Intermediary

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The *Medicare B Update!* is published by the Medicare Publications 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 Publications
P.O. Box 2078
Jacksonville, FL 32231-0048

A PHYSICIAN'S FOCUS

Physicians' Issues with Medicare Regulations

Physicians are increasingly concerned with the burden of regulations placed upon them by Medicare, insurance companies, and other regulatory bodies. Physicians have undertaken a unique responsibility and burden–the trust of the patients when they are most vulnerable. As the federal Medicare agency, the Health Care Financing Administration (HCFA) respects this bond of trust, and appreciates the role it plays to support it. The mission of the Medicare program and of all physicians is the same, to provide high quality medical care for patients.

In response to physicians' concerns of the regulatory burdens facing them, HCFA's administrator, Nancy-Ann Min DeParle, initiated the Physician's Regulatory Issues Team (PRIT). This group includes participation from all components of the agency. It is charged with identifying and, wherever possible, decreasing the regulatory burden placed upon physicians. The team seeks an open channel for ongoing communication with providers.

Information from consultants and pilot studies has indicated that Medicare needs to improve and update its overall strategy for education and training for health care professionals. Recommendations have included the need to take advantage of new technologies, and to leverage resources by partnering with other involved parties. Pertinent, clear, and consistent educational materials must be produced and distributed in the most effective ways possible.

HCFA recognizes the need to work with the physician community to address the burden created by Medicare regulations – whether the burden is caused by the sheer number of pages, complexity or obscurity, or perceived risk for their violation. HCFA has dedicated staff, resources, and commitments of leadership to do so. In response to concerns from physicians, and the results of studies, HCFA is developing several new initiatives. They are:

1) *Toll free inquiry lines*. HCFA is restoring funding for toll free lines for provider inquiries for the Medicare carrier. These numbers will be published when they become effective later this fall.
2) *Rules of the Road*. By culling from the existing array of information and materials and asking the physician community more about their specific needs, HCFA will produce a booklet and a CD-ROM of Medicare basics for physicians.
3) *PPAC*. The Practicing Physicians Advisory Council (PPAC) is a valuable source of information to HCFA regarding the impact of regulations on practicing physicians. HCFA is redoubling their efforts with this group, focusing on specific operational issues that affect physicians' practices, and working through them in greater detail.
4) *HCFA's Web Based Presence to Physicians*. HCFA is taking a fresh look at its website postings and structure, and aims to use this technology to make their regulations and instructions less obscure or complex–thus, less burdensome. This site will include such information as physicians' frequently asked questions, Medicare manuals, and policies important to physicians. Most importantly, HCFA will ask physicians what they need on this website, and provide it. Currently, you can gain much useful information from HCFA's website, **www.hcfa.gov/medlearn**, and our provider website, **www.floridamedicare.com**.
5) *New Communications*. Representatives from your national and state medical societies and national specialty organizations are now being briefed once a month by HCFA leadership and policy staff. This direct communication allows your representatives to get immediate answers to their questions on current issues and topics, and the information is being translated into articles and information for your newsletters, committees, and leaders.
6) *Frequently Asked Questions*. HCFA is developing a system so that the myriad of questions that are individually asked and answered will be monitored, and an ongoing compilation of FAQs will be created and disseminated. The Florida Medicare Carrier will be one source of those questions, and our website will link to the final FAQs.

Florida Medicare applauds the formation of the PRIT as a move in the right direction, and we urge all physicians to support its efforts with thoughtful comments.

Written comments regarding these new efforts can be sent to Barbara Paul, M.D., Director, Physician's Regulatory Issues Team, Mail Stop C5-08-14, HFCA, 7500 Security Blvd., Baltimore, MD 21244-1850. E-mail: Bpaul@hcfa.gov.

Sincerely,

Sidney R. Sewell, M.D.
Medical Director

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ADMINISTRATIVE

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. Florida Medicare Part B 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.

Distribution of the *Update!* is limited to individual providers and professional association (PA) groups who bill at least one claim to Florida Medicare Part B for processing during the six months prior to the release of each issue. Providers meeting this criteria are sent one complimentary copy of that issue. Production, distribution, and postage costs prohibit distributing a copy to all of a 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. For additional copies, providers may purchase a separate annual subscription for $75 (see order form on page 82).

Florida Medicare Part B 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, providers must keep their mailing addresses current with the Medicare Registration Department.

About the Format

The *Update!* is divided into several sections, starting with an article by the **Carrier Medical Director**. Following is **Administrative** information, then **Claims**, that provides claims submission requirements and tips. Correspondence (appeals and hearings) information is in this section. **Coverage/Reimbursement** discusses CPT and HCPCS procedure codes. It is arranged by specialty *categories* (not specialties). For example, "Mental Health" presents coverage information of interest to psychiatrists, clinical psychologists and clinical social workers. Also presented in this section are changes to the Medicare Physician Fee Schedule (MPFS) and other pricing issues. **Local and Focused Medical Review Policies** follows, then **Electronic Media Claims** (EMC). Additional sections include: **General Information** (other information for Medicare providers including Fraud and Abuse issues), and **Educational Resources** that includes seminar schedules and reproducible forms, and important addresses, phone numbers and websites ❖

Advance Notice Requirement

The following information applies to all articles in this publication referencing services that must meet medical necessity requirements (e.g., services with specific diagnosis requirements). Refer to this information for articles that indicate advance notice applies.

Medicare Part B allows coverage for services and items deemed 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 list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- 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., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment 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., the 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 payment is denied as being 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. ❖

CLAIMS

Additional Development Request: "Invalid or incomplete 'to' date"

Additional Development Requests (ADRs) continue to cost Medicare and providers both time and money. In an effort to continue reducing the number of ADR's, **effective for assigned claims received on or after October 2, 2000,** Florida Medicare will no longer develop for the exact dates of service when the number billed (block 24G) does not match the range of dates in block 24A of the HCFA-1500 claim form or the equivalent EMC field(s).

This is a HCFA-1500 claim form submission requirement. Claims submitted that are lacking this information will be returned as unprocessable. Unprocessable claims are not afforded appeal rights; they must be corrected and resubmitted. ❖

Billing for "Not Otherwise Classified" Drugs

If a procedure code cannot be found that closely relates to the actual service rendered, an "unlisted or not otherwise classified" procedure code must be submitted with a complete narrative description of the service rendered and supporting documentation. To ensure accurate processing in these instances, the name, strength and dosage must be indicated in block 19 of the HCFA-1500 claim form (or electronic media claim [EMC] equivalent) or attachments for the following procedure codes:

J3490 (Not otherwise classified drug)
J9999 (Not otherwise classified antineoplastic drug)

Effective for claims received on or after October 2, 2000, Florida Medicare will no longer develop for this information on assigned claims. If the name, strength and/or dosage is not included in block 19 of the HCFA-1500 claim form or attachments, or the equivalent EMC fields, these services will be returned as unprocessable. Unprocessable claims are not afforded appeal rights; they must be corrected and resubmitted. ❖

Correct Coding Initiative Version 6.2

Implementation of version 6.2 of the Correct Coding Initiative (CCI) was effective for services rendered on or after August 14, 2000. Version 6.2 includes all previous versions and updates from January 1996 to the present.

The U.S. Department of Commerce, National Technical Information Service (NTIS) has developed a national correct coding policy manual to assist physicians in correctly coding services for reimbursement. Medicare carriers are prohibited from publishing specific correct coding edits (CCE). Concerns about correct coding edit pairs must be submitted in writing to:

The Correct Coding Initiative
AdminaStar Federal
P. O Box 50469
Indianapolis, IN 46250-0469

Information related to CCI may be obtained by ordering a national correct coding policy manual from NTIS.

- Single issues of the national correct coding policy manual may be requested by calling (703) 605-6000.
- Subscriptions to the national correct coding policy may be requested by calling (703) 605-6060 or (800) 363-2068.
- To receive information from NTIS by mail, call (800) 553-6847.
- Ordering and product information is also available on the World Wide Web at **www.ntis.gov/cci**.

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Timely Claim Filing Guidelines

All Medicare claims must be submitted to the contractor within the established timeliness parameters. For timeliness purposes, services furnished in the last quarter of the calendar year are considered furnished in the following calendar year. The time parameters are:

Dates of Service	*Last Filing Date*
October 1, 1998 – September 30, 1999	by January 2, 2000*
October 1, 1999 – September 30, 2000	by December 31, 2001
October 1, 2000 – September 30, 2001	by December 31, 2002
October 1, 2001 – September 30, 2002	by December 31, 2003

*If the December 31 date falls on a federal nonworking day, the last filing date is extended to the next succeeding workday. A federal nonworking day is considered a Saturday, Sunday, legal holiday, or a day declared by statute or executive order as a nonworking day for federal employees.

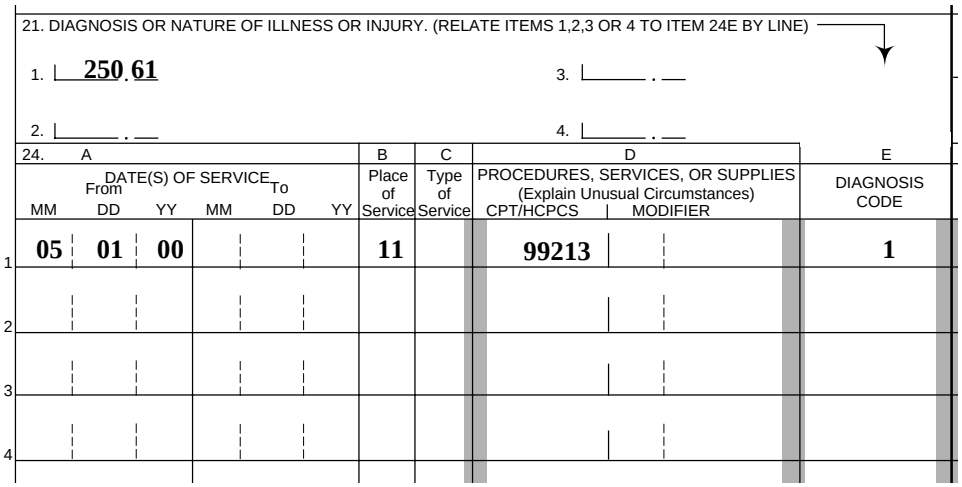
Claims must be submitted complete and free of errors. Any claim filed with invalid or incomplete information and returned as unprocessable (RUC) is not protected from the timely filing guidelines. ❖

HCFA-1500 Claim Filing Requirements – Reporting the One-Digit Diagnosis Reference Code Number

Florida Medicare is working hard to reduce rework for all of our providers. Rework can occur when a provider's office does not submit a Medicare claim according to the HCFA-1500 claim filing requirements. One situation identified as causing a high volume of rework is created when a provider does not submit a **one-digit diagnosis reference code number** in **field 24 E** on the HCFA-1500 Claim Form. The purpose of this article is to provide instructions to avoid this denial.

- Medicare regulations require physicians to submit a valid ICD-9-CM diagnosis code for services provided to the Medicare beneficiary.
- Up to four diagnoses may be reported in **field 21** of the HCFA-1500 Claim Form.
- For each date of service, the provider **must** submit only a **one-digit (1, or 2, or 3, or 4) diagnosis reference code number** in **field 24 E.** Select the diagnosis reference code number from field 21 that corresponds with the service or procedure performed.

The example below illustrates how to report the one-digit diagnosis reference code number.



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250.61 3. ____.__

2. ____.__ 4. ____.__

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE
1 05	01	00				11		99213		1
2										
3										
4										

Providers should examine their billing to ensure compliance with these claim filing guidelines. For more information on ICD-9-CM diagnosis reporting on the HCFA-1500 Claim Form, call our Provider Customer Service Department at (904) 634-4994. ❖

Pneumococcal Pneumonia, Hepatitis B, and Influenza Virus Vaccines

The Health Care Financing Administration (HCFA) has made some changes in the billing and processing of claims for pneumococcal, hepatitis B, and influenza virus vaccines.

Effective for claims with dates of service on or after July 1, 2000, the requirement that the pneumococcal pneumonia vaccine (PPV) be ordered by a physician who is a doctor of medicine or osteopathy has been eliminated. Also eliminated is the requirement to enter the UPIN in Item 17A of the form HCFA-1500 for PPV claims. The instructions for simplified roster bills are revised to require Item 32, Name and Address of Facility, to be completed.

Pneumococcal Pneumonia Vaccinations. The Medicare Part B program covers pneumococcal pneumonia vaccine and its administration when furnished in compliance with any applicable state law by any provider of services or any entity or individual with a supplier number. This includes revaccination of patients at highest risk of pneumococcal infection. Typically, these vaccines are administered once in a lifetime except for persons at highest risk. Effective July 1, 2000, Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

An initial vaccine may be administered only to persons at high risk (see below) of pneumococcal disease. Revaccination may be administered only to persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least 5 years have passed since receipt of a previous dose of pneumococcal vaccine.

Persons at high risk for whom an initial vaccine may be administered include all people age 65 and 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).

PPV, Hepatitis B, and Influenza Virus Vaccines - continued

Persons at highest risk and those most likely to have rapid declines in antibody levels are those for whom revaccination may be appropriate. This group includes persons with functional or anatomic asplenia (e.g., sickle cell disease, splenectomy), HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy. Routine revaccination of people age 65 or older who are not at highest risk is not appropriate.

Those administering the vaccine should not require the patient to present an immunization record prior to administering the pneumococcal vaccine, nor should they feel compelled to review the patient's complete medical record if it is not available. Instead, provided that the patient is competent, it is acceptable for them to rely on the patient's verbal history to determine prior vaccination status. If the patient is uncertain about their vaccination history in the past 5 years, the vaccine should be given. However, if the patient is certain he/she was vaccinated in the last 5 years, the vaccine should not be given. If the patient is certain that the vaccine was given and that more than 5 years have passed since receipt of the previous dose, revaccination is not appropriate unless the patient is at highest risk.

Hepatitis B Vaccine. With the enactment of Public Law 98-369, coverage under Part B was extended to hepatitis B vaccine and its administration, furnished to a Medicare beneficiary who is at high or intermediate risk of contracting hepatitis B.

High-risk groups currently identified include (see exception below):

- End stage renal disease (ESRD) patients;
- Hemophiliacs who receive Factor VIII or IX concentrates;
- Clients of institutions for the mentally retarded;
- Persons who live in the same household as an Hepatitis B Virus (HBV) carrier;
- Homosexual men; and
- Illicit injectable drug abusers.

Coverage of the pneumococcal vaccine (PPV), influenza virus vaccine, and hepatitis B vaccine and their administration is available ***only*** under Medicare Part B, regardless of the setting in which they are furnished, even when provided to an inpatient during a hospital stay covered under Part A. Payment is 100 percent of the Medicare allowed amount for PPV and influenza virus vaccine. Part B deductible and coinsurance do not apply for PPV and influenza virus vaccine. Part B deductible and 80% coinsurance ***do*** apply for hepatitis B vaccine. Mandatory assignment does not apply.

Influenza Virus Vaccine. Influenza virus vaccine and its administration are covered when furnished in compliance with any applicable State law by any provider of service or any entity or individual with a provider or supplier number. Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Frequency of Vaccinations

Typically, PPV is administered once in a lifetime. Pay claims for beneficiaries who are at high risk of pneumococcal disease and have not received PPV within the last five years or are revaccinated because they are unsure of their vaccination status.

Typically, one influenza vaccination is allowable per flu season. Establish an edit to identify more than one influenza virus vaccine in a 12-month period, and determine medical necessity of services failing the edit. Since there is no yearly limit, determine whether such services are reasonable and necessary (e.g., a patient receives an influenza injection in January for the current flu season and is vaccinated again in November of the same year for the next flu season.)

Billing for Additional Services

When an individual or entity administers PPV, influenza virus, or hepatitis B vaccines and additional services are provided, the individual or entity may bill for an office visit and Medicare will pay for an office visit if it is reasonable and medically necessary and for other reasonable and medically necessary services associated with the office visit.

Nonparticipating Physicians and Suppliers

Nonparticipating physicians and suppliers (including local health facilities) that do not accept assignment may collect payment from the beneficiary but must submit an unassigned claim on the beneficiary's behalf. Entities, such as local health facilities, that have never submitted Medicare claims must obtain a provider identification number for Part B billing purposes.

Separate Claims for Vaccines and Their Administration

In situations in which the vaccine and the administration are furnished by two different entities, the entities should submit separate claims. For example, a supplier (e.g., a pharmacist) may bill separately for the vaccine, using the procedure code for the vaccine, and the physician or supplier (e.g., a drugstore) which actually administers the vaccine may bill separately for the administration, using the procedure code for the administration. This process will result in carriers receiving two claims, one for the vaccine and one for its administration.

For example, when billing for influenza vaccine *administration* only, billers should list only code G0008 in block 24D of the HCFA-1500. When billing for the influenza *vaccine* only, billers should list only code 90659 in block 24D of the HCFA-1500. The same applies for PPV and hepatitis B billing using the appropriate PPV and hepatitis B codes.

A preprinted roster bill includes HCPCS codes for both the vaccine and its administration. When billing for influenza vaccine *administration* only, billers should cross out the code for the vaccine. For example, billers should leave HCPCS code G0008 and cross out HCPCS code 90659. Likewise, when billing for the influenza *vaccine* only, billers should leave HCPCS code 90659 and cross out HCPCS code G0008. The same rule applies for PPV HCPCS codes.

PPV, Hepatitis B, and Influenza Virus Vaccines - continued

HCPCS Codes

The following HCPCS codes are used for billing vaccines:

90657	Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use
90658	Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use
90659	Influenza virus vaccine, whole virus, for intramuscular or jet injection use
90669	Pneumococcal conjugate vaccine, polyvalent, for intramuscular *use (NOTE: this procedure is not FDA-approved, and is therefore noncovered by Medicare*)
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use
90744	Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use
90746	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, for intramuscular use
90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use

The above codes are for the vaccines only and do not include their administration. The following HCPCS "G" codes are used to bill for administration of vaccines:

G0009	Administration of pneumococcal vaccine
G0008	Administration of influenza virus vaccine
G0010	Administration of hepatitis B vaccine

Billing Requirements

Physicians and suppliers submit claims on Form HCFA-1500. The Unique Physician Identification Number (UPIN) must be entered in Item 17A of the HCFA-1500 for PPV and hepatitis B vaccines. No UPIN is required in Item 17A of the HCFA-1500 for influenza virus vaccine claims since Medicare does not require that the influenza vaccine be administered under a physician's order or supervision. Effective for claims with dates of service on or after July 1, 2000, no UPIN is required in Item 17A of the HCFA-1500 for PPV claims since Medicare will no longer require that the vaccine be administered under a physician's order or supervision.

Diagnosis Codes

The following diagnosis codes for PPV and influenza virus and hepatitis B vaccines and their administration should appear in Block 21 of the HCFA-1500:

V03.82	PPV
V04.8	Influenza virus vaccine
V05.3	Hepatitis B vaccine

Reimbursement Guidelines

Payment for PPV, influenza virus, and hepatitis B vaccines follows the same standard rules that are applicable to any injectable drug or biological. The allowable charge for the vaccine cannot exceed the lower of the actual charge or 95 percent of the median of all average wholesale prices (AWP).

The administration of PPV, influenza virus, and hepatitis B vaccines, (codes G0009, G0008, and G0010), though not reimbursed directly through the Medicare Physician Fee Schedule Database (MPFSDB), is reimbursed at the same rate as code 90782 on the MPFSDB for the year that corresponds to the date of service of the claim. Limiting charge does not apply to PPV, influenza virus vaccine, or hepatitis B vaccine and their administration. The administration of the influenza virus vaccine is covered in the flu shot benefit, rather than under the physicians' services benefit; therefore, it is not eligible for the ten percent Health Professional Shortage Area (HPSA) incentive payment.

Nongovernmental entities that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the immunizations free of charge to Medicare beneficiaries and may not bill Medicare. Thus, for example, Medicare may not pay for flu vaccinations administered to Medicare beneficiaries if a physician provides free vaccinations to all non-Medicare patients or where an employer offers free vaccinations to its employees. Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients.

Nongovernmental entities that do not charge patients who are unable to pay or reduce their charges for patients of limited means, yet expect to be paid if the patient has health insurance coverage for the services provided, may bill Medicare and expect payment.

Governmental entities (such as public health clinics [PHCs]) may bill Medicare for PPV, hepatitis B, and influenza virus vaccine administered to Medicare beneficiaries when services are rendered free of charge to non-Medicare beneficiaries.

Simplified Roster Bills

The simplified roster billing process was developed to enable Medicare beneficiaries to participate in mass PPV and influenza virus vaccination programs offered by PHCs and other entities that bill the Medicare carriers. Medicare has not developed roster billing for hepatitis B vaccinations.

Properly licensed individuals and entities conducting mass immunization programs may submit claims using a simplified claims filing procedure to bill for the influenza virus vaccine benefit for multiple beneficiaries if they agree to accept assignment for these claims. They may not collect any payment from the beneficiary. Effective November 1, 1996, this simplified claims filing procedure also applies to individuals and entities billing for PPV.

Effective July 1, 1998, immunization of at least five beneficiaries on the same date is no longer required for any individual or entity to qualify for roster billing. However, the rosters should not be used for single patient bills and the date of service for each vaccination administered must be entered.

Entities which submit claims on roster bills (and therefore must accept assignment) may not collect any "donation" or other cost-sharing of any kind from Medicare beneficiaries for PPV or influenza vaccinations. However, the entity may bill Medicare for the amount which is not subsidized from its own budget. For example, an entity that incurs a cost of $7.50 per vaccination and pays $2.50 of the cost from its budget may bill Medicare the $5.00 cost which is not paid out of its budget.

PPV, Hepatitis B, and Influenza Virus Vaccines - continued

Provider Enrollment Criteria. All individuals and entities that will submit PPV and influenza benefit claims to Medicare on roster bills must complete the Provider/ Supplier Enrollment Application, Form HCFA-855. Specialized instructions for these individuals and entities are available in order to simplify the enrollment process. Individuals and entities that use the specialized instructions to complete the form may not bill Medicare for any services other than PPV and influenza virus vaccinations. Establish an edit to identify individuals and entities that plan to participate in the Medicare program only for the purpose of mass immunizing beneficiaries.

Modified HCFA-1500. If the PHC or other individual or entity qualifies to use the simplified billing process, it may use a preprinted HCFA-1500 that contains standardized information about the entity and the benefit.

Entities submitting roster claims to carriers must complete the following blocks on a single modified HCFA-1500 that serves as the cover document for the roster:

HCFA-1500 Block	Influenza Virus Vaccine Claims	PPV Claims
Block 1	Check "Medicare"	Check "Medicare"
Block 2	See attached roster	See attached roster
Block 11	None	None
Block 17	N/A	Name of ordering physician MUST be entered (One name per claim form)
Block 17A	N/A	UPIN of ordering physician MUST be entered (One UPIN per claim form) **Not required for services rendered on or after July 1, 2000**
Block 20	No	No
Block 21	V04.8	V03.82
Block 24B	60-Mass Immunization Center	60-Mass Immunization Center
Block 24D (line 1) (line 2)	 90657, 90658 or 90659 G0008	 90732 G0009
Block 24E (lines 1 AND 2)	1	1
Block 24F	Enter the charge for each listed service.	Enter the charge for each listed service.
Block 27	X in YES block	X in YES block
Block 29	0.00	0.00
Block 31	Entity's representative must sign	Entity's representative must sign
Block 32	N/A	N/A
Block 33	Enter the entity's billing name, address, ZIP code, and telephone number, and enter the carrier-assigned Provider Identification Number	Enter the entity's billing name, address, ZIP code, and telephone number, and enter the carrier-assigned Provider Identification Number

Sample Rosters and HCFA-1500 Claim Forms

Sample rosters and samples of modified HCFA Form-1500s are available to view, print, or download from our provider website – **www.floridamedicare.com** – click on "Forms" in the "Shared" menu . ❖

Written Statements of Intent (SOI) to Claim Medicare Benefits

The Health Care Financing Administration (HCFA) has provided instructions to Medicare contractors on processing claims where a statement of intent (SOI) is used to extend the timely filing period for the submission of claims to the Medicare program. These instructions are effective October 1, 2000, for the claims filing period ending December 31, 2000 (extended through January 2, 2001 because December 31, 2000 and January 1, 2001 are Federal non-workdays).

Purpose of a Statement of Intent

The purpose of a SOI is to extend the timely filing period for the submission of an initial claim. A SOI, by itself, does not constitute a claim, but rather is used as a placeholder for filing a timely and proper claim. A valid SOI may be submitted to the appropriate Medicare carrier or intermediary that will be responsible for processing the claim to extend the timely filing period for filing a specific Medicare claim. A valid SOI may also be submitted to the HCFA regional office (RO) serving the area of the beneficiary's residence. (If a RO receives a SOI, the SOI is date stamped and forwarded to the appropriate Medicare contractor.)

To claim Medicare benefits, a SOI must be postmarked on or before, or received by the appropriate RO or contractor, no later than the last day of the timely filing period that pertains to the service(s) covered by the SOI.

> **NOTE: The filing of an invalid SOI does not extend the timely filing period. If a party submits an invalid SOI prior to the end of the timely period, and the contractor or the RO does not discover the invalidity and alert the submitter of the invalidity until shortly before, or even after the timely filing period has expired, the party may not correct or resubmit the SOI after the timely filing period has expired. In this regard, a party that submits an invalid SOI bears the full risk that he or she may be unable to resubmit a valid SOI within the applicable timely filing period.**

Processing the SOI

- The SOI must be submitted to the appropriate Medicare contractor or be forwarded to the correct Medicare contractor from the appropriate RO. The submitter is responsible for submitting the SOI to the appropriate Medicare contractor. Contractors will return to the submitter any SOI that was intended for a different contractor, with instructions indicating that the submitting entity must forward the SOI to the appropriate contractor.
- The contractor will send a letter of acknowledgment to the submitting entity, (provider, supplier, Medicaid State Agency or entity acting on behalf of the Medicaid State Agency, or beneficiary) upon receipt of a valid or invalid SOI. Before sending the acknowledgment letter, the contractor will research the available history to assure that a claim has not previously been submitted for those services.
- The proper claimant then has six months, after the month in which the acknowledgment letter for a valid SOI is issued, to submit a claim to Medicare. The contractor will not develop a claim from the submitted SOI, nor solicit the submission of claims from entities that have submitted a SOI.
- The contractor must keep the SOI for a minimum of six months after the month of the acknowledgment letter, since the contractor must be able to match the SOI with incoming claims.

Processing of Claims Submitted beyond the Filing Deadline

Within six months after the month of the SOI acknowledgment letter, a valid claim form (either electronic or hardcopy) must be submitted in accordance with Medicare claim standards. When the claim denies for dates of service beyond the timely filing deadline, the contractor will verify that a SOI for the claim exists and that the six months acknowledgement letter time limit has not expired.

The contractor will **deny** the claim:

- If more than six months have passed after the month of the SOI acknowledgment letter.
- If less than six 6 months have passed and a valid SOI does not exist.
- If the information on the claim does not match the information on the SOI.

The contractor will **process** the claim as usual, according to the claims processing sections of the Medicare Carriers Manual, if the SOI was filed correctly and the claim is submitted timely (within six months after the month of the acknowledgment letter).

Special Coding Instructions

- Effective October 1, 2000, modifier **QQ** has been approved for providers/suppliers to place on the claim at the line level. This modifier is defined as "service for which a statement of intent was submitted, deemed as valid, and an acknowledgment letter was received."

If the submitter of the SOI is not the provider/supplier who will be submitting the claim (e.g., an electronic media claims [EMC] vendor), the submitter must instruct the provider/supplier to place modifier QQ on the claim.

Who Can Submit Statements of Intent

Only the following parties may submit a SOI to claim Medicare benefits:

- Providers and parties to whom they may assign their payment for items or services they have furnished or are entitled to bill Medicare.
- Suppliers and parties to whom they can reassign payment for items or services they have furnished or are entitled to bill Medicare.
- Medicaid State agencies and parties authorized to act on behalf of Medicaid State agencies, with respect to items and services rendered to dually eligible beneficiaries.
- Beneficiaries and their authorized representatives, but only where the SOI relates to:
  - (1) a claim for services furnished by a nonparticipating hospital that has elected not to claim payment for emergency services, or
  - (2) a claim for services for which a physician or other supplier, or proper resignee, was required to file a claim under section 1848(g)(4) of the Social Security Act but has not done so.

Contents of a Valid Statement of Intent

A SOI must be signed, and the person signing must indicate the capacity in which he or she is signing (e.g., beneficiary or beneficiary's authorized representative, provider, supplier, Medicaid State agency official, or party authorized to act on behalf of the Medicaid State agency).

For a SOI to be considered valid, it must be submitted to the appropriate contractor, and if a provider or supplier (or the party to whom payment can be assigned), or Medicaid State agency (or a party authorized to act on its behalf) submits a SOI, then the following information must be submitted with the SOI:

- Beneficiary name;
- Medicare Health Insurance Claim (HIC) number;
- Name, address, and Medicare billing number of provider/physician/supplier at time of service;
- Dates of service for which a specific claim will be filed (dates must be reported in a manner that comports with the Medicare claims filing instructions; ranges of dates are acceptable only if a range of dates is properly reportable on the Medicare claim form); and
- CPT, HCPCS or other applicable code, and appropriate modifiers for each service. (Codes must be reported in a manner consistent with the reporting of the codes on the Medicare claim form. Diagnosis codes by themselves are not acceptable.)

In order for a SOI that is submitted to a RO to be valid, the SOI must include all of the above information and must also include the correct name and address of the Medicare contractor that will be responsible for processing the subsequent claim or claims.

If a beneficiary or authorized representative submits a SOI, it must be submitted to the appropriate contractor and must include **all** of the information listed below.

- Beneficiary name
- Medicare health insurance claim (HIC) number
- Name, address, and if available, the Medicare billing number of the provider/physician/supplier at time of service
- Date(s) of service for which a specific claim will be filed (dates must be reported in a manner that comports with the Medicare claims filing instructions; ranges of dates are acceptable only if a range of dates is properly reportable on the Medicare claim form)
- Item(s) or service(s) furnished/received.

In order for a SOI that is submitted to a RO by a beneficiary or a beneficiary's authorized representative to be valid, it must include the information listed above and must also include the name and address of the Medicare contractor that will be responsible for processing the subsequent claim or claims.

Submitters may obtain the name and address of the appropriate Medicare contractor (i.e., Medicare carrier or fiscal intermediary) at the following website:

http://www.medicare.gov/contacts/contact1.asp.

Where to Send A Statement of Intent

A SOI should be sent to:

Medicare Part B
Attention: Statement of Intent
P.O. Box 2078
Jacksonville, FL 32231-0048

COVERAGE/REIMBURSEMENT

AMBULATORY SURGICAL CENTER

New Technology Intraocular Lenses (NTIOLs)

This information was provided to all active Florida ASC facilities in individual letters dated June 23, 2000. It is being reprinted here as a convenience to those facilities, and to provide notification to physicians who may indicate use of NTIOLs for cataract surgeries performed in an ASC.

A notice was published in the May 3, 2000, ***Federal Register*** to announce the effective date for payment of NTIOLs. That effective date is for services rendered on or after May 18, 2000.

Two temporary procedure codes have been assigned for NTIOLs:

- Q1001 — New Technology Intraocular Lens Category 1 as defined in ***Federal Register*** Notice, VOL 65, dated May 3, 2000.
- Q1002 — New Technology Intraocular Lens Category 2 as defined in ***Federal Register*** Notice, VOL 65, dated May 3, 2000.

These lenses are eligible for an additional payment of $50 when furnished by a Medicare-approved Ambulatory Surgical Center (ASC). The approved model for Q1001 is AMO Array Multifocal Model SA4ON, manufactured by Allergan. Q1002 lenses are manufactured by STAAR Surgical Company, and their characteristic is reduction in preexisting astigmatism. The model is an Elastic Ultraviolet-Absorbing Silcone Posterior Chamber. These are the only two NTIOLs that have been approved by Medicare for payment. As other manufacturers and models are approved, they will be announced. The above codes are effective for five years (May 18, 2000 through May 18, 2005).

ASC facilities must bill using two line items on Form HCFA-1500 (or electronic equivalent) to be paid the additional $50. One line item must be for procedure code 66983, 66984, 66985, or 66986, whichever appropriately describes the surgical insertion procedure that was performed. The second line item must show the approved NTIOL that was furnished, either Q1001 or Q1002, billed at $50 (claims submitted where the billed charge is less than $50 will be reimbursed at the submitted charge). The $50 payment is per lense; therefore, modifier –RT or –LT should be used, as appropriate. For example, if a patient has the procedure in August on his/her left eye and then in November has the procedure done on the right eye, the ASC where the second service was furnished would also receive the additional $50 payment. Similarly, in the rare circumstance where the procedure is performed bilaterally, the modifiers would be necessary to allow the additional payment for both NTIOLs.

Effective July 1, 2000 and after, if a claim is submitted containing a line for *only* Q1001 or Q1002 (without the line for 66983, 66984, 66985 or 66986), the claim is incomplete and will be returned as unprocessable. ❖

Billing for Multiple Procedures Performed in an ASC

Ambulatory Surgical Center facility charges are subject to Medicare multiple surgery guidelines. Medicare allows the major surgery at 100%, and each additional payable surgical procedure at 50% of the facility rate.

Surgical procedures that have the terminology "each additional" should not be grouped. Such procedures should be billed on separate detail lines. A single unit charge for each service must be determined; therefore, combining these services on a single line delays payment.

Listed below are covered services that, when performed multiple times in a facility, should be submitted on separate detail lines.

15101, 15121, 15201, 15221, 15241, 15261, 19126, 19291, 26861, 26863, 27692, 64476, 64623, 64778, 64832, 64837, 64859, 64901, 64902 ❖

CARDIOLOGY

Separate Payment for Contrast Media Used In Echocardiography Services

Effective for services rendered on or after October 1, 2000, physicians may separately bill for contrast agents used in echocardiography services. Physicians should use HCPCS Code Q0188 (Supply of injectable contrast material for use in echocardiography, per study). This code will be carrier-priced; therefore, the name, strength, and dosage of the contrast material used must be provided in block 19 of Form HCFA-1500 (or electronic media claim [EMC] equivalent).

Q0188 may be billed in addition to the following procedures:

93303, 93304, 93307, 93308, 93312, 93315, 93320, 93321, 93325, 93350.

If the echocardiography service is denied, Q0188 will be denied as well. Q0188 billed without an associated echocardiography service will also be denied. Additional information regarding echocardiography services may be found in the local medical review policy (LMRP) that was published in the January/February 2000 *Medicare B Update!* (pages 48-49).

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

DURABLE MEDICAL EQUIPMENT (DME)

Oral Anti-Cancer Drugs and Oral Anti-Emetics—Carrier Jurisdiction

Effective October 1, 2000, for services rendered on or after January 1, 1998, under all circumstances all oral anti-cancer drugs and all oral anti-emetic drugs must be submitted to the Durable Medical Equipment Regional Carrier (DMERC) for payment. Local carriers will no longer accept these claims for payment.

In order to receive payment from the DMERC, it is necessary for providers to obtain supplier numbers. The DMERC for this region is Palmetto GBA Medicare. Palmetto GBA may be contacted at (803) 735-1034, or write to:

Palmetto GBA Medicare
DMERC Operations
P.O. Box 10041
Columbia, SC 29202-3141

This change affects oral anti-cancer and anti-emetic drugs only. Intravenous anti-cancer and anti-emetics remain unchanged. Please refer to the following table to determine the correct carrier jurisdiction:

COMBINATION	JURISDICTION
Oral chemotherapy drug with oral anti-emetic drug	DMERC maintains processing responsibility for the National Drug Code (NDC) oral chemotherapy drug and the K0415 oral anti-emetic drug code combinations. DMERC processes the NDC oral chemotherapy drug and Q code oral anti-emetic drug(s) when provided in the physician's office. DMERC processes the NDC oral chemotherapy drug and/or Q code oral anti-emetic drug(s) when supplied by a pharmacy.
Oral chemotherapy drug with rectal anti-emetic drug	DMERC maintains responsibility for processing both the NDC oral chemotherapy drug and the K0416 rectal anti-emetic drug.
Oral chemotherapy drug with intravenous anti-emetic drug	DMERC maintains responsibility for processing the NDC oral chemotherapy drug and the local carrier for processing the intravenous anti-emetic J code drug(s).
Intravenous chemotherapy drug with oral anti-emetic drug	Local carrier processes the intravenous J code chemo therapy drug. The oral anti-emetic Q code drug(s) is processed by the DMERC when provided in the physician's office or when provided by a supplier.
Intravenous chemotherapy drug with intravenous anti-emetic drug	Local carrier processes both intravenous chemotherapy J code drug and intravenous anti-emetic J code drug(s).

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INJECTABLE DRUGS

Allowances for Injectable Drugs

Medicare Part B allowances for certain injectable drugs have been updated, effective for services processed on or after July 3, 2000. The new allowances are:

CODE	NAME OF INJECTABLE DRUG	PAR ALLOWANCE	NON-PAR ALLOWANCE	LIMITING CHARGE
J0702	Injection, betamethasone acetate and betamethasone sodium phosphate, per 3 mg	$4.87	$4.63	$5.32
J1455	Injection, foscarnet sodium, per 1,000 mg	$11.99	$11.39	$13.10
J1644	Injection, heparin sodium, per 1,000 units	$0.22	$0.21	$0.24
J1825	Injection, interferon BETA - 1A, per 33 mcg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	$211.47	$200.90	$221.06
J3305	Injection, trimetrexate glucoronate, per 25 mg	$78.37	$74.45	$85.62
J9001	Doxorubicin hydrochloride, all lipid formulations, 10 mg	$335.46	$318.69	$366.49
J9031	BCG live (intravesical) per installation	$159.91	$151.91	$174.70
J9050	Carmustine, 100 mg	$108.95	$103.50	$119.03
J9062	Cisplatin, 50 mg	$237.48	$225.61	$259.45
J9201	Gemcitabine HCL, 200 mg / Gemzar 200 mg	$94.57	$89.84	$103.32
J9208	Ifosfamide, per 1 gm	$149.18	$141.72	$162.98
J9209	Mesna, 200 mg	$38.52	$36.59	$42.08
Q9920	Injection of EPO, per 1,000 units, at patient HCT of 20 or less	$11.84	$11.25	$12.94
Q9921	Injection of EPO, per 1,000 units, at patient HCT of 21	$11.84	$11.25	$12.94
Q9922	Injection of EPO, per 1,000 units, at patient HCT of 22	$11.84	$11.25	$12.94
Q9923	Injection of EPO, per 1,000 units, at patient HCT of 23	$11.84	$11.25	$12.94
Q9924	Injection of EPO, per 1,000 units, at patient HCT of 24	$11.84	$11.25	$12.94
Q9925	Injection of EPO, per 1,000 units, at patient HCT of 25	$11.84	$11.25	$12.94
Q9926	Injection of EPO, per 1,000 units, at patient HCT of 26	$11.84	$11.25	$12.94
Q9927	Injection of EPO, per 1,000 units, at patient HCT of 27	$11.84	$11.25	$12.94
Q9928	Injection of EPO, per 1,000 units, at patient HCT of 28	$11.84	$11.25	$12.94
Q9929	Injection of EPO, per 1,000 units, at patient HCT of 29	$11.84	$11.25	$12.94
Q9930	Injection of EPO, per 1,000 units, at patient HCT of 30	$11.84	$11.25	$12.94
Q9931	Injection of EPO, per 1,000 units, at patient HCT of 31	$11.84	$11.25	$12.94
Q9932	Injection of EPO, per 1,000 units, at patient HCT of 32	$11.84	$11.25	$12.94
Q9933	Injection of EPO, per 1,000 units, at patient HCT of 33	$11.84	$11.25	$12.94
Q9934	Injection of EPO, per 1,000 units, at patient HCT of 34	$11.84	$11.25	$12.94
Q9935	Injection of EPO, per 1,000 units, at patient HCT of 35	$11.84	$11.25	$12.94
Q9936	Injection of EPO, per 1,000 units, at patient HCT of 36	$11.84	$11.25	$12.94
Q9937	Injection of EPO, per 1,000 units, at patient HCT of 37	$11.84	$11.25	$12.94
Q9938	Injection of EPO, per 1,000 units, at patient HCT of 38	$11.84	$11.25	$12.94
Q9939	Injection of EPO, per 1,000 units, at patient HCT of 39	$11.84	$11.25	$12.94
Q9940	Injection of EPO, per 1,000 units, at patient HCT of 40 and/or above	$11.84	$11.25	$12.94

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LABORATORY/PATHOLOGY

Reimbursement For 2000 Automated Multipanel Laboratory Tests

The 2000 Clinical Diagnostic Laboratory Fee Schedule was published in the December 1999 *Medicare B Special Issue Update!* (page 84). This fee schedule did not provide guidelines for automated multi-channel chemistry tests billed on the same date as organ/disease panels.

When both automated multi-channel chemistry tests and organ/disease panels are billed on the same date for the same patient, reimbursement is based on the allowance for the total number of tests performed. This pricing logic is also applied when an automated multi-channel test or organ/disease panels are billed on the same date of service as an individual automated laboratory service. The allowance for all covered tests is calculated, prorated, and distributed among all the detail lines billed. Note - although the reimbursement allowance is the same when the same number of tests are paid, the distribution may vary on the detail line for each patient.

2000 Automated Multi-Channel Chemistry Tests

82040	Albumin
84075	Alkaline phosphatase
84460	ALT (SGPT)
84450	AST (SGOT)
82247	Bilirubin, total
82248	Bilirubin, direct
82310	Calcium
82435	Chloride
82465	Cholesterol
82550	CK, CPK
82374	C02 (bicarbonate)
82565	Creatinine
82977	GGT
82947	Glucose
83615	LDH
84100	Phosphorus
84132	Potassium
84155	Protein, total
84295	Sodium
84478	Triglycerides
84520	Urea nitrogen (BUN)
84550	Uric Acid

Claims for automated multi-channel chemistry tests, organ/disease panels and individual automated laboratory services are reimbursed based on the total number of laboratory procedures allowed. To calculate the allowance, use the chart below.

NUMBER OF TESTS	2000 ALLOWANCE
1 OR 2	$ 7.20
3	$ 9.18
4	$ 9.69
5	$ 10.81
6	$ 10.84
7	$ 11.29
8	$ 11.70
9-10	$ 12.00
11	$ 12.21
12	$ 12.48
13-16	$ 14.61
17-18	$ 14.71
19	$ 15.28
20	$ 15.78
21	$ 16.27
22	$ 16.77

For more information concerning organ or disease panels, refer to the March/April 2000 *Medicare B Update!* (pages 17-18). ❖

Laboratory/Pathology - continued

New CLIA Waived Tests

Listed below are the latest tests approved by the Center for Disease Control as waived tests under the Clinical Laboratory Improvement Amendments (CLIA). The Current Procedural Terminology (CPT) codes for these new tests must have the modifier QW to be recognized as a waived test.

- Roche Diagnostics Chemstrip Micral (urine dipstick), effective: 5/7/1999
- Quidel QuickVue One-Step H. pylori II Test, effective: 8/27/1999
- Ballard Medical Products CLOtest, effective: 10/5/1999
- AvoSure PT System (prescription home use), effective: 2/16/2000
- AvoSure Pro (professional use), effective: 2/16/2000
- Remel RIM7 A.R.C. Mono Test, effective: 2/28/2000
- Remel RIM7 A.R.C. Strep A Test, effective: 2/28/2000
- JANT Pharmacal Corp. H. pylori WBTest, effective: 3/8/2000
- Polymer Technology Systems (PTS) MTM Bioscanner 1000 (for OTC use) for cholesterol, effective: 8/9/1999
- PTS Bioscanner (for OTC use) - for HDL cholesterol, effective: 2/28/2000
- PTS Bioscanner (for OTC use) - for ketones, effective: 3/1/2000
- Phamatech At Home Drug Test (Model 9063), effective: 4/19/2000
- Phamatech At Home Drug Test (Model 9068), effective: 4/19/2000
- Phamatech At Home Drug Test (Model 9073), effective: 4/19/2000
- Phamatech At Home Drug Test (Model 9078), effective: 4/19/2000
- Phamatech At Home Drug Test (Model 9083), effective: 4/19/2000
- Phamatech At Home Drug Test (Model 9133), effective: 4/19/2000

New waived CPT codes have been assigned for the following tests:

- 82010QW for the PTS Bioscanner (for OTC use) - for blood ketones
- 80101QW for the Phamatech At Home Drug Test (Model 9063)
- 80101QW for the Phamatech At Home Drug Test (Model 9068)
- 80101QW for the Phamatech At Home Drug Test (Model 9073)
- 80101QW for the Phamatech At Home Drug Test (Model 9078)
- 80101QW for the Phamatech At Home Drug Test (Model 9083)
- 80101QW for the Phamatech At Home Drug Test (Model 9133)

TEST NAME	MANUFACTURER	CODE	USE
Roche Diagnostics Chemstrip Micral (urine dipstick)	Roche Diagnostics Corporation	82044QW	Monitors low concentrations of albumin in urine which is helpful for early detection in patients at risk for renal disease
Quidel QuickVue One-Step H.pylori II Test.	Quidel Corporation	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to *Helicobacter pylori* in whole blood
Ballard Medical Products CLOtest	Ballard Medical Products	87072QW	Presumptive identification of *Helicobacter pylori* in gastric biopsy tissue, which has been shown to cause chronic active gastritis (ulcers)
AvoSure PT System (prescription home use)	Avocet Medical, Inc.	85610QW	Aid in screening for congenital deficiencies of Factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumarin or warfarin effect; screen for Vitamin K deficiency
AvoSure Pro (professional use)	Avocet Medical, Inc.	85610QW	Aid in screening for congenital deficiencies of Factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumarin or warfarin effect; screen for Vitamin K deficiency

CLIA Waived Tests - continued

TEST NAME	MANUFACTURER	CODE	USE
Remel RIM7 A.R.C. Mono Test	Applied Biotech, Inc.	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis
Remel RIM7 A.R.C. Strep A Test	Applied Biotech, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
JANT Pharmacal Corp. H. pylori WBTest	Applied Biotech, Inc.	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to *Helicobacter pylori* in whole blood
Polymer Technology Systems (PTS) MTM Bioscanner 1000 (for OTC use) for cholesterol	Polymer Technology Systems, Inc.	82465QW	Cholesterol monitoring
PTS Bioscanner (for OTC use) - for HDL cholesterol	Polymer Technology Systems, Inc.	83718QW	Measures ketones in whole blood
PTS Bioscanner (for OTC use) - for blood ketones	Polymer Technology Systems, Inc.	82010QW	Measures ketones in whole blood
Phamatech At Home Drug Test (Model 9063)	Pharmatech	80101QW**	Screening test for the presence/detection of amphetamine in urine
Phamatech At Home Drug Test (Model 9068)	Pharmatech	80101QW**	Screening test for the presence/detection of methamphetamines in urine
Phamatech At Home Drug Test (Model 9073)	Pharmatech	80101QW**	Screening test for the presence/detection of cocaine metabolites in urine
Phamatech At Home Drug Test (Model 9078)	Pharmatech	80101QW**	Screening test for the presence/detection of cannabinoids (THC) in urine
Phamatech At Home Drug Test (Model 9083)	Pharmatech	80101QW**	Screening test for the presence/detection of opiates in urine
Phamatech At Home Drug Test (Model 9133)	Pharmatech	80101QW**	Screening test for the presence/detection of phencyclidine in urine

** This test may not be covered in all instances. ❖

Revised Allowances for Thin–Prep Pap Smears

After review of additional information, Florida Medicare is revising the 2000 fees for the gap filled clinical laboratory codes listed below. Fees have been increased to $27.90 for each of these procedures:

G0123	88142
G0143	88143
G0144	88144
G0145	88145

The revised fees are effective for services rendered on or after January 1, 2000, processed on or after April 24, 2000. ❖

MEDICARE PHYSICIAN FEE SCHEDULE

Fourth Quarter Changes to the 2000 Medicare Physician Fee Schedule

The Health Care Financing Administration (HCFA) provides quarterly adjustments to the MPFS. This article outlines changes for the fourth quarter of calendar year 2000 (there were no changes for the third quarter).

These changes are effective for services rendered on or after January 1, 2000, and will be implemented in the Florida Medicare Part B processing system on October 5, 2000. The allowances listed herein supersede those published in the *2000 Medicare Part B Physician and Non-Physician Practitioner Fee Schedule* book (November 1999).

	PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE			
CODE	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	
G0167	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	
J3370	5.19	5.19	5.19	4.93	4.93	4.93	5.67	5.67	5.67	
76873	133.22	144.58	154.16	126.56	137.35	146.45	145.54	157.95	168.42	
7687326	53.67	56.83	59.77	50.99	53.99	56.78	58.63	62.09	65.30	
90748	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	
17304	487.34	514.89	537.43	462.97	489.15	510.56	532.42	562.52	587.14	
	387.03	406.33	423.47	367.68	386.01	402.30	422.83	443.92	462.64	*
17305	207.74	220.05	229.73	197.35	209.05	218.24	226.96	240.40	250.98	
	152.21	159.95	166.64	144.60	151.95	158.31	166.29	174.75	182.05	*
17306	191.78	202.77	211.60	182.19	192.63	201.02	209.52	221.53	231.17	
	144.22	151.31	157.57	137.01	143.74	149.69	157.56	165.31	172.15	*
17310	62.03	65.71	68.79	58.93	62.42	65.35	67.77	71.79	75.15	
	45.71	48.05	50.25	43.42	45.65	47.74	49.94	52.49	54.90	*
43239	248.33	265.09	278.24	235.91	251.84	264.33	271.30	289.61	303.98	
	176.14	186.96	196.22	167.33	177.61	186.41	192.43	204.25	214.37	*
45330	90.43	96.68	101.64	85.91	91.85	96.56	98.79	105.62	111.04	
	53.64	56.86	59.84	50.96	54.02	56.85	58.60	62.12	65.38	*
58100	73.38	78.64	82.81	69.71	74.71	78.67	80.17	85.91	90.47	
	39.37	41.83	44.17	37.40	39.74	41.96	43.01	45.70	48.26	*
65855	356.48	378.65	395.65	338.66	359.72	375.87	389.45	413.68	432.25	
	277.00	292.63	305.35	263.15	278.00	290.08	302.62	319.70	333.59	*
66172	1027.21	1086.61	1134.15	975.85	1032.28	1077.44	1122.23	1187.12	1239.06	
66761	318.98	338.43	353.51	303.03	321.51	335.83	348.49	369.73	386.21	
	257.20	271.56	283.32	244.34	257.98	269.15	280.99	296.68	309.53	*
66762	351.00	372.23	388.77	333.45	353.62	369.33	383.47	406.66	424.73	
	285.05	300.86	313.85	270.80	285.82	298.16	311.42	328.69	342.88	*
66770	390.75	414.20	432.51	371.21	393.49	410.88	426.89	452.51	472.52	
	318.90	336.44	350.88	302.96	319.62	333.34	348.40	367.56	383.34	*
66821	191.49	203.42	212.66	181.92	193.25	202.03	209.20	222.24	232.33	
	179.00	189.90	198.46	170.05	180.41	188.54	195.56	207.47	216.82	*
88104	45.75	48.68	51.00	43.46	46.25	48.45	49.98	53.18	55.72	
88104TC	16.59	18.21	19.47	15.76	17.30	18.50	18.12	19.89	21.27	
88304	35.34	38.16	40.33	33.57	36.25	38.31	38.61	41.69	44.06	
88304TC	20.76	22.72	24.20	19.72	21.58	22.99	22.68	24.82	26.44	
88305	77.80	83.21	87.38	73.91	79.05	83.01	85.00	90.91	95.46	
88305TC	34.08	37.27	39.65	32.38	35.41	37.67	37.23	40.72	43.32	
88312	52.88	56.31	58.86	50.24	53.49	55.92	57.77	61.52	64.30	
88312TC	26.52	28.83	30.44	25.19	27.39	28.92	28.97	31.50	33.26	
92004	103.14	108.77	113.36	97.98	103.33	107.69	112.68	118.83	123.85	
	79.89	83.60	86.94	75.90	79.42	82.59	87.28	91.33	94.98	*
95819	132.55	142.64	150.62	125.92	135.51	143.09	144.81	155.83	164.55	
95819TC	75.04	82.23	87.72	71.29	78.12	83.33	81.98	89.84	95.83	
95904	30.60	32.76	34.54	29.07	31.12	32.81	33.43	35.79	37.73	
95904TC	8.95	9.95	10.79	8.50	9.45	10.25	9.78	10.87	11.79	
97022	16.97	18.12	19.01	16.12	17.21	18.06	18.54	19.80	20.77	
	10.72	11.36	11.91	10.18	10.79	11.31	11.71	12.41	13.01	*
97035	12.49	13.19	13.79	11.87	12.53	13.10	13.65	14.41	15.07	
	10.76	11.32	11.82	10.22	10.75	11.23	11.76	12.37	12.91	*

N/C = Noncovered service

* = These amounts apply when service is performed in a facility setting

SURGERY

Billing for G0170, G0171—Clarification

Information regarding billing for Apligraf® was published in the March/April 2000 *Medicare B Update!* (page 14). Since that time, additional clarification has been received.

Although the original article was specific to use of the Apligraf® product, only procedure code Q0185 should be used in that instance. Codes Q0183 and Q0184 are used for other brands/types of cultured skin substitutes. In any case, when billing for these services, documentation should be submitted with the claim including but not limited to operative report, office records, and/or progress notes.

Physician Billing

Physicians should bill for the surgical service being performed using the following procedure code(s):

G0170 Application of tissue cultured skin grafts, including bilaminate skin substitutes or neodermis, including site preparation, **initial 25 sq. Cms.**

G0171 Application of tissue cultured skin grafts, including bilaminate skin substitutes or neodermis, including site preparation, **each additional 25 sq. Cms**.

Allowances for G0170 and G0171 do not contain payment for the specific tissue cultured skin graft product used in the procedure. In order to provide payment for the product used, code Q0183, Q0184, or Q0185 should be used in conjunction with the G codes. For example, if a physician used Apligraf® on a vascular wound measuring 70 square centimeters, proper coding would be G0170 (1) and G0171 (2), plus 70 units of Q0185.

Reimbursement for the surgical supply is made on an individual consideration basis; an invoice for the supply must accompany the claim.

Q0183 Dermal tissue of human origin, with and without bioengineered or processed elements, but **without** metabolically active elements, per square centimeters.

Q0184 Dermal tissue of human origin, with and without bioengineered or processed elements, but **with** metabolically active elements, per square centimeters.

Q0185 Dermal **and epidermal** tissue of human origin, with and without bioengineered or processed elements, with metabolically active elements, per square centimeters.

Indications

- Apligraf® is indicated for use with standard therapeutic compression for the treatment of non-infected partial and full-thickness skin ulcers due to venous insufficiency of greater than one-month duration *and* that have not adequately responded to conventional ulcer therapy.
- Apligraf® is indicated for use with standard diabetic foot ulcer care for treatment of full-thickness neuropathic foot ulcers of greater than three weeks duration which have not adequately responded to conventional ulcer therapy and which extend through the dermis but without tendon, muscle, capsule or bone exposure.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

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 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.

LMRP Format

The LMRP format is now more consistent with the manner in which the carrier reports LMRPs to the Health Care Financing Administration (HCFA). Information now provided in the *Update!* includes (where applicable) HCFA's national coverage policy, the sources of information used in developing local policy, and the policy's revision history.

Effective Dates

The effective dates are provided in each policy. Effective dates are based on the date claims are *processed*, not the date of service (unless otherwise noted in the policy).

More Information

Additional LMRPs may be obtained by accessing Florida Medicare's provider website at **www.floridamedicare.com.** ❖

Medical Policy Table of Contents

Corrections to Policy

A0320: Ground Ambulance Services

The LMRP for Ground Ambulance Services was published in the July/August 2000 *Medicare B Update!* (pages 26-30) The information under the Coding Guidelines section of the policy referencing modifiers QM (Ambulance service provided under arrangement by a provider of services) and QN (Ambulance service furnished directly by a provider of services) are valid for services billed only to the intermediary (Medicare Part A). Therefore, the statement indicating that modifier QM or QN must be billed with every HCPCS code has been deleted.

Additionally, the policy indicated that advance beneficiary notice (ABN) is required for reasons of medical necessity. This is incorrect; the limitation of liability provision does not apply to ambulance services. Therefore, that statement has also been deleted.

J7190: Hemophilia Clotting Factors

The LMRP for Hemophilia Clotting Factors was published in the May/June 2000 *Update!* (pages 17-18). Since that time it has been determined that clotting factors are billed to the carrier per International Unit (I.U.), not per 100 I.U.s. Therefore, the statement under the Coding Guidelines section of the policy referencing the billing per 100 I.U.s has been deleted. ❖

2001 ICD-9-CM Coding Changes

The 2001 update to the ICD-9-CM diagnosis coding structure is effective October 1, 2000. Providers may begin using the updated ICD-9-CM codes for claims submitted on or after October 1, 2000 and the updated diagnostic codes must be used for all services billed on or after January 1, 2001. A 90-day grace period is provided, during which Florida Medicare will accept both old and new ICD-9-CM codes, for claims received October 1 through December 31, 2000. This grace period is to allow providers sufficient time to obtain and integrate the updated ICD-9-CM codes into their billing systems. For claims received on or after January 1, 2001, the latest version of the ICD-9-CM codes *must* be used.

Florida Medicare has reviewed local medical review policies (LMRPs) for procedure codes with specific diagnosis criteria that are affected by the 2001 ICD-9-CM update. The following table lists the LMRPs affected, the publication in which diagnosis criteria appeared, and the specific conditions revised as a result of the 2001 update:

LMRP TITLE	PUBLICATION LISTING COVERED CONDITIONS	2001 CHANGES
44388: Colonoscopy	Jul/Aug 1998 *Update!* (page 48) Nov/Dec 1998 *Update!* (page 7)	Change descriptor for 564.1 to read irritable *bowel syndrome*; Change 783.2 to 783.21 (Loss of weight)
52282: Urethral Stents	Jul/Aug 1998 *Update!* (page 49) Sep/Oct 1998 *Update!* (page 35)	Change 600 to 600.0-600.9
53850: Prostate Treatments	Jan/Feb 1998 *Update!* (page 13) Nov/Dec 1998 *Update!* (page 24) Nov/Dec 1999 *Update!* (page 31)	Change 600 to 600.0 Hypertrophy (benign) of prostate
70450: Computerized Tomography Scans	Sep/Oct 1999 *Update!* (page 31) Nov/Dec 1999 *Update!* (page 31)	Change 781.0-781.9 to 781.0-781.8; Add 781.99 (Other symptoms involving nervous and musculoskeletal systems)
70551: Magnetic Resonance Imaging of the Brain	Mar/Apr 1997 *Update!* (page 55) May/Jun 1997 *Update!* (page 13) Nov/Dec 1997 *Update!* (page 5)	Change 781.0-781.9 to 781.0-781.8; Add 781.99 (Other symptoms involving nervous and musculoskeletal systems)
71010: Chest X-Ray	Mar/Apr 1997 *Update!* (page 56) Sep/Oct 1997 *Update!* (page 36) Nov/Dec 1997 *Update!* (page 5) Nov/Dec 1998 *Update!* (page 28)	Change 493.00-493.91 to 493.00-493.92; Change 494 to 494.0-494.1; Change 783.2 to 783.21 (Loss of weight)
72141: Magnetic Resonance Imaging of the Spine	Mar/Apr 1997 *Update!* (page 57) May/Jun 1997 *Update!* (page 13)	Change 781.0-781.9 to 781.0-781.99
72192: Computed Tomography of the Pelvis	Jul/Aug 1999 *Update!* (page 30)	Change 996.89 to 996.87 (Complications of transplanted organ, intestines) Add V42.84 (Organ or tissue replaced by transplant, intestines
78460: Myocardial Perfusion Imaging	Jan/Feb 1999 *Update!* (page 29)	Change V67.0 to V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery)
78472: Cardiac Blood Pool Imaging	Mar/Apr 2000 *Update!* (page 38)	Change V67.0 to V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery)
82270: Fecal Occult Blood Testing	Mar/Apr 1997 *Update!* (page 43) Nov/Dec 1998 *Update!* (page 7)	Change 783.2 to 783.21 (Loss of weight)
82607: Vitamin B-12 Assay	Mar/Apr 2000 *Update!* (page 39)	Add 558.3 (Allergic gastroenteritis and colitis)
82784: Gammaglobulin; IgA, IgD, IgG, IgM, each	Mar/Apr 1997 *Update!* (page 59) Jul/Aug 1997 *Update!* (page 31) Nov/Dec 1997 *Update!* (page 32)	Change 600 to 600.0-600.9 (Hyperplasia of prostate)

2001 ICD-9-CM Coding Changes - continued

82947: Blood Glucose Testing	Jan/Feb 1998 *Update!* (page 48) May/Jun 1998 *Update!* (page 49) Jul/Aug 1999 *Update!* (page 32)	Change 783.2 to 783.21 (Loss of weight)
83970: Parathormone	Nov/Dec 1998 *Update!* (page 32)	Change V67.0 to V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery)
84436: Thyroid Function Tests	Mar/Apr 2000 *Update!* (page 40)	Change 783.2 to 783.21 (Loss of weight); Change descriptor for 783.4 (Lack of expected normal physiological development *in childhood*)
93015: Cardiovascular Stress Test	Oct 1996 Special Issue *Update!* Jul/Aug 1997 *Update!* (page 22)	Change V67.0 to V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery)
93350: Stress Echocardiography	Jan/Feb 1998 *Update!* (page 30)	Change V67.0 to V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery)
93875: Non-Invasive Extracranial Arterial Studies	Sep/Oct 1999 *Update!* (page 37)	Change V67.0 to V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery)
93922: Non-Invasive Physiologic Studies of Upper or Lower Extremity Arteries	Nov/Dec 1999 *Update!* (page 37)	Change 707.1 to 707.10-707.19
93925: Duplex Scan of Lower Extremity Arteries	Jan/Feb 1997 *Update!* (page 44)	Change V67.0 to V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery)
93975: Duplex Scanning	May/Jun 1999 *Update!* (page 26)	Change 783.2 to 782.21 (Loss of weight); Change V67.0 to V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery)
94010: Spirometry	Jul/Aug 1998 *Update!* (page 54) Nov/Dec 1998 *Update!* (page 38)	Change 493.00-493.91 to 493.00-493.92; Change 494 to 494.0-494.1
94240: Functional Residual Capacity or Residual Volume	Jul/Aug 1998 *Update!* (page 56) Nov/Dec 1998 *Update!* (page 38)	Change 493.00-493.91 to 493.00-493.92; Change 494 to 494.0-494.1
94620: Pulmonary Stress Test	Jul/Aug 1998 *Update!* (page 57) Nov/Dec 1998 *Update!* (page 7) Jan/Feb 1999 *Update!* (page 13)	Change 493.00-493.91 to 493.00-493.92; Change 494 to 494.0-494.1
94642: Aerosolized Pentamidine Isethionate	Nov/Dec 1998 *Update!* (page 38)	Change V42.0-V42.83 to V42.0-V42.84
94664: Diagnostic Aerosol or Vapor Inhalation	Nov/Dec 1998 *Update!* (page 39)	Change 493.00-493.91 to 493.00-493.92; Change 494 to 494.0-494.1
94760: Non-Invasive Ear or Pulse Oximetry for Oxygen Saturation	Sep/Oct 1998 *Update!* (page 40) Nov/Dec 1998 *Update!* (page 7)	Change 493.00-493.01 to 493.00-493.02; Change 493.10-493.11 to 493.10-493.12; Change 493.20-493.21 to 493.20-493.22; Change 493.90-493.91 to 493.90-493.92; Change 494 to 494.0-494.1
94799: Pulmonary Rehabilitation Services	Mar/Apr 1998 *Update!* (page 51) Jul/Aug 1998 *Update!* (page 58) Nov/Dec 1998 *Update!* (page 7)	Change 494 to 494.0-494.1

2001 ICD-9-CM Coding Changes - continued

95004: Allergy Skin Tests	May/Jun 2000 *Update!* (page 51)	Add 995.7 (Other adverse food reactions, not elsewhere classified)
95816: Electroencephalography	May/Jun 1996 *Update!* (page 46) Jul/Aug 1996 *Update!* (page 40) Sep/Oct 1996 *Update!* (page 51) Jan/Feb 1998 *Update!* (page 50)	Change 294.0-294.1 to 294.0-294.11
95937: Neuromuscular Junction Testing	Mar/Apr 1999 *Update!* (page 61)	Change 781.9 to 781.99
A4644: Low Osmolar Contrast Media	Jul/Aug 1998 *Update!* (page 44) Nov/Dec 1998 *Update!* (page 7) Jan/Feb 2000 *Update!* (page 30)	Add 493.02 (Extrinsic asthma with acute exacerbation) Add 493.12 (Intrinsic asthma with acute exacerbation) Add 493.22 (Chronic obstructive asthma with acute exacerbation) Add 493.92 (Asthma, unspecified with acute exacerbation) Change V15.0 to V15.01-V15.09
Q0136: Non-ESRD Epoetin	May/Jun 2000 *Update!* (page 19)	Add 285.22 (Anemia in neoplastic disease) *Note: dual diagnoses are required. - ICD-9-CM code 285.22* ***must*** *be billed with V58.1.*

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

HealthCare Consultants of America (800) 253-4945	Medicode Publications (800) 999-4600	St. Anthony's Publishing (800) 632-0123

ICD-9-CM and other coding materials may also be obtained from local medical publishing and consulting firms. ❖

A9270: The List of Medicare Noncovered Services

The following additions to Local Noncoverage are effective October 16, 2000:

SpineCATHÔ IntraDiscal ElectroThermalÔ Therapy (IDETÔ) - IDET (also referred to as intradiscal electrothermal annuloplasty) is a new outpatient procedure for the treatment of patients with painful degenerative disc disease. It involves threading a flexible heating electrode percutaneously into the disc, such that the electrode passes circumferentially around the inner surface of the annulus of the disc. The electrode is then heated and denatures (shrinks) the collagen fibers of the annulus, and coagulates the nerve endings in it. The heat is slowly increased and lasts for 14-17 minutes. Treating one disc takes about an hour, and patients recover in the hospital for about 30-40 minutes before going home.

Only one study has been published in a peer reviewed medical. The study was a prospective nonrandomized clinical trial involving 25 consecutive patients. This study was nonrandomized and therefore, a placebo effect could not be definitively evaluated. The other available literature consists of abstracts of small case series. In addition, the scientific rationale underlying the therapy is still preliminary. There is also no evidence as to whether the effects of the collagen shrinkage are permanent, or what the impact of the thermal treatment on the disc nucleus may be.

Florida Medicare has determined that SpineCATHÔ IntraDiscal ElectroThermalÔ Therapy (IDETÔ) is an investigational/experimental procedure and therefore, not considered medically reasonable and necessary. Providers should bill this procedure with HCPCS code **A9270*** (noncovered item or service). Any services related to this procedure (e.g., HCPCS codes 62292, 72295, 76000, and 76001) should not be submitted for reimbursement, as services performed in relation to a noncovered service/ procedure are also considered noncovered.

Quantitative Sensory Testing (QST) - QST performed with portable hand-held devices (e.g., current, vibration, thermal perception, or tactile measurements) does not represent the services involved in performing nerve conduction studies (95900, 95903, or 95904) or short-latency somatosensory evoked potentials (95925, 95926, or 95927). QST testing is considered part of the evaluation and management service and, therefore, is not separately reimbursable. These services should be billed with **A9270** (noncovered service).

Leukocyte histamine release test (LHR) - 86343* - is considered investigational/experimental and therefore, not considered medically reasonable and necessary.

* Denotes services that are noncovered due to their being investigational/experimental ❖

J2430: Pamidronate (Aredia®, APD)

The complete local medical review policy (LMRP) for Pamidronate was published in the March/April 2000 *Medicare B Update!* (page 28). Since that time, an additional ICD-9-CM code (198.5 - Secondary malignant neoplasm of the bone and bone marrow) has been added to the policy.

Pamidronate is FDA-approved as an adjunct treatment of osteolytic lesions of breast cancer and myeloma. Please note that the billing of Pamidronate for metastatic breast cancer requires submission of dual diagnoses. The primary and secondary site of the malignancy must *both* be billed, to indicate that the breast malignancy is metastatic (i.e., both ICD-9-CM codes 198.5 and a code in the range 174.0-175.9 must be billed). ❖

J9999: Antineoplastic Drugs–Addition to Policy

The complete local medical review policy (LMRP) for Antineoplastic Drugs was published in the March/April 1999 Medicare B Update! *(pages 45-48). Another drug, Irinotecan (Camptosar®) has since been added to the policy. The entire Antineoplastic Drugs policy will be published in a future issue of the* Update!

Irinotecan (Camptosar®)

Irinotecan, also known as CPT-11, is an analog of camptothecin, a plant alkaloid. It inhibits the enzyme, topoisomerase I, which is necessary for DNA replication. Irinotecan is FDA approved for the treatment of colorectal carcinoma.

Florida Medicare will cover Irinotecan for its FDA approved use, as well as for the treatment of the following off-labeled indications:

- Small-cell lung carcinoma
- Cervical carcinoma

HCPCS CODES

J9206 Irinotecan, 20 mg

ICD-9-CM Codes That Support Medical Necessity

153.0-154.8 Malignant neoplasm of colon, rectum, rectosigmoid juction, and anus

162.2-162.9 Malignant neoplasm of lung (small-cell lung carcinoma)

180.0-180.9 Malignant neoplasm of cervix uteri

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must substantiate the medical need for the use of these chemotherapy drugs by clearly indicating the condition for which these drugs are being used. This documentation is usually found in the history and physical or in the office/progress notes.

Effective Date

The addition of Irinotecan iseffective for services processed on or after October 16, 2000.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

Medical Policy Procedures: 20600

This LMRP was originally published in the September/October 1995 Medicare B Update! *(pages 23-26).Because Florida Medicare continues to receive significantly more claims for arthrocentesis per 1,000 Medicare beneficiaries for rheumatologists than Medicare does nationally per 1,000 beneficiaries for the same specialty, the policy is being republished below.*

Arthrocentesis is the puncture of a joint space with a needle in order to aspirate (withdraw) accumulated fluid from the joint and/or to inject an anesthetic agent and/or a steroid agent into the joint to relieve inflammation and pain.

Policy Type

Local medical necessity policy

Indications and Limitations of Coverage and/or Medical Necessity

Arthrocentesis, Small Joint:

Arthrocentesis, aspiration and/or injection (20600) is a covered service under the Medicare program when performed by a physician within the accepted standards of medical practice.

The following Indications and Limitations statement applies to Arthrocentesis, Small Joint, Intermediate Joint, and Major Joint.

Arthrocentesis, injection or aspiration would be medically necessary when fluid (effusion) or inflammation is present in a joint or bursa. Inflammation would be characterized by the presence of warmth, pain and/or swelling.

Arthrocentesis, aspiration, or injection of a joint or bursa would be considered medically necessary when (see Covered ICD-9-CM Codes):

- there is localized pain at a joint or over the site of a bursa. Pain over the bursa may be increased when muscles and tendons over the bursa are moved against resistance. Joint pain may be increased at night and on motion,
- there is pain swelling, warmth and/or redness at the joint site or over the bursa if the bursa is superficial,
- there is an accumulation of fluid. Repeat aspiration may be warranted based on the clinical situation when there is a re-accumulation of fluid,
- necessity for fluid aspiration for biochemical, or cellular diagnosis and/or culture, and
- pyarthrosis is present and repeat aspirations are necessary (sometimes at intervals of 2-6 hours) for decompressing a joint and instilling antibiotics.

20600 - continued

Claims submitted for arthrocentesis performed at unusually frequent intervals will be reviewed by Medicare to make certain that the services were medically reasonable.

HCPCS Codes

20600 Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (e.g., fingers, toes)

ICD-9-CM Codes That Support Medical Necessity

Appropriate ICD-9-CM codes for arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (e.g., fingers, toes) (CPT code 20600) include:

274.0	Gouty arthropathy
696.0	Psoriatic arthropathy
711.04	Pyogenic arthritis, hand
711.07	Pyogenic arthritis, ankle and foot
712.84	Other specified crystal arthropathies, hand
712.87	Other specified crystal arthropathies, ankle and foot
714.0	Rheumatoid arthritis
714.9	Unspecified inflammatory polyarthropathy
715.04	Osteoarthrosis of hand, generalized
715.09	Osteoarthrosis of multiple sites generalized
715.14	Osteoarthrosis of multiple sites, localized, primary
715.17	Osteoarthrosis of foot, localized primary
715.24	Osteoarthrosis of hand, localized, secondary
715.27	Osteoarthrosis of foot, localized, secondary
715.34	Osteoarthrosis of hand, localized, not specified whether primary or secondary
715.37	Osteoarthrosis of foot, localized, not specified whether primary or secondary
715.89	Osteoarthrosis involving, or with mention of more than one site, but not specified as generalized
715.94	Osteoarthrosis of hand, unspecified whether generalized or localized
715.97	Osteoarthrosis of foot, unspecified whether generalized or localized
716.14	Traumatic arthropathy of the hand
716.17	Traumatic arthropathy of the foot
716.19	Traumatic arthropathy of multiple sites
716.54	Unspecified polyarthropathy or polyarthritis of the hand
716.57	Unspecified polyarthropathy or polyarthritis of the foot
716.59	Unspecified polyarthropathy or polyarthritis of multiple sites
716.84	Other specified arthropathy of the hand
716.87	Other specified arthropathy of the foot
716.89	Other specified arthropathy of multiple sites
716.94	Arthropathy of the hand, unspecified
716.97	Arthropathy of the foot, unspecified
716.99	Arthropathy of multiple sites, unspecified
719.04	Effusion of joint of hand
719.07	Effusion of joint of foot
719.09	Effusion of joint, multiple sites
719.24	Villonodular synovitis of the hand
719.27	Villonodular synovitis of the foot
719.29	Villonodular synovitis of multiple sites
719.44	Pain in joint of the hand
719.47	Pain in joint of the foot
719.49	Pain in joint, multiple sites
726.4	Enthesopathy of carpus
726.70	Enthesopathy, of ankle and tarsus, unspecified
726.73	Calcaneal spur
726.90	Enthesopathy, unspecified site
727.00	Synovitis, unspecified
727.01	Synovitis in diseases classified elsewhere
727.03	Trigger finger (acquired)
727.1	Bunion
727.3	Other bursitis
727.40	Synovial cyst, unspecified
727.41	Ganglion of joint
727.49	Cyst of bursa
728.71	Plantar fascial fibromatosis
733.90	Disorder of bone and cartilage, unspecified
733.99	Other disorders of bone and cartilage
735.2	Hallux rigidus
735.4	Other hammer toe (acquired)

Arthrocentesis, Intermediate Joint:

See narrative for Arthrocentesis, Small Joint

Arthrocentesis, aspiration and/or injection (20605) is a covered service under the Medicare program when performed by a physician within the accepted standards of medical practice.

HCPCS Codes

20605 intermediate joint, bursa or ganglion cyst (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)

ICD-9-CM Codes That Support Medical Necessity

Appropriate ICD-9-CM codes for arthrocentesis, aspiration and/or injection; intermediate joint, bursa or ganglion cyst (e.g., tempomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) (CPT code 20605) include:

274.0	Gouty arthropathy
696.0	Psoriatic arthropathy
711.03	Pyogenic arthritis, forearm
711.07	Pyogenic arthritis, ankle and foot
712.83	Other specified crystal arthropathies, forearm
712.87	Other specified crystal arthropathies, ankle and foot
714.0	Rheumatoid arthritis
714.9	Unspecified inflammatory polyarthropathy
715.09	Osteoarthrosis of multiple sites generalized
715.13	Osteoarthrosis of forearm, localized, primary
715.16	Osteoarthrosis of lower leg, localized, primary

20600 - continued

715.17	Osteoarthrosis of ankle, localized primary
715.18	Osteoarthrosis of other specified sites, localized, primary
715.23	Osteoarthrosis of forearm, localized, secondary
715.26	Osteoarthrosis of lower leg, localized, secondary
715.27	Osteoarthrosis of ankle, localized, secondary
715.28	Osteoarthrosis of other specified sites, localized, secondary
715.33	Osteoarthrosis of forearm, localized, not specified whether primary or secondary
715.36	Osteoarthrosis of lower leg, localized, not specified whether primary or secondary
715.37	Osteoarthrosis of ankle, localized, not specified whether primary or secondary
715.38	Osteoarthrosis of other specified sites, localized, not specified whether primary or secondary
715.89	Osteoarthrosis involving, or with mention of more than one site, but not specified as generalized
715.93	Osteoarthrosis of forearm, unspecified whether generalized or localized
715.97	Osteoarthrosis of ankle, unspecified whether generalized or localized
715.98	Osteoarthrosis of other specified sites, unspecified whether generalized or localized
716.13	Traumatic arthropathy of the forearm
716.16	Traumatic arthropathy of the lower leg
716.17	Traumatic arthropathy of the ankle
716.18	Traumatic arthropathy of other specified sites
716.19	Traumatic arthropathy of multiple sites
716.53	Unspecified polyarthropathy or polyarthritis of the forearm
716.56	Unspecified polyarthropathy or polyarthritis of the lower leg
716.57	Unspecified polyarthropathy or polyarthritis of the ankle
716.58	Unspecified polyarthropathy or polyarthritis of other specified sites
716.59	Unspecified polyarthropathy or polyarthritis of multiple sites
716.83	Other specified arthropathy of the forearm
716.86	Other specified arthropathy of the lower leg
716.87	Other specified arthropathy of the ankle
716.88	Other specified arthropathy of other specified sites
716.89	Other specified arthropathy of multiple sites
716.93	Arthropathy of the forearm, unspecified
716.96	Arthropathy of the lower leg, unspecified
716.97	Arthropathy of the ankle, unspecified
716.98	Arthropathy of other specified sites, unspecified
716.99	Arthropathy of multiple sites, unspecified
719.03	Effusion of joint of the forearm
719.06	Effusion of joint of the lower leg
719.07	Effusion of joint of the ankle
719.08	Effusion of joint of other specified sites
719.09	Effusion of joint, multiple sites
719.23	Villonodular synovitis of the forearm
719.26	Villonodular synovitis of the lower leg
719.27	Villonodular synovitis of the ankle
719.28	Villonodular synovitis of other specified sites
719.29	Villonodular synovitis of multiple sites
719.43	Pain in joint of the forearm
719.46	Pain in joint of the lower leg
719.47	Pain in joint of the ankle
719.48	Pain in joint of other specified sites
719.49	Pain in joint of multiple sites
726.33	Olecranon bursitis
726.70	Enthesopathy of ankle and tarsus, unspecified
726.90	Enthesopathy, unspecified site
727.00	Synovitis, unspecified
727.01	Synovitis in diseases classified elsewhere
727.06	Tenosynovitis of foot and ankle
727.3	Bursitis, other
727.40	Synovial cyst, unspecified
727.41	Ganglion of joint
727.49	Cyst of bursa
733.90	Disorder of bone and cartilage, unspecified
733.99	Other disorders of bone and cartilage

Arthrocentesis, Major Joint:

See narrative for Arthrocentesis, Small Joint

Arthrocentesis, aspiration and/or injection (20610) is a covered service under the Medicare program when performed by a physician within the accepted standards of medical practice.

HCPCS Codes

20610	major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa)

ICD-9-CM Codes That Support Medical Necessity

Appropriate ICD-9-CM codes for arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa) (CPT code 20610) include:

274.0	Gouty arthropathy
696.0	Psoriatic arthropathy
711.01	Pyogenic arthritis, shoulder region
711.05	Pyogenic arthritis, pelvic region and thigh
711.06	Pyogenic arthritis, lower leg
712.81	Other specified crystal arthropathies, shoulder region
712.85	Other specified crystal arthropathies, pelvic region and thigh
712.86	Other specified crystal arthropathies, lower leg
714.0	Rheumatoid arthritis
714.9	Unspecified inflammatory polyarthropathy
715.06	Osteoarthrosis, generalized, lower leg
715.09	Osteoarthrosis of multiple sites generalized

20600 - continued

715.11	Osteoarthrosis of shoulder region, localized, primary
715.12	Osteoarthrosis of upper arm, localized, primary
715.15	Osteoarthrosis of pelvic region and thigh, localized, primary
715.16	Osteoarthrosis, localized, primary, lower leg
715.18	Osteoarthrosis of other specified sites, localized, primary
715.21	Osteoarthrosis of shoulder region, localized, secondary
715.22	Osteoarthrosis of upper arm, localized, secondary
715.25	Osteoarthrosis of pelvic region and thigh, localized, secondary
715.26	Osteoarthrosis, localized, secondary, lower leg
715.28	Osteoarthrosis of other specified sites, localized, primary
715.31	Osteoarthrosis of shoulder region, localized, not specified whether primary or secondary
715.32	Osteoarthrosis of upper arm, localized, not specified whether primary or secondary
715.35	Osteoarthrosis of pelvic region and thigh, localized, not specified whether primary or secondary
715.36	Osteoarthrosis, localized, not specified as primary or secondary, lower leg
715.38	Osteoarthrosis of other specified sites, localized, not specified whether primary or secondary
715.86	Osteoarthrosis involving, or with mention of more than one site, but not specified as generalized, lower leg
715.89	Osteoarthrosis involving, or with mention of more than one site, but not specified as generalized
715.91	Osteoarthrosis of the shoulder region, unspecified whether generalized or localized
715.92	Osteoarthrosis of the upper arm, unspecified whether generalized or localized
715.95	Osteoarthrosis of the pelvic region and thigh, unspecified whether generalized or localized
715.96	Osteoarthrosis, unspecified whether generalized or localized, lower leg
715.98	Osteoarthrosis of other specified sites, unspecified whether generalized or localized
716.11	Traumatic arthropathy of the shoulder region
716.12	Traumatic arthropathy of the upper arm
716.15	Traumatic arthropathy of the pelvic region and thigh
716.18	Traumatic arthropathy of other specified sites
716.19	Traumatic arthropathy of multiple sites
716.51	Unspecified polarthropathy or polyarthritis of the shoulder region
716.52	Unspecified polyarthropathy or polyarthritis of the upper arm
716.55	Unspecified polyarthropathy or polyarthritis of the pelvic region and thigh
716.58	Unspecified polyarthropathy or polyarthritis of other specified sites
716.59	Unspecified polyarthropathy or polyarthritis of multiple sites
716.81	Other specified arthropathy of the shoulder region
716.82	Other specified arthropathy of the upper arm
716.85	Other specified arthropathy of the pelvic region and hip
716.86	Other specified arthropathy, lower leg
716.88	Other specified arthropathy of other specified sites
716.89	Other specified arthropathy of multiple sites
716.91	Arthropathy of the shoulder region, unspecified
716.92	Arthropathy of the upper arm, unspecified
716.95	Arthropathy of the pelvic region and hip, unspecified
716.96	Arthropathy, unspecified, lower leg
716.98	Arthropathy of other specified sites, unspecified
716.99	Arthropathy of multiple sites, unspecified
717.0	Old bucket handle tear of medial meniscus
717.1	Derangement of anterior horn of medial meniscus
717.2	Derangement of posterior horn of medial meniscus
717.3	Other and unspecified derangement of medial meniscus
717.40	Derangement of lateral meniscus, unspecified
717.41	Bucket handle tear of lateral meniscus
717.42	Derangement of anterior horn of lateral meniscus
717.43	Derangement of posterior horn of lateral meniscus
717.5	Derangement of meniscus not elsewhere classified
719.01	Effusion of joint of the shoulder region
719.02	Effusion of joint of the upper arm
719.05	Effusion of joint of pelvic region and thigh
719.06	Effusion of joint, lower leg
719.08	Effusion of joint of other specified sites
719.09	Effusion of joint of multiple sites
719.21	Villonodular synovitis of the shoulder region
719.22	Villonodular synovitis of the upper arm
719.25	Villonodular synovitis of pelvic region and thigh
719.26	Villonodular synovitis, lower leg
719.28	Villonodular synovitis of other specified sites
719.29	Villonodular synovitis of multiple sites
719.41	Pain in joint of the shoulder region
719.42	Pain in joint of the upper arm
719.45	Pain in joint of the pelvic region and thigh

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719.46	Pain in joint, lower leg
719.48	Pain in joint of other specified sites
719.49	Pain in joint of multiple site
720.2	Sacroiiliitis, not elsewhere classified
724.1	Pain in the thoracic spine
724.2	Lumbago
724.79	Other disorders of the coccyx
726.0	Adhesive capsulitis of shoulder
726.10	Disorders of bursae and tendons in shoulder region unspecified
726.11	Calcifying tendinitis of shoulder
726.2	Other affections of shoulder region, not elsewhere classified
726.5	Enthesopathy of hip region
726.60	Enthesopathy of knee, unspecified (Bursitis of knee NOS)
726.61	Pes anserinus bursitis
726.90	Enthesopathy, unspecified site
727.00	Synovitis, other
727.09	Other synovitis and tenosynovitis
727.3	Bursitis, other
727.40	Synovial cyst, unspecified
727.41	Ganglion of joint
727.49	Cyst of bursa
727.61	Complete rupture of rotator cuff
729.1	Myalgia and myositis, unspecified
733.6	Tietze's disease
846.0-846.9	Sprains and strains of sacroiliac region
847.1	Sprains and strains of Thoracic region of the back
847.2	Sprains and strains of Lumbar region of the back
847.3	Sprains and strains of Sacrum region of the back
847.4	Sprains and strains of Coccyx region of the back
847.9	Sprains and strains of unspecified site of the back
848.41	Other and ill-defined sprains and strains, Sternoclavicular (joint) (ligament)
848.42	Other and ill-defined sprains and strains, Chondrosternal (joint)

HCPCS Section and Benefit Category
Surgery

HCFA National Coverage Policy
N/A

Reasons for Denial
N/A

Noncovered ICD-9-CM Code(s)
N/A

Sources of Information
Webster's Medical Desk Dictionary
Taber's Cyclopedic Medical Dictionary

Coding Guidelines
Reimbursement for the cost of the drug or biological used in an arthrocentesis joint injection is allowed in addition to the injection.

Multiple injections may be allowed by the same provider on the same day. When appropriate, multiple injections may be billed with a -LT or -RT modifier. When -LT or -RT does not apply, a -76 modifier may be used.

Documentation Requirements
Office records and/or test results documenting medical necessity should be maintained and made available upon request. The records must clearly indicate the number of injections given per session and site(s) injected. Records must clearly state the medical necessity for repeat injections.

Other Comments
N/A

Rationale For Creating Policy
Analysis of 1992 Medicare claims data for the state of Florida indicates that the Florida Carrier has allowed significantly more reimbursement for arthrocentesis (CPT codes 20600, 20605, and 20610) per 1,000 Medicare beneficiaries for rheumatologists than Medicare has paid nationally per 1,000 beneficiaries for the same specialty.

Follow-up analysis of 1994 Medicare claims data indicated that arthrocentesis (CPT code 20600, 20605, and 20610) continued to be an aberrancy for rheumatologists in the state of Florida. Further analysis of data indicated that these services are being billed at an excessive rate per patient on the same date of service, are being repeated at unusually frequent intervals, and are being administered for an unusually prolonged period of time. In addition, these services are being billed with inappropriate diagnosis for the CPT description of the code (i.e., a diagnosis involving a small joint with a CPT code for a large joint) or with diagnoses that do not substantiate medical necessity.

Follow-up analysis of July through December 1995 Bess data indicated that arthocentesis (CPT codes 20600, 20605 and 20610) continued to be an aberrancy for multiple specialties in the state of Florida.

CAC Notes
This policy does not reflect the sole opinion of the carrier or Carrier Medical Director. Conversely, this policy was developed in consultation with the medical community via the Carrier Advisory Committee on October 23, 1993.

Start Date of Comment Period:	N/A	
Start Date of Notice Period:	07/08/96	
Original Effective Date:	12/01/93	
Revision Date/Number:	08/19/96 PCR 96-177	4

Revision History:

Start Date of Comment Period:	N/A	
Start Date of Notice Period:	01/12/96	
Original Effective Date:	12/01/93	
Revision Date/Number:	02/19/96 PCR 95-118A	3
Start Date of Comment Period:	04/28/95	
Start Date of Notice Period:	09/15/95	
Original Effective Date:	12/01/93	
Revision Date/Number:	10/16/95 PCR 95-118	2
Start Date of Comment Period:	N/A	
Start Date of Notice Period:	N/A	
Original Effective Date:	N/A	
Revision Date/Number:	07/21/95	1

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Start Date of Comment Period: 10/23/93
Start Date of Notice Period: 11/01/93
Original Effective Date: 12/01/93

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

Medical Policy Procedures: 31231

Policy Number

31231

Contractor Name

First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type

Carrier

LMRP Title

Diagnostic Nasal Endoscopy

AMA CPT Copyright Statement

HCFA National Coverage Policy

N/A

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

10/16/2000

Revision Effective Date

N/A

Revision Ending Effective Date

N/A

Policy Ending Date

N/A

LMRP Description

A diagnostic nasal endoscopic examination permits visualization of upper airway structures inaccessible to the conventional otoscope or nasal speculum. The endoscopic examination is a safe and rapid (10-15 minutes) procedure used to diagnose nasal and/or sinus pathologic conditions and is performed with a rigid nasal endoscope and/or a flexible endoscope. A nasopharynx examination inspects the posterior naspharyngeal wall, posterior choanae, fossa of Rosenmueller, eustachian tube orifices, and the superior aspect of the soft palate. The nasal/sinus examination involves the inspection of the above mentioned areas in addition to the spheno-ethnoidal recess.

Indications and Limitations of Coverage and/or Medical Necessity

Any symptom that refers to the upper airway may be an indication for endoscopy when routine clinical evaluation including a nasal speculum examination does not provide a satisfactory diagnosis or when the response to medical management is not satisfactory (i.e., the patient condition is not improving or is worsening).

Florida Medicare will consider a nasopharyngoscopy with endoscope (procedure code 92511) medically reasonable and necessary when performed for the following indications:

- To evaluate a patient with suspected adenoid hypertrophy.
- To evaluate a patient presenting with recurrent serous otitis media.
- To evaluate a patient with chronic serous and/or suppurative otitis media.
- To evaluate a patient with suspected eustachian tube dysfunction. This condition is suspected in cases when a patient presents with recurrent otitis after tympanic tube placement.
- To evaluate a patient with a neck mass of unknown etiology.
- To evaluate a patient with nasopharyngeal signs/symptoms in which a physical examination including a nasal speculum exam failed to determine the etiology. These include such symptoms as recurrent epistaxis, throat pain, ear pain/fullness, anosmia (loss of smell), hyposnia (defect in sense of smell), anterior facial pain, nasal crusting, rhinorrhea (thin, watery discharge from the nose), etc.
- To evaluate a patient with known neoplastic disease of the upper airway.
- To evaluate a patient with acute or chronic pharyngitis.

Note: It is not expected that a nasopharyngoscopy will be performed on a patient with a chronic condition such as otitis media at each patient encounter unless the symptoms are not improving or are getting worse.
Florida Medicare will consider a diagnostic nasal endoscopy (procedure codes 31231-31235) medically reasonable and necessary when performed for the following indications:

- To evaluate a patient with nasal polyposis to assess extent of disease and/or evaluate the response to treatment.
- To evaluate a patient with chronic or recurrent rhinosinusitis to determine the source of the purulent material (sphenoid, maxillary, ethmoid ostia). Patients with sinusitis are diagnosed based on a combination of major and minor factors. The major factors are: facial pain/pressure (must accompany another major symptom); facial congestion/fullness; nasal obstruction/blockage; infected nasal drainage (thick and green/yellow); decreased or absent sense of smell; pus in the nose on physical examination, and fever

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(acute sinusitis only and must accompany another nasal symptom). The minor factors are: headache (must accompany another major symptom); fever; halitosis; fatigue; dental pain; cough; ear pain/pressure/ fullness.

- To evaluate a patient with a chronic cough in which an upper airway etiology is suspected.
- To evaluate a patient with persistent nasal obstruction not due to septal deviation and not responding to standard medical therapy (e.g., decongestants, steriods).
- To evaluate a patient presenting with moderate to severe signs and/or symptoms of upper airway abnormalites in which a physical examination including a nasal speculum exam failed to determine etiology. These include but are not limited to anosmia (loss of smell), hyposmia (defect in sense of smell), persistent hoarseness, recurrent epistaxis, serosanguineous nasal discharge, facial pain, odynophagia (pain during swallowing), dysphagia (difficulty swallowing), tightness in throat, change in voice quality, halitosis, obstructive apnea, etc.
- To evaluate a patient with known or suspected granulomatous disease (e.g., sarcoidosis, Wegener's disease, tuberculosis, syphillis) to rule out upper airway granulomas or ulcerations.
- To evaluate a patient with suspected or known neoplastic disease of the upper airway.
- To postoperatively evaluate the surgical site of the upper airway to determine functional status.
- To evaluate a patient with chronic dacryocystitis (inflammation of the tear sac involving the mucous membrane of the lacrimal sac) to assess the nasolacrimal duct inferior to the inferior turbinate.
- To evaluate a patient with atypical asthma refractory to usual treatment.

Note: It is not expected that a nasal endoscopy be performed on patients with uncomplicated allergic rhinitis or for random screening for nasal polyps in asymptomatic patients or patients with simple allergic rhinitis. In addition, it is not expected that a nasal endoscopy will be performed on a patient with a chronic condition such as sinusitis and nasal congestion unless the symptoms are not improving or are getting worse after undergoing standard medical treatment.

HCPCS Section & Benefit Category

Respiratory System/Surgery
Medicine/Special Otorhinolaryngologic Services

HCPCS Codes

31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
31233	Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)
31235	Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)
92511	Nasopharynogoscopy with endoscope (separate procedure)

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

Nasal Endoscopy (31231-31235)

135	Sarcoidosis
146.0-146.9	Malignant neoplasm of oropharynx
147.0-147.9	Malignant neoplasm of nasopharynx
148.0-148.9	Malignant neoplasm of hypopharynx
149.0-149.9	Malignant neoplasm of other and ill-defined sites within the lip, oral cavity, and pharynx
161.0-161.9	Malignant neoplasm of larynx
210.5-210.9	Benign neoplasm of oral cavity and pharynx
212.0	Benign neoplasm of nasal cavities, middle ear, and accessory sinuses
235.1	Neoplasm of uncertain behavior of lip, oral cavity, and pharynx
375.42	Chronic dacryoscystitis
375.56	Stenosis of nasolacrimal duct, acquired
381.00-381.9	Nonsuppurative otitis media and Eustachian tube disorders
382.00-328.9	Suppurative and unspecified otitis media
446.4	Wegener's granulomatosis
461.0-461.9	Acute sinusitis
462	Acute pharyngitis
464.0-464.4	Acute laryngitis and tracheitis
465.0	Acute laryngopharyngitis
470	Deviated nasal septum
471.0-471.8	Nasal polyps
472.0-472.2	Chronic pharyngitis and nasopharyngitis
473.0-473.9	Chronic sinusitis
476.0	Chronic laryngitis
478.0-478.29	Other diseases of upper respiratory tract
493.90-493.91	Asthma, unspecified (atypical)
530.10-530.19	Esophagitis
780.50-780.57	Sleep disturbances
780.63	Fever
780.79	Other malaise and fatigue
781.1	Disturbances of sensation of smell and taste
782.2	Localized superficial swelling, mass, or lump (neck mass)
784.0	Headache
784.1	Throat pain
784.40-784.49	Voice disturbance
784.5	Other speech disturbance
784.7	Epistaxis
784.9	Other symptoms involving head and neck
786.2	Cough
786.3	Hemoptysis
787.2	Dysphagia
925.2	Crushing injury of neck
V67.00	Follow-up examination, following surgery, unspecified

Nasopharynogoscopy (92511)

146.0-146.9	Malignant neoplasm of oropharynx
147.0-147.9	Malignant neoplasm of nasopharynx
148.0-148.9	Malignant neoplasm of hypopharynx
149.0-149.9	Malignant neoplasm of other and ill-defined sites within the lip, oral cavity, and pharynx
210.5-210.9	Benign neoplasm of oral cavity and pharynx

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212.0	Benign neoplasm of nasal cavities, middle ear, and accessory sinuses
235.1	Neoplasm of uncertain behavior of lip, oral cavity, and pharynx
381.00-381.9	Nonsuppurative otitis medial and Eustachian tube disorders
382.00-382.9	Suppurative and unspecified otitis media
462	Acute pharyngitis
472.0-472.2	Chronic pharyngitis and nasopharyngitis
474.12	Hypertrophy of adenoids alone
478.0-478.29	Other disease of upper respiratory tract
780.6	Fever
780.79	Other malaise and fatigue
781.1	Disturbances of sensation of smell and taste
782.2	Localized superficial swelling, mass, or lump (neck mass)
784.0	Headache
784.1	Throat pain
784.7	Epistaxis
784.9	Other symptoms involving head and neck
786.2	Cough
786.3	Hemoptysis
787.2	Dysphagia

Diagnosis that Support Medical Necessity
N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity
N/A

Diagnosis that DO NOT Support Medical Necessity
N/A

Reasons for Denial
When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9-CM Code(s)
Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

Noncovered Diagnosis
N/A

Coding Guidelines
When a nasal endoscopy (31231-31235) is performed, the nasopharynogoscopy (92511) is considered part of the nasal endoscopy. Therefore, procedure code 92511 is included in the basic allowance of the nasal endoscopy when performed on the same day.

Documentation Requirements
Medical record documentation maintained by the performing physician must clearly indicate the medical necessity of the service being billed. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the office/progress notes, hospital notes, and/or procedure report.

Documentation should support the criteria for coverage as set forth in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Utilization Guidelines
N/A

Other Comments
N/A

Sources of Information
Citardi, M. J. (2000). Sinusitis FAQs. [On-line]. Available: http://american-rhinologic.org.

Golish, J. A. (Ed.). (1994). Diagnostic Procedure Handbook. Hudson: Lexi-Comp Inc.

Middleton, E., Ellis, E. F., Yunginger, J. W., Reed, C. E., Adkinson, N. F., & Busse, W. W. (Eds.). Allergy principles & practice. (Vol II). St. Louis: Mosby.

Network of Florida Otolaryngologists. Nasal endoscopy and naspharyngoscopy with endoscopy practice parameters. Unpublished manuscript.

Taber's cyclopedic medical dictionary (17th ed.). (1993). Philadelphia: F. A. Davis Company.

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from the Florida Society of Allergy, Asthma and Immunology and the Florida Society of Otolaryngology.

Presented at the May 13, 2000 Carrier Advisory Committee meeting.

Start Date of Comment Period
05/05/2000

Start Date of Notice Period
09/01/2000

Revision History

Revision:	Original PCR B2000-137
Start date of comment period:	05/05/2000
Start date of notice period:	09/01/2000 Sep/Oct 2000 *Update!*
Original effective date:	10/16/2000

Advance Notice Statement
Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

33999: Transmyocardial Revascularization (TMR)

The local medical review policy (LMRP) for TMR was published in the January/February 2000 *Medicare B Update!* (pages 33-34), with a clarification in the May/June 2000 *Update!* (page 39). Since that time, clarification has been received from the Health Care Financing Administration (HCFA) regarding the billing of TMR when it is an add-on procedure to a thoracotomy performed for other reasons.

Effective for dates of service on and after July 1, 2000, procedure code 33999 (Unlisted procedure, cardiac surgery) should be billed when an add-on TMR is performed. The indications and limitations of coverage, along with the ICD-9-CM diagnosis codes that support medical necessity, were published in the above mentioned articles. Those guidelines also apply to procedure code 33999 when billed for an add-on TMR. ❖

71010: Chest X-Ray—Correction to Policy

The local medical review policy (LMRP) for chest X-rays was published in the July/August 2000 *Update!* (pages 43-51). Three ranges of ICD-9-CM diagnoses were inadvertently omitted from that article. The diagnosis ranges are as follows:

176.4-176.5	Karposi's sarcoma, lung and lymph nodes
410.00-410.92	Acute myocardial infarction
869.0-869.1	Internal injury to unspecified or ill-defined organs

Please add these diagnoses to the list of conditions for which a chest X-ray may be covered. ❖

78472: Cardiac Blood Pool Imaging

The Local Medical Review Policy (LMRP) for Cardiac Blood Pool Imaging was published in the March/April 2000 *Medicare B Update!* (pages 38-39).Since that time, there have been numerous inquiries regarding the appropriate diagnosis to bill for the following indication:

> "Evaluation and management of a patient with a neoplastic disease who will be receiving an anthrocycline-like neoplastic drug."

Based on the comments, diagnosis V58.83 (Encounter for therapeutic drug monitoring) has been added to the "ICD-9-CM Codes That Support Medical Necessity" section of the policy. *This diagnosis is not effective until 10/01/2000.* It is expected that this diagnosis is will be billed when the cardiac blood pool imaging is performed prior to initiation of therapy and during the management of the patient with the anthrocycline-like neoplastic drug. Diagnosis E930.7 (Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antineoplastic antibiotics) or E933.1 (Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antineoplastic and immunosuppressive drugs) should be used when the patient is experiencing an adverse effect of the neoplastic drug. Until the implementation of diagnosis V58.83 on 10/01/2000, continue to bill either diagnosis E930.7 or E933.1 for the above indication regardless of when the study is performed (i.e., prior to therapy).

Effective Date

This change is effective for services processed on or after October 1, 2000.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

Medical Policy Procedures: 80048

Policy Number
80048

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Automated Multichannel Tests

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Carriers Manual 5114.1, 7517.1, 7517.2

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
1993

Revision Effective Date
07/18/2000

Revision Ending Effective Date
07/17/2000

Policy Ending Date
N/A

LMRP Description
The common automated tests comprise specific groupings of blood chemistries which enable physicians to more accurately diagnose their patients' medical problems.

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The following list contains the tests that can be and are frequently done as groups and combinations on automated profile equipment:

Albumin; serum (82040)
Bilirubin, total (82247)
Bilirubin, direct (82248)
Calcium; total (82310)
Carbon dioxide (bicarbonate) (82374)
Chlorides; blood (82435)
Cholesterol, serum, total (82465)
Creatine kinase (CK), (CPK); total (82550)
Creatinine; [blood] (82565)
Glucose; quantitative (82947)
Glutamyltransferase, gamma (GGT) (82977)
Lactic dehydrogenase (LD), (LDH); (83615)
Phosphatase, alkaline; (84075)
Phosphorus inorganic (phosphate); (84100)
Potassium; serum (84132)
Protein, total, except refractometry (84155)
Sodium; serum (84295)
Transferase; aspartate amino (AST) (SGOT) (84450)
Transferase; alanine amino (ALT) (SGPT) (84460)
Triglycerides, (84478)
Urea nitrogen, quantitative (84520)
Uric acid; blood (84550)

Indications and Limitations of Coverage and/or Medical Necessity

Automated Multichannel Tests:
Blood chemistry testing identifies many chemical blood constituents. It is often necessary to measure several blood chemicals to establish a pattern of abnormalities. The automated multichannel tests can range from 2 to 22 tests and can be grouped under the headings of enzymes, electrolytes, blood sugar, lipids, hormones, vitamins, minerals, and drug investigation.

Albumin; serum (Procedure Code 82040):
Albumin is a protein that is formed within the liver. This makes up approximately 60% of the total protein. The major purpose of albumin within the blood is to maintain colloidal osmotic pressure. Further, albumin transports important blood constituents such as drugs, hormones, and enzymes. Albumin is synthesized within the liver and is therefore, a measure of hepatocyte function. Normal serum albumin is 3.5-5.0g/dl.

Serum albumin tests are used to evaluate nutritional status, blood oncotic pressure, renal disease with proteinuria, and other chronic diseases.

Florida Medicare will consider an albumin test medically necessary for the following conditions:

Increased or decreased total protein levels cause no symptoms per se. Symptoms may arise, however, from underlying conditions.

Conditions in which serum albumin test may be medically reasonable and necessary include, but are not limited to, the following which are related to decreased albumin levels: liver disease (e.g., hepatitis, cirrhosis, hepato-cellular necrosis); protein-losing enteropathies and nephropathies (e.g., nephrotic syndrome, glomerulo-nephritis); third-space losses (e.g., ascites, third-degree burns); malnutrition; protein dilution secondary to excessive intravenous fluids; increased capillary permeability (e.g., collagen vascular diseases such as lupus erythematosus); extensive metastatic tumor; thyroid disease; essential hypertension; pregnancy and oral contraceptive use; prolonged immobilization; and heart failure.

Conditions which are associated with increased albumin levels include, but are not limited to, the following: dehydration.

Even though a patient has a condition stated above, it is not expected that a serum albumin test be performed frequently for stable chronic symptoms that are associated with that disease.

Bilirubin (Procedure Codes 82247-82251):
Bilirubin results from the breakdown of hemoglobin in red blood cells (RBCs). Bilirubin is removed from the body by the liver by way of bile. Bilirubin gives bile its major color pigmentation. Normally, there is a small amount of bilirubin in the blood, however, a rise in serum levels may indicate that there is excessive destruction of RBCs or it may indicate a liver disorder.

There are two forms of bilirubin in the body; 1) indirect or unconjugated which is bound to protein (normal levels are 0.2 to 0.8 mg/dl) and 2) direct or conjugated bilirubin which circulates in the blood until it reaches the liver and is excreted into the bile (normal levels are 0.0 to 0.2 mg/dl).

An increase in the indirect bilirubin is more frequently associated with the destruction of RBCs (hemolysis), and an increase in direct bilirubin is more frequently associated with a liver disorder.

Florida Medicare will consider a serum bilirubin; total and/or direct medically necessary in the following circumstances:

- When the patient presents with jaundice which may indicate any of the following illnesses or disorders:

  Hepatocellular jaundice results from injury or disease of the parenchymal cells of the liver and can be caused by:

  Viral hepatitis (generally, transaminase ALT/SGPT and AST/SGOT are also increased and performed with the serum bilirubin) in which the patient may present with some or all of the following signs and symptoms: 1) nausea or vomiting, 2) alaise, 3) flu-like syndrome, 4) fever, and 5) tender, enlarged liver.

  Cirrhosis in which the patient may present with some or all of the following signs and symptoms: 1) weakness and fatigability, 2) weight loss, 3) extreme anorexia, nausea and occasional vomiting, 4) enlarged liver which may be firm and has a blunt or nodular edge, 5) spider nevi, palmar erythema, and evidence of vitamin deficiencies, 6) jaundice, 7) ascites, pleural effusions, peripheral edema, 8) ecchymotic lesions, and 9) encephalopathy.

  Infectious mononucleosis in which the patient presents with some or all of the following signs and symptoms: 1) marked lymphadenopathy, 2) sore throat, 3) hite-purple tonsillar exudate, and 4) hepatosplenomegaly.

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Drug reactions in which cholestasis and/or hepatocellular damage may occur include, but are not limited to, the following:

diphenylhydantoin (Phenytoin, Dilantin) - it is expected that liver function tests be monitored no more frequently than monthly for several months then only periodically unless the patient presents with signs and symptoms of a hepatic disorder;

azathioprine (Imuran) - it is expected that hepatic function tests (including serum Bilirubin) would be monitored no more frequently than weekly during the first month, bimonthly for the next two to three months, and monthly thereafter unless the patient becomes symptomatic of a hepatic disorder;

erythromycin - this antibiotic is generally used cautiously in patients with liver disease or other hepatic disorders; however, routine monitoring of serum Bilirubin, AST, and ALT is not medically necessary or reasonable unless the patient has a hepatic disorder; presents with signs and symptoms of a liver disorder; or is on high-dose, long-term therapy;

penicillin - this antibiotic may, in rare instances, cause hemolytic anemia; however, routine monitoring of the patient's bilirubin while on penicillin without signs and symptoms of hemolytic anemia is not considered to be medically necessary and reasonable;

sulfonamides - see erthromycin;

oral contraceptives - these drugs may cause cholestatic jaundice, or in rare instances liver tumors; however, routine monitoring of serum Bilirubin, AST, and ALT is not considered medically necessary unless the patient presents with jaundice or other signs and symptoms of these hepatobiliary disorders;

anabolic-androgenic steroids - these drugs are used cautiously in patients with hepatic disorders and it is acceptable for hepatic function tests to be monitored periodically throughout treatment for those patients who are on long-term, high-dose therapy and/or show signs and symptoms of a hepatic disorder;

acetaminophen (Tylenol) - this drug should be used cautiously in patients with known hepatic disorders or chronic alcoholism;

isoniazid (INH) - it is expected that hepatic function be evaluated no more frequently than monthly through-out therapy unless the patient demonstrates signs and symptoms of a hepatic disorder;

pyrazinamide - it would not be expected that hepatic function tests be evaluated more frequently than every two to four weeks during therapy unless the patient presents with signs and symptoms of hepatic dysfunction; and

lovastatin (Mevacor) - this and other lipid-lowering agents can be very hepatotoxic; however, generally it would not be expected that liver function tests be monitored more often than every four to six weeks during the first 3 months of therapy, every six to eight weeks for the remainder of the first year and every six months while the patient is on therapy unless the there is an increase in the test results.

Obstructive Jaundice (caused by stones or neoplasms blocking the common bile or hepatic ducts). This produces high, direct (conjugated) bilirubin levels due to bile regurgitation. There is also a proportionate rise in Alkaline Phosphatase (ALP) levels which are out of proportion to the transaminases. Signs and symptoms of biliary obstruction may include the following:

abdominal pain, generally, upper right quadrant, if present,
nausea and vomiting,
indigestion, anorexia and/or intolerance to fatty foods,
chills and low-grade fever,
diaphoresis,
clay-colored stools, and/or
jaundice

Hemolytic jaundice is due to an overproduction of bilirubin which is caused by hemolytic processes that produce high levels of indirect (unconjugated) bilirubin. Some conditions which cause hemolytic jaundice are:

hemolytic disease of the newborn (erythroblastosis) due to a) RH incompatibility or b) ABO incompatibility;

pernicious anemia [generally results in high levels of indirect (unconjugated) levels of bilirubin];

sickle cell anemia leads to chronic hemolytic anemia with a variety of severe clinical consequences;

transfusion reactions are one of the most dreaded complications of transfusions and can be fatal if the hemolytic reaction is major. Less severe reactions can occur and may be delayed 5 to 10 days after transfusion; and

Crigler-Najjar syndrome is a severe disease that results from a genetic deficiency of a hepatic enzyme needed for the conjugation of bilirubin.

- Patients who present without jaundice but demonstrate signs and symptoms of the following disorders that are usually characterized by elevated indirect serum bilirubin levels:

  hemolytic anemias
  trauma in the presence of a large hematoma
  hemorrhagic pulmonary infarcts
  Gilbert's Disease which is a disease that causes impaired bilirubin uptake and storage.

- Patients who present with signs and symptoms of the following that may be characterized by elevated direct serum bilirubin levels:

  Cancer of the head of the pancreas in which vague, diffuse epigastric or left upper quadrant pain may be the first symptoms. Choledocholithiasis is characterized by a sudden onset of severe right upper quadrant or epigastric pain, nausea and vomiting, jaundice and fever.

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*Dubin-Johnson syndrome is a hereditary disorder which is characterized by the faulty excretion of bilirubin conjugates and is also referred to as familial chronic idiopathic jaundice. The gallbladder can not be visualized on cholecystography and the liver is darkly pigmented.

*Rotor syndrome is similar to Dubin-Johnson syndrome, but the liver is not pigmented and the gallbladder can be visualized on cholecystography.

*Both of these diseases are benign, asymptomatic hereditary jaundice disorders with an excellent prognosis; therefore, routine testing after this disorder is diagnosed would be considered medically unnecessary and unreasonable, unless the patient presents with signs and symptoms which indicate a change in the status of the liver.

In summary, the serum bilirubin test is indicated in the evaluation of liver function; to aid in the differential diagnosis of jaundice and to monitor the progression of the disorder; to aid in the diagnosis of biliary obstruction and hemolytis anemia; and to determine whether a newborn requires an exchange transfusion or phototherapy because of dangerously high unconjugated bilirubin.

Calcium; total (Procedure Code 82310):
Calcium is a predominantly extracellular cation. It is of great importance in blood coagulation; gives firmness and rigidity to bones and teeth; is important in acid-base balance; is essential for lactation; is important in activating enzymes; is essential for the function of nerves and muscles, including the myocardium; and for maintaining the permeability of membranes. Over 98% of body's calcium is found in the bones and teeth. Serum calcium test is used to evaluate parathyroid function and calcium metabolism by directly measuring the total amount of calcium in the blood. About 50% of blood calcium is ionized; the rest is protein bound(with albumin). The serum calcium level is a measurement of both. Normal calcium is 8.5-10.5 mg/dl.

Florida Medicare will consider a calcium test medically necessary for the following conditions:

- Evaluation of patients with clinical signs and symptoms of hypercalcemia. Signs and symptoms of hypercalcemia are not limited to the following:

nausea and vomiting
anorexia
constipation
abdominal pain
dehydration
lethargy
confusion
prominent skeletal muscle weakness
polyuria, nocturia, polydipsia
stupor
coma
ECG changes/prolongation of QT interval
death
flank pain due to renal calculi

Conditions in which a serum calcium test may be medically reasonable and necessary for hypercalcemia include, but are not limited to, the following: hyperparathyroidism; malignancies; adrenal insufficiency; acromegaly; hypervitaminosis D; immobilization; and drugs (e.g., thiazide diuretics, calcium salts, etc.)

Evaluation of patients with clinical signs and symptoms of hypocalcemia. Signs and symptoms of hypocalcemia include, but are not limited to, the following:

arrhythmias
bronchospasm
muscle cramping
seizure activity
diplopia and photophobia
trousseau's sign (carpopedal spasm)
chvostek's sign (facial muscle spasm)
ECG changes/shortened QT interval
unexplained dementia, depression, psychosis
circumoral and peripheral numbness and tingling
anxiety
malaise
tetany
dysphagia
muscle twitching

Conditions in which a serum calcium test may be medically reasonable and necessary for hypocalcemia include, but are not limited to the following: hypoparathyroidism; hypoalbuminemia; renal failure; pancreatitis; vitamin D deficiency; severe malnutrition and malabsorption; septic shock; and drugs (e.g., anticonvulsants, heparin, laxatives, loop diuretics, magnesium salts, and etc.).

Even though a patient has a condition stated above, it is not expected that a serum calcium test be performed frequently for stable chronic symptoms that are associated with that disease.

Disorders of calcium metabolism are initially evaluated with measurements of serum phosphorus, albumin, chloride, magnesium, potassium, total protein, parathyroid hormone levels, and often 24-hour urine calcium level.

Carbon dioxide (bicarbonate) (Procedure Code 82374):
Carbon dioxide contents are used to evaluate acid-base balance. Total carbon dioxide content reflects the adequacy of gas exchange in the lungs and the efficiency of the carbonic acid-bicarbonate buffer system, which maintains acid-base balance and normal p.H. 95% of the total carbon dioxide content is contributed by bicarbonate, which is regulated by the kidneys. The other 5% of carbon dioxide is contributed by dissolved carbon dioxide gas, which is regulated by the lungs, and carbonic acid. Normal carbon dioxide is 22-28meq/liter.

Florida will consider a carbon dioxide content test medically necessary for the following conditions:

- Evaluation of patients with signs and symptoms of respiratory acidosis which can include, but are not limited to, the following:

headache
restlessness
irritability
disorientation
blurred vision
depressed reflexes
cardiac dysrhythmias

Conditions in which serum CO_2 may be medically reasonable and necessary include, but are not limited to, the following which are related to respiratory acidosis:

airway obstruction (e.g., extrathoracic tumors, asthma, bronchitis, pneumonia, emphysema, etc.)

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depression of respiratory center (e.g., drug overdose, use of anesthetics , etc.)
interference with mechanical function of thoracic cage (e.g., deformity/trauma of thoracic cage, kyphoscoliosis, etc.)
circulatory disorders (e.g. congestive heart failure, shock, etc.)

- Evaluation of patients with signs and symptoms of respiratory alkalosis which can include, but are not limited to, the following:

lightheadness	tetany and hyperreflexia
anxiety	inability to concentrate
hyperventilation	mental confusion
numbness or tingling of nose, circumoral area and extremities	lethargy
	coma

Conditions in which serum CO_2 may be medically reasonable and necessary include, but is not limited to, the following which are related to respiratory alkalosis:

hyperventilation
hysteria
lack of oxygen
Toxic stimulation of respiratory center (e.g., fever, cerebral hemorrhage, excessive artificial respirations, etc.)

- Evaluation of patients with signs and symptoms of metabolic acidosis which can include, but are not limited to, the following:

lethargy	vomiting
drowsiness	diarrhea
headache	abdominal pain
liver damage	hyperventilation
nausea	cardiac dysrhythmias

Conditions which may be medically reasonable and necessary include, but are not limited to, the following which are related to metabolic acidosis:

diabetic ketoacidosis
renal failure, acute or chronic
lactic acidosis
renal tubular acidosis
anaerobic metabolism
salicylate toxicity

- Evaluation of patients with signs and symptoms of metabolic alkalosis which can include, but are not limited to, the following:

anorexia	tetany
nausea and vomiting	chvostek's sign (facial muscle spasm)
tremors	mental confusion
muscle hypertonicity	stupor
muscle cramps	coma

Conditions in which serum CO_2 may be medically reasonable and necessary include, but are not limited to, the following which are related to metabolic alkalosis:

acid loss (e.g., loss of gastric juice, vomiting, etc.)
potassium or chloride depletion
base gain (e.g., excessive bicarbonate or lactate administration, etc.)
aldosteronism

Signs and symptoms may vary depending on the severity of acid-base imbalance.

Even though a patient has a condition stated above, it is not expected that a serum CO_2 test be performed frequently for stable chronic symptoms that are associated with that disease.

Interpretation requires clinical information and other tests such as electrolytes and/or arterial blood gases (ABG's).

Chloride, blood (Procedure Code 82435):
Chloride, a blood electrolyte, is the major extracellular anion. It maintains cellular integrity through its influence on osmotic pressure and acid-base and water balance. Measurement of chloride is usually done for inferential value and is helpful in diagnosing disorders of acid-base and water balance. Normal serum chloride is 96-106 meq/liter.

Florida Medicare will consider a chloride test medically necessary for the following conditions:

- Evaluation of patients with signs and symptoms of hypochloremia. Signs and symptoms can include, but are not limited to, the following:

  hyperexcitability of the nervous system and muscles
  shallow breathing
  hypotension
  tetany

Condition in which serum chloride may be medically reasonable and necessary include, but are not limited to, the following which are related to hypochloremia:

overhydration
congestive heart failure
vomiting, diarrhea, excessive sweating
chronic respiratory acidosis
metabolic alkalosis
primary aldosteronism

- Evaluation of patients with signs and symptoms of hyperchloremia. Signs and symptoms can include, but are not limited to, the following:

  lethargy
  weakness
  deep breathing

Conditions in which serum chloride may be medically reasonable and necessary include, but are not limited to, the following which are related to hyperchloremia:

dehydration
renal tubular acidosis (hyperchloremic metabolic acidosis)
multiple myeloma
diabetes insipidus
cushing's syndrome
metabolic acidosis
renal failure, acute or chronic
hyperventilation
excessive infusion of sodium chloride

Even though a patient has a condition stated above, it is not expected that a serum chloride test be performed frequently to stable chronic symptoms that are associated with that disease.

Interpretation of chloride usually requires clinical information and other electrolytes such as sodium, potassium, CO_2, to assess electrolyte, acid-base, and water balance.

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Cholesterol, serum, total (Procedure Code 82465):
Cholesterol is a fat-soluble steroid alcohol found in animal fats and oils. It is widely distributed, especially in the blood, brain, liver, kidneys, and nerve fiber's myelin sheaths, and is an essential component of cell membrane development and production of bile acids, adrenal steroids, and sex hormones. The liver metabolizes the cholesterol to its free form and cholesterol is transported in the bloodstream by lipoproteins. Nearly 75% of the cholesterol is bound to low-density lipoproteins (LDLs) and 25% to high-density lipoproteins (HDLs). Because cholesterol is the main lipid involved in arteriosclerotic disease, high levels of free and bound LDLs are associated with increased risk for arteriosclerotic vascular disease. Cholesterol levels 140-199 mg/dl is desirable, 200-239 mg/dl is borderline, and 240 mg/dl and above is considered as high.

Cholesterol testing detects disorders of blood lipids; indicates potential risk for atherosclerotic coronary artery disease; and aids in the diagnosis of nephrotic syndrome, pancreatitis, hepatic disease, and hypo- and hyperthyroidism.

Florida Medicare will consider a serum cholesterol test medically reasonable and necessary for the following conditions:

- Most patients with elevated serum cholesterol levels have no signs and symptoms *per se*, although some patients may present with signs and symptoms of, but not limited to, the following which include certain disease processes:

  premature atherosclerotic vascular disease
  chest pain associated with coronary disease
  claudication associated with peripherial vascular disease
  transient or permanent neurologic deficits associated with cerebrovascular disease
  abdominal pain associated with acute pancreatitis
  physical findings could include: cutaneous and tendinous xanthomas, xanthelesma, and premature arcus corneae

Conditions in which serum cholesterol test may be medically reasonable and necessary include, but are not limited to, the following: patients with coronary risk factors (positive family history of hyperlipidemia, hypertension, tobacco abuse, smoking, obesity, diabetes mellitus, etc.); hypercholesterolemia; hyperlipidemias; hypothyroidism; uncontrolled diabetes mellitus; nephrotic syndrome; pregnancy; high-cholesterol diet; xanthomatosis; hypertension; myocardial infarction; atherosclerosis; biliary cirrhosis; pancreatitis; stress; nephrosis; pancreatic and prostatic malignant neoplasms; obesity; glycogen storage disease; malnutrition and malabsorption syndrome; pernicious anemia and hemolytic anemia; hyperthyroidism; malignancy; analphalipoproteinemias; abetalipoproteinemia; sepsis; stress; and liver disease.

Even though a patient has a condition stated above, it is not expected that a serum cholesterol test be performed frequently for stable chronic symptoms that are associated with that disease.

Cholesterol measurement should not be done immediately after a myocardial infarction. A three month wait is suggested.

Creatine kinase (CK), (CPK); total (Procedure Code 82550):
Creatine kinase (CK) is an enzyme that catalyzes the creatine-creatinine metabolic pathway in muscle cells and brain tissue. Because of its intimate role in energy production, CK reflects normal tissue catabolism; an increase above normal serum levels indicates trauma to cells with high CK content. An assay of total serum CK was once widely used to detect acute myocardial infarction (MI), but elevated serum CK levels caused by skeletal muscle damage reduce the test's specificity for this disorder. CK isoenzymes have replaced use of total CK levels to accurately localize sites of increased tissue destruction. Normal CK for females is 30-135U/L and for males is 55-170U/L. CK levels may be significantly higher in muscular people and after strenuous exercise.

The CK (CPK) test is used in the diagnosis of myocardial infarction and as a reliable measure of skeletal and inflammatory muscle diseases.

Florida Medicare will consider a serum creatine kinase test medically necessary for the following conditions:

- Conditions in which serum creatine kinase test may be medically reasonable and necessary include, but are not limited to, the following: acute myocardial infarction, acute cerebrovascular disease, cardioversion and/or defibrillation, cardiac surgery, myocarditis, central nervous system trauma, hypothyroidism, malignant hyperthermia syndrome, hypokalemia, convulsions, electric shock, muscular stress, muscle trauma, muscular dystrophy, polymyositis, dermatomyositis, myositis, rhabdomyolysis, delirium tremens and chronic alcoholism.
- Conditions which are associated with decreased CK levels include, but are not limited to, the following: decreased muscle mass and prolonged bed rest.

Even though a patient has a condition stated above, it is not expected that a serum creatine kinase test be performed frequently for stable chronic symptoms that are associated with that disease.

Creatinine, blood (Procedure Code 82565):
Creatinine is a nonprotein end product of creatine metabolism. It is produced at a constant rate, depending on the muscle mass of the individual, and is removed from the body by the kidneys. Production of creatinine is constant as long as muscle mass remains constant. A serum creatinine level is proportional to lean body muscle mass. It is unaffected by most diet or activity and is freely filtered by the glomerular. Creatinine levels, therefore, are directly related to the glomerular filtration rate. Because creatinine levels normally remain constant, elevated levels usually indicate diminished renal function. Concentration of creatinine only become abnormal when about half or more of the nephrons have stopped functioning in chronic progressive renal disease. Normal creatinine is .6-1.2 mg/dl.

The measurement of serum creatinine is useful in evaluating any type of renal dysfunction in which a large number of nephrons have been destroyed. It is the most common clinical renal function test, providing a rough approximation of glomerular filtration.

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Florida Medicare will consider a serum creatinine test medically necessary for the following conditions:

Evaluation of patients with signs and symptoms of an elevated serum creatinine. Patients with mild elevation of serum creatinine levels usually have no clinical manifestations. Clinical findings below usually occur when the serum creatinine levels are severely elevated:

General:	fatigue, weakness, sallow-appearance
Skin:	pruritus, easy bruisability, pallor, ecchymoses, edema, xerosis(abnormal dryness of skin, mucous membranes, or the conjunctiva)
ENT:	metallic taste in mouth, urinous breath
Eye:	pale conjunctiva
Pulmonary:	shortness of breath, rales, pleural effusion
Cardiovascular:	dyspnea on exertion, pericarditis, hypertension, cardiomegaly, friction rub
Gastrointestinal:	anorexia, nausea, vomiting, hiccup
Genitourinary:	nocturia, impotence, isosthenuria
Neuromuscular:	restless legs, numbness and cramps in legs
Neurologic:	generalized irritability and inability to concentrate, decreased libido, stupor, asterixis, myoclonus, peripheral neuropathy

Decreased creatinine levels cause no symptoms per se. Symptoms may arise, however, from underlying diseases.

Conditions in which serum creatinine test may be medically reasonable and necessary include, but are not limited to, the following: impaired renal function; chronic nephritis; obstruction of the urinary tract; muscle disease (gigantism, acromegaly, muscular dystrophy, myasthenia gravis, poliomyelitis); congestive heart failure; atherosclerosis; shock; dehydration; diabetes mellitus; rhabdomyolysis; dialysis patients; renal transplant patients; and to detect potential renal damage when nephrotoxic drugs are used.

Conditions which are associated with a decrease in serum creatinine include, but are not limited to, the following: decreased muscle mass; debilitation; aging; advanced and severe liver disease; and inadequate dietary protein intake.

Even though a patient has a condition stated above, it is not expected that a serum creatinine test be performed frequently for stable chronic symptoms that are associated with that disease.

Creatinine levels are interpreted in conjunction with the blood urea nitrogen (BUN).

Glucose; quantative (Procedure Code 82947):
Glucose is formed from carbohydrate digestion and conversion of glycogen to glucose by the liver. The two hormones that directly regulate blood glucose are glucagon and insulin. Glucagon accelerates glycogen breakdown in the liver and causes the blood glucose to rise. Insulin increases cell membrane permeability to glucose, transports glucose into cells (for metabolism), stimulates glycogen formation, and reduces blood glucose levels. Normal serum fasting glucose is 80-120 mg.

Fasting glucose tests are performed to evaluate disorders of carbohydrate metabolism, acidosis and ketoacidosis, dehydration, coma and hypoglycemia. Glucose tests are also performed to establish a diagnosis of diabetes mellitus; aid in the management of diabetes mellitus; evaluate hyperglycemia; and to investigate polyuria, polydipsia, polyphagia, weight loss, obesity, and dehydration.

Florida Medicare will consider a serum fasting glucose test medically reasonable and necessary for the following conditions:

Evaluation of clinical signs and symptoms of hypoglycemia. Signs and symptoms of hypoglycemia include, but are not limited to, the following:

sweating	fatigue
nervousness	confusion
tremulousness	inappropriate
faintness	behavior
palpitations	visual distrubances
hunger	stupor
headache	coma
irritability	seizures

Conditons in which a serum glucose test may be medically reasonable and necessary for hypoglycemia would include, but are not limited to, the following: hyperinsulinism (excess insulin); insulinoma; hypothyroidism; hypopituitarism; adrenal insufficiency (e.g., Addison's disease); liver damage (alcoholism); starvation and malabsorption.

Evaluation of clinical signs and symptoms of hyperglycemia. Signs and symptoms of hyperglycemia include, but are not limited to, the following:

polyuria	weight loss
polydipsia	obesity
polyphagia	hypotension with tachycardia
fatigue	deep breathing
nausea and vomiting	fruity breath odor
dry mouth	mental stupor
abdominal pain/tenderness	coma

Conditions in which a serum glucose test may be medically reasonable and necessary for hyperglycemia would include, but are not limited to, the following: diabetes mellitus; acute stress response (e.g., myocardial infarct, CVA, brain damage, convulsive episodes, trauma, severe infections, general anesthesia); Cushing's disease; pheochromocytoma; hyperparathyroidism; adenoma of the pancreas; pancreatitis; chronic renal disease: chronic liver disease; diuretic or corticosteroid therapy; and acromegaly.

Even though a patient has a condition stated above, it is not expected that a serum glucose test be performed frequently for stable chronic symptoms that are associated with that disease.

Florida Medicare would not consider glucose testing medically reasonable and necessary for:

- screening purposes in asymptomatic patients
- for individuals without signs and symptoms of hypoglycemia or hyperglycemia, without diagnoses related to diabetes mellitus
- for a diagnostic condition unrelated to hypoglycemia or hyperglycemia or diabetes mellitus

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Glutamyltransferase, gamma (GGT) (Procedure Code 82977):
This test is used to determine liver cell dysfunction and to detect alcohol-induced liver disease. It is also useful in determining the liver status of chronic alcoholics and can be useful in determining the cessation or reduction of alcohol consumption. The GGT is elevated in all forms of liver disease and is much more sensitive than either the alkaline phosphatase test, because it is generally not elevated in bone growth or pregnancy, or the transaminase tests (AST, ALT) in detecting certain liver ailments such as obstructive jaundice, cholangitis, and cholecystitis. It can also be used as a cancer marker because levels tend to reflect remission and recurrence. Normal levels range from 5 to 24 U/L in females and 8 to 37 U/L in males.

Florida Medicare will consider the serum GGT test medically necessary in any of the following circumstances:

- When the patient presents with signs and symptoms of obstructive jaundice, GGT is more sensitive to biliary obstruction than are aspartate aminotransferase (AST/SGOT) and alanine aminotransferase (ALT/SGPT) and may include, but is not limited to, the following signs and symptoms:

  colicky, right upper quadrant pain,
  weight loss (which may suggest carcinoma),
  jaundice,
  dark urine, and/or
  light-colored stools.

- When the patient presents with signs and symptoms of intrahepatic cholestasis which may include, but are not limited to, the following:

  signs and symptoms which may mimic those of viral hepatitis (such as nausea or vomiting, malaise, flu-like syndrome, fever, and tender, enlarged liver) or biliary tract obstruction,
  history of recent and/or long-term use of hepatotoxic medications, particularly those which can cause intrahepatic cholestasis such as estrogens, anabolic steroids, azathioprine (Imuran), erythromycin, and sulfadiazine.
  a history of alcoholism,
  a history of a spirochetal infection, sarcoidosis, and/or
  a history or biliary cirrhosis.

- When the patient presents with signs and symptoms of pancreatitis which may include, but are not limited to, the following:

  epigastric abdominal pain, generally abrupt in onset, that is steady and severe, and is often made worse by walking and lying supine and better by sitting and leaning forward,
  nausea and vomiting,
  weakness, sweating and anxiety,
  history of alcohol intake, or a heavy meal immediately preceding the attack,
  history or milder similar episodes or biliary colic in the past,
  abdominal tenderness and distention,
  bowel sounds may be absent,
  tachycardia, hypotension, pallor, and cool, clammy skin,
  mild jaundice,
  steatorrhea (as indicated by bulky, foul, fatty stools), and/or
  tenderness over pancreas.

- When the patient presents with signs and symptoms of a hepatoma (primary liver carcinoma that originates from the parenchymal cells) which include, but are not limited to, the following:

  history of alcoholism in general, hepatitis B or C in particular,
  cachexia,
  weakness,
  weight loss,
  sudden appearance of ascites,
  tender enlargement of the liver, with an occasional palpable mass, and/or
  presence of bruit or friction rub over tumor.

- When the patient presents with signs and symptoms of metastatic carcinoma of the liver which include, but are not limited to, the following:

  history of primary cancer,
  weakness,
  weight loss,
  tender enlargement of the liver, with an occasional palpable mass, and/or
  presence of bruit or friction rub over tumor.
  * The alkaline phosphatase (ALP), the CEA (carcinoembryonic antigen), and GGT when performed together, are useful markers for hepatic metastasis from breast and colon primary cancer. Increasing levels indicate progression of the disease while decreasing levels indicate response to treatment.

- Patients who present with signs and symptoms of hepatic necrosis which may include, but are not limited to, the following:

  malaise,
  dark urine,
  anorexia,
  right upper outer quadrant abdominal pain,
  enlarged, tender liver, and/or
  ascites.

- When the patient presents with signs and symptoms of primary biliary cirrhosis which include, but are not limited to, the following:

  pruritis,
  jaundice,
  hepatosplenomegaly, and/or
  xanthomatous lesions in the skin and tendons and around the eyelids.

- When patients present with signs and symptoms of cholecystitis which include, but are not limited to, the following:

  steady, severe pain and tenderness in the right hypochondrium or epigastrim,
  nausea and vomiting, and/or
  fever and leukocytosis.

- When the patient presents with signs and symptoms of cholangitis which include, but are not limited to, the following:

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Charcot's triad: fever and chills, right upper outer quadrant pain and jaundice.

In summary, indications for the serum GGT include, but may not be limited to, the following: 1) monitoring the cessation or reduction of alcohol consumption, 2) detecting obstructive jaundice, 3) detecting other acute hepatic and biliary tract diseases, 4) detecting and monitoring of primary and/or metastatic liver cancer, 5) detecting primary biliary cirrhosis, 6) aiding in the differential diagnosis of chronic hepatitis, 7) aiding in the differential diagnosis of alcoholic cirrhosis, and 8) aiding in the differential diagnosis of other conditions which may cause extrahepatic obstruction (such as pancreatic carcinoma and common duct stones).

Lactate dehydrogenase (LD), (LDH); (Procedure Code 83615):
Lactate dehydrogenase is an intracellular enzyme that is widely distributed in the tissues of the body, particularly in the kidney, heart, skeletal muscle, brain, liver, lungs, and red blood cells. Increases in the reported value usually indicate cellular death and leakage of the enzyme from the cell. Because LDH is widely distributed through the body, the total LDH is not a specific indicator of a disease but is more useful diagnostically when fractionated into isoenzymes. Normal LDH is 45-90 U/L.

LDH tests are used to aid in the differential diagnosis of myocardial infarction, pulmonary infarction, anemias, hepatic disease, and to monitor patients response to some forms of chemotherapy.

Florida Medicare will consider a serum lactate dehydrogenase (LDH) medically necessary for the following conditions:

Conditions in which serum LDH test may be medically reasonable and necessary include, but are not limited to, the following: myocardial infarction; pulmonary disease (e.g., infarction); hepatic diseases (e.g., hepatitis, cirrhosis, alcoholism); red blood cell diseases (e.g., hemolytic anemias, megaloblastic anemias such as pernicious anemia); skeletal muscle disease and injury; renal parenchymal diseases (e.g., infarction); intestinal ischemia and infarction; cerebrovascular accident; neoplastic states; infectious mononucleosis; heat stroke; pancreatitis; collagen diseases; fracture; muscular dystrophy; shock; hypotension; and evaluation of some forms of chemotherapy.

Even though a patient has a condition stated above, it is not expected that a serum LDH test be performed frequently for stable chronic symptoms that are associated with that disease.

Phosphatase, alkaline; (Procedure Code 84075):
This test measures serum levels of Alkaline Phosphatase (ALP), an enzyme that influences bone calcification and lipid and metabolite transport. It normally originates from the liver and bone and is excreted in bile. Therefore, this test may be performed in conjunction with other liver enzyme tests for hepatobiliary disorders and may be used as a diagnostic tool when bone disorders are suspected. Normal values for an adult range from 17 to 142 U/L.

Florida Medicare will consider serum ALP testing medically necessary under any of the following circumstances:

- When the patient is suspected of having a biliary obstruction. Generally, with total biliary obstruction there is a parallel increase in serum bilirubin. However, in cases of mild biliary obstruction, the serum ALP is particularly sensitive and may be elevated without a concurrent rise in serum bilirubin. Signs and symptoms of biliary obstruction may include the following:

  abdominal pain, generally, upper right quadrant, if present,
  nausea and vomiting,
  indigestion, anorexia and/or intolerance to fatty foods,
  chills and low-grade fever,
  diaphoresis,
  clay-colored stools, and/or
  jaundice.

- When the patient is suspected of having a space-occupying hepatic lesion. Signs and symptoms of a primary hepatic tumor may include, but are not limited to, the following:

  history of alcoholism in general, hepatitis B or C in particular,
  cachexia,
  weakness,
  weight loss,
  sudden appearance of ascites,
  tender enlargement of the liver, with an occasional palpable mass, and/or
  presence of bruit or friction rub over tumor.

- When the patient presents with signs and symptoms of metastatic carcinoma of the liver which include, but are not limited to, the following signs and symptoms:

  history of primary cancer,
  weakness,
  weight loss,
  tender enlargement of the liver, with an occasional palpable mass, and/or
  presence of bruit or friction rub over tumor.

*With a primary or metastatic tumor in the liver, the Gamma Glutamyl Transferase (GGT) may be performed in conjunction with the serum ALT and is usually elevated.

*The alkaline phosphatase (ALP), the CEA (carcinoembryonic antigen), and GGT when performed together, are useful markers for hepatic metastasis from breast and colon primary cancer. Increasing levels indicate progression of the disease while decreasing levels indicate response to treatment.

- Patients who present with signs and symptoms of a hepatic abscess which may include, but are not limited to, the following:

  Pyogenic:
  fever,
  prominent pain in right hypochondrium or epigastric area,
  jaundice, and/or
  tenderness in right upper abdomen.

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Amebic:
right upper quadrant pain, often associated with fever,
tender palpable liver with "punch" tenderness,
right lung base abnormalities, and/or
localized intercostal tenderness.

*With a liver abcess, other lab tests such as Alanine Aminotransferase (ALT/SGPT); Asparate Aminotransferase (AST/ SGOT); and White Blood Cell (WBC) counts may be performed in conjunction with the ALT and are usually elevated.

- When the patient is suspected of having an acute fatty liver which may be indicated by the following signs and symptoms:

history of chronic alcoholism (although, it may be caused by other conditions such as malnutrition),
large, tender liver (hepatomegaly), and/or
other signs and symptoms as indicated for hepatic lesions (particularly, ascites) and biliary obstructions, although nausea, vomiting and anorexia are less common.

*With an acute fatty liver, the total bilirubin, asparate aminotransferase, globulin and cholesterol may be performed in conjunction with ALP and may also be elevated.

- When the patient presents with signs and symptoms of cirrhosis which may include, but is not limited to, the following signs and symptoms.

In earlier stages:
weakness, fatigability, and weight loss may be the only presenting signs and symptoms.

In late stages:
extreme anorexia with nausea and occasional vomiting,
enlarged liver which is firm and has a blunt or nodular edge,
spider nevi, palmar erythema and evidence of vitamin deficiencies,
jaundice which is usuaully mild at first,
ascities, pleural effusions, peripheral edema, and
ecchymotic lesions; and/or encephalopathy.

*Generally, the serum AST, ALP and gamma globulin are increased with cirrohsis. There is, also, a progressive increase in serum bilirubin.

- When the patient is suspected of having Paget's Disease which may include, but is not limited to, the following signs and symptoms:

bone pain often described by the patient as 'deep',
bowed tibias, kyphosis, and frequent fractures with mild trauma due to softening of the bone,
headaches and deafness, if the skull is involved, and/or
increased vascularity over the involved bones causing increased warmth.

*Fibrogenic imperfecta ossium is a rare symmetric disorder that can mimic Paget's Disease; likewise the ALP is elevated.

- When the patient presents with signs and symptoms of primary or metastatic bone carcinoma which may include, but is not limited to, the following:

persistent skeletal pain and swelling with or without limitation of motion of adjacent joints, and/or
spontaneous fractures.

- When the patient has a diagnosis of deficiency-induced rickets and the serum ALP is used to assess response to Vitamin D therapy.

There may be other instances in which an ALP is elevated; however, when performed alone, it is particularly useful in diagnosing mild biliary obstruction, useful as a tumor marker in bone carcinoma (particularly, metastatic), and in diagnosing metabolic bone disorders, particularly Paget's Disease.

Phosphorus (inorganic phosphate); (Procedure Code 84100):

Phosphorus is a non-metal chemical element. Most of the body's phosphorus is combined with calcium within the skeleton; however, approximately 15% of the phosphorus exists in the blood as a phosphate salt. Phosphates help store and utilize body energy, and help regulate calcium levels, carbohydrate and lipid metabolism, and acid-base balance. Vitamin D is important in the absorption and metabolism of phosphorus. Phosphorus levels are determined by calcium metabolism, parathormone, and to a lesser degree by intestinal absorption. Normal serum phoshorus is 2.5-4.5 mg/dl. Serum phosphate levels help to detect endocrine, skeletal, and calcium disorders, and aid in the diagnosis of renal disorders and acid-base imbalance.

Florida Medicare will consider a phosphorus test medically necessary for the following conditions:

- Evaluate patients with signs and symptoms of hypophosphatemia. Patients with mild hypophosphatemia usually have no clinical manifestations. Clinical findings below usually occur when the phosphate deficit is severe:

anorexia	hypercalciuria
nausea	osteomalacia
muscle weakness and soreness	rhabdomyolysis
bone pain	encephalopathy
apprehension	seizures
confusion	hemolysis
paresthesia's	platelet dysfunction
mental obtundation	thrombocytopenia

Conditions in which serum phosphorus test may be medically reasonable and necessary include, but are not limited to, the following which are related to hypophosphatemia:

Decreased phosphate ingestion or absorption:
Malnutrition: alcoholism, starvation
Vitamin D deficiency
Malabsorption syndromes
Hyperalimentation without phosphate supplements

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Increased utilization or consequence of metabolism:
Pregnancy
Recovery from malnutrition or diabetic ketoacidosis: insulin and glucose therapy
Respiratory alkalosis: salicylate poisoning; gram-negative bacteremia
Lactate, sodium bicarbonate, or sodium chloride infusions
Absorption by bone following parathyroidectomy

Excess losses of phosphate:
Dialysis
Diuretic therapy
Primary hyperparathyroidism
Renal tubular defects: congenital, after renal transplant, toxic, and diuretic phase following acute renal failure or burns
Oral antacid therapy
Hypomagnesemia

- Evaluate patients with hyperphosphatemia. Patients with hyperphosphatemia usually have no clinical symptoms per se. Symptoms may arise, however, from underlying conditions. Some signs of hyperphosphatemia can include, but are not limited to, the following:

serum phosphorus level greater than 4.5 mg/dl on two fasting blood levels
skeletal lesions on x-ray
elevation of serum creatinine and alkaline phosphatase

Conditions in which serum phosphate test may be medically reasonable and necessary include, but are not limited to, the following which are related to hyperphosphatemia:

Excess phosphate from exogenous sources:
ingestion of dairy products
ingestion of phosphate salts or use of phosphate enemas in patients with renal disease
hypervitaminosis D
sacroidosis

Excess phosphate from endogenous sources:
metabolic or respiratory acidosis
skeletal lesion, local: myeloma, Padget's disease, metastatic carcinoma
skeletal lesion, diffuse: prolonged skeletal immobilization, severe hyperparathyroidism secondary to renal disease
phosphate release from tissue destruction or ischemia
irradiation or chemotherapy
hemolysis
lactic acidosis

Impaired excretion of phosphate: renal disease, hypoparathyroidism

Even though a patient has a condition stated above, it is not expected that a serum phosphorus test be performed frequently for stable chronic symptoms that are associated with that disease.

Tests useful in the differential diagnosis include repeat serum phosphorus, alkaline phosphatase, calcium, parathyroid hormone, and skeletal x-ray.

Potassium; serum (Procedure Code 84132):
Potassium is the principal cation in intracellular fluid. In conjunction with sodium and chloride, it aids in regulation of osmotic pressure and acid-base balance. A proper balance of potassium, calcium, and magnesium ions is essential for normal excitability of muscle tissues, especially cardiac muscle, and it plays a role in the conduction of nerve impulses.

Potassium levels are affected by variations in the secretion of adrenal steroid hormones, and by fluctuations in pH., serum glucose levels, and serum sodium levels. Normal serum potassium is 3.5-5.0 meq/liter.

Serum potassium levels are done to evaluate clinical signs of hyperkalemia and hypokalemia; monitor renal function, acid-base balance, and glucose metabolism; evaluate neuromuscular and endocrine disorders; and to detect the origin of arrhythmias.

Florida Medicare will consider a serum potassium test medically necessary for the following conditions:

- Evaluation of patients with signs and symptoms of hypokalemia. Signs and symptoms can include, but are not limited to, the following:

nausea
vomiting
anorexia
muscle weakness
fatigue
muscle cramps
constipation
ileus
apathy
flaccid paralysis
hyporeflexia
paresthesia
tetany
increased sensitivity to digoxin
dizziness
hypotension
rapid pulse
palpitations
ECG changes: flattened T-waves;
prominent U-waves;
depressed ST segments;
atrioventricular block
cardiac arrhythmia
ventricular fibrillation
respiratory paralysis
cardiopulmonary arrest

Conditions in which serum potassium test may be medically reasonable and necessary include, but are not limited to, the following which are related to hypokalemia: decreased potassium intake(deficiency in dietary and/or intravenous intake, starvation, and malabsorption); excessive potassium loss (e.g., diarrhea, vomiting, nasogastric suction, drainage tubes, laxative abuse, diuretics, antibiotics, mineralocorticoid administration, aldosteronism, Cushing's syndrome, excessive sweating, osmotic hyperglycemia, renal tubular acidosis, excessive licorice ingestion); and/or a shift to intracellular space (e.g., alkalosis, insulin or glucose administration, calcium administration, etc.)

- Evaluate patients with signs and symptoms of hyperkalemia. Signs and symptoms can include, but are not limited to, the following:

nausea
weakness
malaise
abdominal distention
diarrhea
flaccid paralysis

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ECG changes:
- peaked T waves
- prolonged P-R interval
- S-T depression
- widening of QRS
- biphasic QRS-T complexes
- bradycardia
- arrhythmia's
- atrial arrest
- ventricular tachycardia
- ventricular fibrillation
- cardiac arrest

Conditions in which serum potassium may be medically reasonable and necessary include, but are not limited to, the following and may be related to hyperkalemia: increase potassium intake (e.g., excessive dietary and/or intravenous intake); decreased potassium loss (e.g., renal failure acute or chronic, adrenal insufficiency, aldosterone-inhibiting diuretics, etc.); shift from intracellular space (metabolic acidosis, hyperosmolality, infection, burns, crush injury to tissues, vigorous exercise, etc.); and pseudohyperkalemia (e.g., hemolysis, transfusion of hemolyzed blood, thrombocytosis, leukocytosis, specimen drawn from arm with potassium infusion, etc.)

Even though a patient has a condition stated above, it is not expected that a serum potassium test be performed frequently for stable chronic symptoms that are associated with that disease.

When abnormal potassium levels are a transient problem with the cause resolved, follow-up may not be necessary as long as proper education has been accomplished.

When treatment of a chronic hyperkalemia problem is instituted, follow-up may be necessary each time a medication change is done. Once the patient is stabilized, follow-up will be determined by the requirements of the underlying disease.

More frequent monitoring is indicated in the presence of heart failure, with symptoms of hypokalemia or with the onset of superimposed illness (e.g., gastroenteritis) that could cause additional potassium loss.

Protein; total, except refractometry (Procedure Code 84155):
Proteins are constituents of muscle, enzymes, hormones, transport vehicles, hemoglobin, and several other key functional and structural entities within the body. Proteins are the most significant component contributing to the osmotic pressure within the vascular space. This osmotic pressure keeps fluid within the vascular space, minimizing extravasation of fluid. Albumin and globulin constitute most of the protein within the body and are measured in the total protein. Normal total protein is 6.4-8.3 g/dl.

Protein testing can diagnose some inflammatory and neoplastic states, nephrotic syndromes, liver disease, and can evaluate nutritional states and osmotic pressures in edematous and malnourished patients.

Florida Medicare will consider a total protein test medically necessary for the following conditions:

Increased or decreased total protein levels cause no symptoms per se. Symptoms may arise, however, from underlying conditions.

Conditions in which serum protein test may be medically reasonable and necessary include, but are not limited to, the following which are related to increased protein levels:

dehydration, hemoconcentration states owing to fluid loss(e.g., vomiting, diarrhea, poor kidney function); liver disease; multiple myeloma and other gammopaths; Waldenstrom's microglobulinemia; tropical diseases; sarcoidosis and other granulomatous diseases; collagen disorders (e.g., systemic lupus erythematosus(SLE), and rheumatoid arthritis); chronic inflammatory states; and chronic infections.

Conditions in which serum protein test maybe associated with decreased protein levels include, but are not limited to, the following: insufficient nutritional intake(starvation or malabsorption); severe liver disease and alcoholism; renal disease, nephrotic syndrome; diarrhea (Crohn's disease, ulcerative colitis); severe skin diseases and burns; severe hemorrhage; heart failure; hyperthyroidism; and prolonged immobilization(e.g., trauma, orthopedic surgery).

Even though a patient has a condition stated above, it is not expected that a serum protein test be performed frequently for stable chronic symptoms that are associated with that disease.

Sodium; serum (Procedure Code 84295):
Sodium is the major extracellular cation. Normal serum sodium is 135-145 meq/liter. Sodium affects body water distribution, maintains osmotic pressure of extracellular fluid, and helps promote neuromuscular function; it also helps maintain acid-base balance and influences chloride and potassium levels. Sodium is absorbed by the intestines and is excreted primarily by the kidneys; a small amount is lost through the skin. Sodium is regulated in the kidneys by several hormones: aldosterone, ADH, and the third factor, a kidney tubular enzyme. Serum sodium tests are used to evaluate fluid-electrolyte and acid-base balance, and related neuromuscular, renal, and adrenal functions.

Florida Medicare will consider a serum sodium test medically necessary for the following conditions:

- Evaluation of clinical signs and symptoms of hyponatremia. Clinical manifestations of hyponatremia can include, but are not limited to, the following:

  Cardiovascular:
  - normovolemic: rapid pulse rate, normal blood pressure
  - hypovolemic: rapid pulse rate, hypotensive, central venous pressure normal or low, flat neck veins
  - hypervolemic: rapid bounding pulse, central venous pressure normal or elevated, blood pressure normal or elevated

  Respiratory:
  - late manifestations related to:
  - skeletal muscle weakness: shallow, ineffective respiratory movements
  - hypervolemia
  - pulmonary edema: rapid shallow respiration, moist rales

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Neuromuscular:
generalized skeletal muscle weakness
deminished deep tendon reflexes
personality changes
headache

Renal:
increased urinary output
decreased specific gravity

Gastrointestinal:
increased motility
nausea
hyperactive bowel sounds
diarrhea

Symptoms vary with change in vascular volume.

Conditions in which serum sodium test may be medically reasonable and necessary include, but are not limited to, the following and may be related to hyponatremia: increased sodium excretion (e.g., vomiting, diarrhea, gastric suction, excessive diaphoresis, diuretics, wound drainage, etc.); inadequate sodium intake (e.g., decreased intake, low-salt diet); dilution of serum sodium (e.g., excessive ingestion of hypotonic fluids, psychogenic polydipsia, renal failure, syndrome of inappropriate antidiuretic hormone secretion (SIADH), hyperglycemia, congestive heart failure, hepatic failure, etc.).

- Evaluation of clinical signs and symptoms of hypernatremia. Clinical manifestation of hypernatremia can include, but not limited to, the following:

  Cardiovascular:
  decreased myocardial contractility
  deminished cardiac output
  heart rate and blood pressure respond to vascular volume

  Respiratory:
  problems associated with pulmonary edema when related to hypervolume

  Neuromuscular:
  normvolemia or hypovolemia: agitation, confusion, seizures
  hypervolemia: lethargy, stupor, coma
  mild hypernatremia: spontaneous muscle twitches, irregular contractions
  severe hypernatremia: skeletal muscle weakness, hyporeflexia

  Renal:
  decreased urinary output
  increased specific gravity

  Integumentary:
  dry, flaky skin
  presence of absence of edema related to accompanying fluid volume changes

  Symptoms vary with changes in vascular volume.

Conditions in which serum sodium test may be medically reasonable and necessary include, but are not limited to, the following and may be related to hypernatremia: decreased sodium excretion (e.g., hyperaldosteronism, renal failure, corticosteroids, Cushing's syndrome); increased sodium intake (e.g., excessive oral/parental intake of sodium); decreased water intake; and increased water loss (e.g., increased rate of metabolism, fever, hyperventilation, infection, excessive diaphoresis, diarrhea, dehydration).

Even though a patient has a condition stated above, it is not expected that a serum sodium test be performed frequently for stable chronic symptoms that are associated with that disease.

Serum sodium results should be interpreted in light of the patient's state of hydration. Changes in serum sodium most often reflect changes in water balance rather than sodium balance.

When abnormal sodium levels are a transient problem with the cause resolved, follow-up may not be medically necessary as long as proper education has been accomplished.

More frequent testing may be medically necessary at the time of initial diagnosis of abnormal sodium levels until the levels are stabilized and signs and symptoms reside.

Transferase; aspartate amino (AST)(SGOT) (Procedure Code 84450):
Aspartate aminotransferase (AST) is one of two enzymes which is released into serum in proportion to cellular damage especially in damage related to the liver and heart. AST is also found to a lesser extent in the skeletal muscle, kidney, brain, pancreas, spleen and lungs. The test is primarily used in the evaluation of liver and heart diseases. Normal values for adults range from 5 to 40 U/L while normal values for infants may be four times higher.

Florida Medicare will consider serum AST testing medically necessary under any of the following circumstances:

- When the patient presents with signs and symptoms of acute or chronic hepatitis which may include, but are not limited to, the following:

  Acute:
  anorexia,
  nausea and vomiting,
  malaise,
  symptoms of upper respiratory infection or flu-like symptoms,
  fever,
  enlarged tender liver, and/or
  jaundice,

  Chronic:
  some or all of the signs and symptoms of acute hepatitis,
  splenomegaly,
  ascites, and/or
  encephalopathy.

- When the patient presents with signs and symptoms of active cirrhosis which may include, but are not limited to, the following:

  Earlier stages:
  weakness and fatigability, and
  weight loss.

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Late stage:
extreme anorexia with nausea and occasional vomiting,
enlarged liver which is firm and has a blunt or nodular edge,
spider nevi, palmar erythema and evidence of vitamin deficiencies,
jaundice which is usually mild at first,
ascites, pleural effusions, peripheral edema, and ecchymotic lesions, and/or
encephalopathy.

- When the patient presents with signs and symptoms of hepatic necrosis which may include, but are not limited to, the following:

  malaise,
  dark urine,
  anorexia,
  right upper outer quadrant abdominal pain,
  enlarged, tender liver, and/or
  ascites.

- When the patient presents with signs and symptoms of acetaminophen hepatotoxicity which may include, but are not limited to, the following:

  history of alcohol abuse,
  recent episode of heavy drinking,
  recent history of acetaminophen ingestion, and/or signs and symptoms of viral hepatitis or biliary obstruction.

  *An increase in LDH, AST/SGOT, ALT/SGPT, and prothrombin time may indicate hepatotoxicity. Also, there are other medications which may cause this condition. For examples of medications to which anyone, not just those who have a history of chronic alcohol abuse and/or a recent episode of alcohol abuse, may develop hepatotoxicity[,] see the indications and limitations for Alanine Aminotransferase (ALT).

- When the patient presents with signs and symptoms of primary or metastatic liver carcinoma which may include, but are not limited to, the following:

  abdominal pain, generally, upper right quadrant, if present,
  nausea and vomiting,
  anorexia,
  chills and low-grade fever,
  diaphoresis,
  clay-colored stools,
  jaundice,
  firm, blunt, irregular mass may be palpated in the epigastric region or below the right costal margin with or without pain or tenderness, and/or
  ascities.

When the patient, generally a child, presents with signs and symptoms of Reye's syndrome which may include, but are not limited to, the following:

recent history of influenza or other virus,
change in mental status due to encephalopathy,
hepatomegaly,
convulsions, and/or
recent history of aspirin ingestion.

- When the patient presents with signs and symptoms of infectious mononucleosis which may include, but are not limited to, the following:

  marked lymphadenopathy,
  sore throat,
  white-purple tonsillar exudate, and/or
  hepatosplenomegaly.

  *There is usually a considerable increase in the Lactate Dehydrogenase (LDH) in addition to an increase in liver transminases (ALT and AST) with infectious mononucleosis.

- To monitor a patient's progress and prognosis in cardiac or hepatic disorders.

In summary, Florida Medicare will consider a serum Aspartate Aminotransferase medically necessary and reasonable to aid in the detection and differential diagnosis of acute hepatic disease; to monitor the progress and prognosis of patients with known cardiac or hepatic diseases; and when performed in conjunction with other laboratory tests to aid in the detection of cellular damage of skeletal muscles, kidneys, and the pancreas.

The AST may be useful in monitoring the progress and prognosis of those patients who have had a Myocardial Infarction (MI), those patients who have hepatic congestion due to heart failure, suspected pericarditis, myocarditis, or when it is suspected that a patient has extended a MI (generally AST levels return to normal the third or fourth day after a MI; however, a secondary rise, i.e. after the fourth day, may indicate an extension or reoccurrence of the MI).

Transferase; alanine amino (AST)(SGPT) (Procedure Code 84460):
Alanine Aminotransferase (ALT) is present in tissues with high metabolic activity such as the liver where high concentrations can be found. There are lesser concentrations found in the kidneys, heart and skeletal muscles. It is used to diagnose liver disease and to monitor the course of treatment for hepatitis and postnecrotic cirrhosis and later drug therapy. Normal values range from 8 to 20 U/L.

Florida Medicare will consider serum ALT medically necessary under any of the following circumstances:

- When the patient is suspected of having any type of liver injury or hepatocellular disease such as viral hepatitis, active cirrhosis, and alcoholic hepatitis:

  Viral hepatitis is characterized by such signs and symptoms as anorexia, nausea, vomiting, malaise, symptoms of upper respiratory infection or flu-like symptoms. Also, the patient may present with fever, an enlarged, tender liver and jaundice. The white blood cell count (WBC) may be normal to low.

  Hepatitis A:
  Hepatitis A is generally spread by the fecal-oral route and is enhanced in areas where there is overcrowding and/or poor sanitation. The ALT usually peaks between one and two months post exposure. This is typically the time that jaundice and other symptoms will be seen.

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Hepatitis B:
Hepatitis B is generally transmitted through infected blood and blood products. The incubation period of Hepatitis B is six weeks to six months. Symptoms including jaundice usually appear between two and three months after exposure and the ALT is generally extremely elevated.

Hepatitis C:
In Hepatitis C, the source of infection may be uncertain; however, up to 50% of known cases is attributable to intravenous drug use. Serum ALT levels generally peak when physical signs and symptoms are noted which is generally between two and three months after exposure.

Hepatitis D:
Hepatitis D is usually only seen in conjunction with acute cases of Hepatitis B, chronic Hepatitis B, or asymptomatic Hepatitis B carriers. In the United States, Hepatitis D is generally seen in intravenous drug users and is diagnosed by detection of the antibody to Hepatitis D antigen.

Alcoholic Hepatitis:
Alcoholic Hepatitis can be acute or chronic and is the most common pre-cursor of cirrhosis. Generally signs and symptoms include, but are not limited to, a history of a recent episode of heavy drinking, complaints of anorexia and nausea, and the demonstration of hepatomegaly and jaundice. In addition, abdominal pain and tenderness, particularly of the upper right quadrant, spleno-megaly, ascities, fever, ascites, and encephalopathy may be present. Usually moderate elevations of serum ALT are seen in conjunction with higher serum levels of AST.

Drug- and Toxin-Induced Liver Disease:
Many widely used therapeutic agents may cause hepatic injury and toxicity and can mimic viral hepatitis or biliary tract obstruction. Those which cause a direct hepatotoxic reaction and in which all individuals are susceptible include, but are not limited to, the following: acetaminophin, alcohol, tetracyclines, Vitamin A, carbon tetrachloride, chloroform, heavy metals, and phosphorus. Other drugs which are dose-dependent and may or may not affect a particular patient include, but are not limited to, the following: azathioprine (Imuran); estrogens, anabolic steroids, mercaptopurine (Purinethol), and methyl-testosterone (non-inflammatory cholestatic reactions). In addition, chloro-thiazide, chlorpromazine, chlorporpamide, erythromycin, estolate, penicillamine, prochlorperazine, promazine, sulfadiazine, and thiouracils can also be toxic to the liver and may cause inflammation of the portal areas.

Other drugs which may be toxic to the liver are amiodarone, corticosteroids, and methetrexate, quinidine phenytoin (Dilantin) and oral contraceptive steroids.

Very high levels of ALT (up to 50 times normal) suggest viral or severe drug-induced hepatitis, or other hepatic disease with extensvie necrosis (AST levels are also usually elevated but to a lesser degree.) Ingestion of lead or exposure to carbon tetrachloride causes direct injury to hepatic cells and sharp elevations of ALT.

Therefore, the general indications for the serum ALT are to help detect and evaluate treatment of acute hepatic disease especially hepatitis and cirrhosis in patients who present without jaundice. It is also used in conjunction with serum AST to distinguish between myocardial and hepatic tissue damage. In addition, it is used to assess the hepatotoxicity which may be caused by high doses or long-term therapy of some drugs and to differentiate between hemolytic jaundice and jaundice caused by liver disease. It is also used in conjunction with serum AST in the absence of other clinical markers to diagnose such infectious disorders as mononucleosis.

Triglycerides (Procedure Code 84478):
Triglycerides are a family of complex lipids composed of glycerol esterified with three fatty acids of the same or different lengths Triglycerides are not soluble in blood and are therefore transported as chylomicrons or as VLDL. The degradation of triglyceride leads directly to production of fatty acid. Together with carbohydrates, these compounds furnish energy for metabolism. Normal triglycerides for females is 35-135 mg/dl and for males is 40-160 mg/dl.

This test provides quantitative analysis of triglycerides, the main storage form of lipids, which constitute about 95% of fatty tissue. Although not in itself diagnostic, serum triglyceride analysis permits early identification of hyperlipemia and risk of coronary artery disease.

Florida Medicare will consider a serum triglyceride test medically reasonable and necessary for the following conditions:

- Most patients with high triglyceride levels have no clinical signs or symptoms per se., although some patients may present with signs and symptoms of, but not limited to, the following which include certain disease processes:

  premature atherosclerotic vascular disease
  chest pain associated with coronary disease
  claudication associated with peripheral vascular disease
  transient or permanent neurologic deficits associated with cerebrovascular disease
  abdominal pain associated with acute pancreatitis
  physical findings could include: cutaneous and tendinous xanthomas, xanthelasma, and premature arcus corneae

Conditions in which a serum triglyceride test may be medically reasonable and necessary include, but are not limited to, the following: patients with coronary risk factors (positive family history of hyperlipidemia, hypertension, tobacco abuse, smoking, obesity, etc.); evidence of atheroclerotic coronary, peripheral, or cerebrovascular disease; xanthomas; oral contraceptive agents or cortiscosteroid therapy; hyperlipoproteinemias; biliary disease; liver disease and alcoholism; nephrotic syndromes; carbohydrate-sensitive hypertriglyceridemia; glycogen storage disease; poorly controlled diabetes mellitus; hypothyroidism; myocardial infarction; pancreatitis; obesity; hyperthyroidism; malnutrition; and malabsorption syndrome.

Even though a patient has a condition stated above, it is not expected that a serum triglyceride test be performed frequently for stable chronic symptoms that are associated with that disease.

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Nitrogen; quantitative (Procedure Code 84520):
The blood urea nitrogen (BUN) measures the amount of urea nitrogen in the blood. Urea is formed in the liver as the end product of protein metabolism. During digestion, protein is broken down into amino acids. In the liver, these amino acids are catabolized and free ammonia is formed. The ammonia is combined to form urea, which is then deposited into the blood and transported to the kidneys for excretion. Therefore, the BUN is directly related to the metabolic function of the liver and the excretory function of the kidney. It serves as an index of the function of these organs. Normal BUN is 10-20 mg/dl.

BUN test are used to evaluate renal function, aid in the diagnosis of renal disease, and aid in the assessment of hydration.

Florida Medicare will consider a blood urea nitrogen (BUN) test medically necessary for the following conditions:

Evaluate patients with signs and symptoms of elevated BUN levels. Patients with mild elevation of serum BUN levels usually have no clinical manifestations. Clinical findings below usually occur when serum BUN levels are severely elevated:

General:	fatigue, weakness, sallow-appearance
Skin:	pruritus, easy bruisability, pallor, ecchymoses, edema, xerosis(abnormal dryness of skin, mucous membranes, or the conjunctiva)
ENT:	metallic taste in mouth, urinous breath
Eye:	pale conjunctiva
Pulmonary:	shortness of breath, rales, pleural effusion
Cardiovascular:	dyspnea on exertion, pericarditis, hypertension, cardiomegaly, friction rub
Gastrointestinal:	anorexia, nausea, vomiting, hiccup
Genitourinary:	nocturia, impotence, isosthenuria
Neuromuscular:	restless legs, numbness and cramps in legs
Neurologic:	generalized irritability and inability to concentrate, decreased libido, stupor, asterixis, myoclonus, peripheral neuropathy

Decreased BUN levels cause no symptoms per se. Symptoms may arise, however, from underlying diseases.

Conditions in which serum BUN test may be medically reasonable and necessary include, but are not limited to, the following which are related to increased BUN levels: impaired renal function (e.g., glomerulonephritis, pyelonephritis, acidotic tubular necrosis); urinary tract obstruction (e.g., tumors, stones, prostatic hypertrophy); reduced renal blood flow (e.g., dehydration, hypovolemia, shock, gastrointestinal bleeding, myocardial infarction, congestive heart failure); increased protein catabolism (e.g., burns, starvation); renal failure; nephrotoxic drugs; and excess protein ingestion.

Conditions which are associated with decreased BUN levels include, but are not limited to, the following: liver failure; overhydration; negative nitrogen balance (e.g., malnutrition); and pregnancy.

Even though a patient has a condition stated above, it is not expected that a serum BUN test be performed frequently for stable chronic symptoms that are associated with that disease.

BUN levels are interpreted in conjunction with the serum creatinine level.

Uric acid; blood (Procedure Code 84550):
Uric acid is formed from the breakdown of nucleonic acids and is an end product of purine metabolism. A lack of the enzyme uricase allows this poorly soluble substance to accumulate in body fluids. Two-thirds of the uric acid produced daily is excreted by the kidneys, whereas the remaining one-third exits by the stool. The basis for this test is that an overproduction of uric acids occurs when there is excessive cell breakdown and catabolism of nucleonic acids (as in gout), excessive production and destruction of cells (as in leukemia), or an inability to excrete the substance produced (as in renal failure).

Normal uric acid is 3.0-8.0 mg/dl. Measurement of uric acid is used most commonly in the evaluation of renal failure, gout, and leukemia. This test is also valuable in assessing the prognosis of eclampsia because of the uric acid level's ability to reflect the extent of liver damage in toxemia of pregnancy.

Florida Medicare will consider a serum uric acid tests medically necessary for the following conditions:

Increased or decreased serum uric acid levels cause no symptoms per se. Symptoms may arise, however, from underlying conditions.

Conditions in which serum uric acid test may be medically reasonable and necessary include, but are not limited to, the following which are associated with increased uric acid levels: gout; renal diseases and renal failure; alcoholism; dehydration (prerenal azotemia); lead poisoning; leukemia; lymphoma; starvation; metabolic acidosis; toxemia of pregnancy; infectious mononucleosis; hyperlipidemia; hypoparathyroidism; hemolytic anemia; and following excessive cell destruction, as in chemotherapy and radiation treatment; congestive heart failure; hypothyroidism; and toxemia of pregnancy.

Conditions which are associated with decreased uric acid levels include, but not limited to, the following: defective tubular absorption; syndrome of inappropriate adrenal hormone (SIADH); heavy-metal poisoning; some malignancies (e.g., Hodgkin's disease, multiple myeloma); xanthinuria; acute hepatic atropy; poor diet intake of purines and protein.

Even though a patient has a condition stated above, it is not expected that a serum uric acid test be performed frequently for stable chronic symptoms that are associated with that disease.

HCPCS Section & Benefit Category

Pathology and Laboratory

80048 - continued

HCPCS Codes

80048 Basic metabolic panel
This panel must include the following:
- Calcium (82310)
- Carbon dioxide (bicarbonate) (82374)
- Chloride (82435)
- Creatinine (82565)
- Glucose (82947)
- Potassium (84132)
- Sodium (84295)
- Urea Nitrogen (BUN) (84520)

80051 Electrolyte panel
This panel must include the following:
- Carbon dioxide (82374)
- Chloride (82435)
- Potassium (84132)
- Sodium (84295)

80053 Comprehensive metabolic panel
This panel must include the following:
- Albumin (82040)
- Bilirubin, total (82247)
- Calcium (82310)
- Carbon dioxide (bicarbonate) (82374)
- Chloride (82435)
- Creatinine (82565)
- Glucose (82947)
- Phosphatase, alkaline (84075)
- Potassium (84132)
- Protein, total (84155)
- Sodium (84295)
- Transferase, alanine amino (ALT) (SGPT) (84460)
- Transferase, aspartate amino (AST) (SGOT) (84450)
- Urea Nitrogen (BUN) (84520)

80069 Renal function panel
This panel must include the following:
- Albumin (82040)
- Calcium (82310)
- Carbon dioxide (bicarbonate) (82374)
- Chloride (82435)
- Creatinine (82565)
- Glucose (82947)
- Phosphorus inorganic (phosphate) (84100)
- Potassium (84132)
- Sodium (84295)
- Urea Nitrogen (BUN) (84520)

80076 Hepatic function panel
This panel must include the following:
- Albumin (82040)
- Bilirubin, total (82247)
- Bilirubin, direct (82248)
- Phosphatase, alkaline (84075)
- Protein, total (84155)
- Transferase, alanine amino (ALT) (SGPT) (84460)
- Transferase, aspartate amino (AST) (SGOT) (84450)

82040 Albumin; serum
82247 Bilirubin, total
82248 Bilirubin, direct
82251 Bilirubin; total AND direct
82310 Calcium; total
82374 Carbon dioxide (bicarbonate)
82435 Chloride; blood
82465 Cholesterol, serum, total
82550 Creatine kinase (CK), (CPK); total
82565 Creatinine; blood
82947 Glucose; quantitative
82977 Glutamyltransferase, gamma (GGT)
83615 Lactate dehydrogenase (LD), (LHD);
84075 Phosphatase, alkaline;
84100 Phosphorus inorganic (phosphate);
84132 Potassium; serum
84155 Protein; total, except refractometry
84295 Sodium; serum
84450 Transferase; aspartate amino (AST) (SGOT)
84460 Transferase; alanine amino (ALT) (SGPT)
84478 Triglycerides
84520 Urea nitrogen; quantitative
84550 Uric acid; blood

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

N/A

Diagnoses that Support Medical Necessity

N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity

N/A

Diagnoses that DO NOT Support Medical Necessity

N/A

Reasons for Denial

Screening or routine use of the battery is not covered by Medicare.

General health panel (80050) is considered screening; therefore, is non-covered by Medicare.

Noncovered ICD-9-CM Code(s)

N/A

Noncovered Diagnoses

N/A

Coding Guidelines

Under the Medicare fee schedule, any one or more tests, which can be automated, are paid as if done with a multichannel instrument.

Physicians who order tests should be careful to only order tests which are medically necessary, as financial liability lies with the laboratory when medical necessity is not met. When ordering a profile or panel, remember that all tests in the panel must be performed for reimbursement, and that medical necessity must be met on all component tests performed.

Effective January 1, 1998 CPT codes 80002 through 80019 and HCPCS codes G0058 through G0060 were discontinued and are no longer valid codes for the automated multichannel tests.

80048 - continued

The American Medical Association (AMA) CPT Board has approved new automated laboratory panels. These panels are comprised of specific automated tests that are frequently performed in conjunction with one another. They were developed to facilitate ordering of common groupings of tests. The CPT codes for these new panels can only be used for a date of service of January 1, 1998 or after.

To order any of the 22 tests, a physician may select individual tests or the panel. A physician may order a mix of panels and individual tests. The physicians should review what tests are in the panels and not order individual tests which might duplicate tests. Any duplicates tests will be denied by Medicare.

QP is a national HCPCS modifier which will allow laboratories to attest that documentation exists to show that the ordering physician or authorized health professional ordered the test(s) individually or as a CPT-recognized panel. The use of the QP modifier is optional and does not assure payment.

Effective April 1, 2000, CPT codes 80049, 80054, and 80058 are discontinued and will no longer be valid codes for the automated multichannel tests.

Procedure Code 82251 is not considered a valid procedure code for Medicare purposes.

Documentation Requirements

Documentation supporting the medical justification for components of the test billed must be contained in the patient's medical records. (e.g., office/progress notes). In addition, laboratory results of the tests ordered must be available upon request. If the provider of the service is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of the 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 each test billed.

Utilization Guidelines

N/A

Other Comments

Physicians should select or tailor the tests used to fit the clinical situation being evaluated or managed to prevent the inappropriate or wasteful use of the multichannel test.

Sources of Information

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Advisory Committee Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from multiple societies.

Start Date of Comment Period

N/A

Start Date of Notice Period

09/01/2000

Revision History

Revision Number: 11	PCR B2000-128
Start Date of Comment Period:	N/A
Start Date of Notice Period:	09/01/2000 Sep/Oct 2000 *Update!*
Revised Effective Date	07/18/2000
Explanation of Revision:	Addition of statement to coding guidelines section regarding procedure code 82251
Start Date of Comment Period:	N/A
Start Date of Notice Period:	01/13/2000 Jan/Feb 2000 *Update!*
Original Effective Date:	1993
Revised Effective Date Number:	04/01/2000 10 (PCR B2000-018) HCPCS 2000
Start Date of Comment Period:	N/A
Start Date of Notice Period:	12/98
Original Effective Date:	1993
Revised Effective Date Number:	01/01/99 9 (PCR B99-012) 1999 HCPCS

80048 - continued

Start Date of Comment Period:	N/A	
Start Date of Notice Period:	12/20/97	
Original Effective Date:	1993	
Revised Effective Date Number:	01/01/98 (PCR B98-011) 1998 HCPCS	8
Start Date of Comment Period:	07/20/96	
Start Date of Notice Period:	10/16/96	
Original Effective Date:	1993	
Revised Effective Date/Number:	11/18/96 (PCR 96-247A) 6 (PCR 96-247) 5 (PCR 96-086	7
Start Date of Comment Period:	N/A	
Start Date of Notice Period:	N/A	
Original Effective Date:	1993	
Revised Effective Date Number:	01/01/96 (PCR 96-001)	4
Start Date of Comment Period:	N/A	
Start Date of Notice Period:	N/A	
Original Effective Date:	1993	
Revision Date/Number:	3 (PCR 94-159) 2 (PCR 94-139) 1 (PCR 93-144)	
Original Effective Date:	1993 PCR 93-084	

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

80100: Qualitative Drug Screen—Revision to Policy Coding Guidelines

The Qualitative Drug Screen (80100) policy was previously published in the July/August 1999 Medicare B Update! *(pages 31-32). Since that time, the following revisions have been made to the "Coding Guidelines" section of the policy based on new information published in the March 2000* cpt Assistant *regarding the proper billing for CPT codes 80100-80102.*

Coding Guidelines

The codes used to report qualitative drug testing distinguish between screening tests (80100 and 80101) and confirmatory testing (80102). The screening tests are further distinguished by the methods used to analyze *multiple drug classes* (80100) and those that test for *a single drug class* (80101).

The codes are intended to distinguish among analytical methods rather than the platform or instrumentation on which a particular method is run.

For example, chromatography, which can identify multiple drug classes, is coded using 80100 (when used in drug screening). For code 80100, each combination of stationary and mobile phase is to be counted as one procedure. For example, if screening for three drugs by chromatography requires one stationary phase with three mobile phases, report 80100 with a number billed of three (do not bill three separate lines). However, if multiple drugs can be detected using a single analysis (e.g., one stationary phase with one mobile phase), report 80100 only once.

Immunoassays, which are used to identify single drug classes, should be coded using 80101 (when used in drug screening), whether the test is performed using a random access analyzer, a single analyte test kit, or a multiple analyte test kit. For procedure code 80101, each single drug class method tested and reported is to be counted as one drug class. For example, if a sample is aliquoted to five wells and separate class-specific immunoassays are run on each of the five wells and reported separately, report 80101 five times. Similarly, if a sample is run on a rapid assay kit comprising five class-specific immunoassays in a single kit, and the five classes are reported separately, code 80101 should be reported with a number billed of five.

Use procedure code 80102 for each procedure necessary for confirmation. For example, if confirmation of three drugs by chromatography requires three stationary or mobile phases, bill 80102 with a number billed of three. However, if multiple drugs can be confirmed using a single analysis, bill 80102 only once.

For *quantitation* of drugs screened, use the appropriate code (80150-80299 or 82000-84999).

Effective Date

This revision is effective for services processed on or after August 14, 2000.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

Medical Policy Procedures: 82728

Policy Number
82728

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Serum Ferritin

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Section 50-17
Medicare Provider Reimbursement Manual, Section 2711

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
08/01/1994

Revision Effective Date
07/17/2000

Revision Ending Effective Date
07/16/2000

Policy Ending Date
N/A

LMRP Description
Ferritin is a major iron-storage protein, normally found in small quantities in the blood. Iron is stored in the form of ferritin in the tissues of the liver, spleen, and bone marrow. Serum ferritin levels can be beneficial in diagnosing disorders associated with the body's metabolism of iron.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will provide coverage for a ferritin level when it is performed for any one of the following conditions:

- The patient has anemia with possible iron deficiency. (This includes necessary monitoring of serum ferritin during the course of treatment for anemia: e.g., periodic determination of serum ferritin for a patient receiving treatment with epoetin alpha or with anemia due to chronic renal failure);
- The patient has unexplained microcytic and/or hypochromic red blood cell indices;
- The patient has hemochromatosis, iron overload or clinical findings (e.g., skin coloration, hepatomegaly, hyperglycemia, multiple transfusions, polyarthropathy, hemochromatosis) suggestive of iron overload; *or*
- The patient has suspected deficiency of iron due to factors identified in the patient's history (e.g., prior gastrectomy, intestinal malabsorption, a history of gastrointestinal hemorrhage).

Serum ferritin is routinely covered once every three months for beneficiaries who undergo hemodialysis, intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD) and hemofiltration. Services performed more frequently must meet the medical necessity requirements listed above.

HCPCS Section & Benefit Category
Pathology and Laboratory/Chemistry

HCPCS Codes
82728 Ferritin

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

275.0	Disorders of iron metabolism
280.0-280.9	Iron deficiency anemias
281.0-281.9	Other deficiency anemias
282.0-282.9	Hereditary hemolytic anemias
283.0-283.9	Acquired hemolytic anemias
285.0-285.9	Other and unspecified anemias
585	Chronic renal failure
789.1	Hepatomegaly
999.8	Other transfusion reaction

Diagnoses that Support Medical Necessity
N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity
N/A

Diagnoses that DO NOT Support Medical Necessity
N/A

Reasons for Denial
When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9-CM Code(s)
Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

Noncovered Diagnoses
N/A

Coding Guidelines
For beneficiaries who undergo hemodialysis, intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD) and hemofiltration, a serum ferritin level

82728 - continued

is routinely covered every three months and does not require additional documentation. It is considered a separately billable laboratory test and it is not part of the composite rate.

If this test is performed at a frequency greater than what is specified above, then it is covered only if medically justified by accompanying documentation. A diagnosis from the ICD-9-CM coding system may be shown in lieu of a narrative description. In order to document the medical necessity of the test, the nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test must be present on the claim. A diagnosis of end stage renal disease (ESRD) (ICD-9-CM code 585) alone is not sufficient documentation.

Documentation Requirements

Medical record documentation (e.g., office/progress notes) maintained by the ordering/referring physician must indicate the medical necessity for performing the test. Additionally, a copy of the test results should be maintained in the medical records.

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 study. The physician must state the clinical indication/medical necessity for the study in the order for the test.

Utilization Guidelines

In accordance with national Medicare coverage policy, a serum ferritin laboratory test is routinely covered at a frequency of once every three months for hemodialysis, intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD) and hemofiltration beneficiaries. Services performed at a greater frequency are covered if medically necessary and used in timely medical decision making.

Other Comments

N/A

Sources of Information

N/A

Advisory Committee Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from numerous societies.

Start Date of Comment Period

N/A

Start Date of Notice Period

09/01/2000

Revision History:

Revision Number:	4	PCR B2000-126
Start Date of Comment Period:		N/A
Start Date of Notice Period:		09/01/2000 Sep/Oct 2000 *Update!*
Revised Effective Date:		07/16/2000
Explanation of Revision:		Statement was added regarding ferritin as stated in the national guidelines for separately billable tests. Policy was placed in the new format.
Start Date of Comment Period:		04/19/97
Start Date of Notice Period:		07/18/97
Original Effective Date:		08/01/94
Revision Date/Number:		08/25/97 3 (PCR 97-090)
Start Date of Comment Period:		N/A
Start Date of Notice Period:		N/A
Original Effective Date:		08/01/94
Revision Date/Number:		09/09/96 2 (PCR 96-218A) Policy revised to update Covered ICD-9-CM Codes to fifth-digit specificity and to reformat policy into the national format MARS 3.0.
Start Date of Comment Period:		N/A
Start Date of Notice Period:		N/A
Original Effective Date:		08/01/94
Revision Date/Number:		09/09/96 1 (PCR 96-218)
Start Date of Comment Period:		04/16/94
Start Date of Notice Period:		07/01/94
Original Effective Date:		08/01/94 PCR 94-151

The analysis of 1993 Medicare claims payment data indicates that expenditures per 1,000 beneficiaries by the Florida Carrier for serum ferritin determinations (CPT 82728) significantly exceeded national expenditures per 1,000 beneficiaries for the Specialty of Rheumatology (66) and the category of Independent Clinical Laboratories (69).

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

Medical Policy Procedures: 83540

Policy Number
83540

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Iron

AMA CPT Copyright Statement

HCFA National Coverage Policy
N/A

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
04/01/1994

Revision Effective Date
08/01/2000

Revision Ending Effective Date
07/31/2000

Policy Ending Date
N/A

LMRP Description
Iron is essential to the formation and function of hemoglobin. Iron is contained in several components. Transferrin (also called siderophilio), regulates iron absorption. High levels of transferrin relate to the ability of the body to deal with infections. Total iron-binding capacity (TIBC) measures the amount of iron that would appear in plasma if all the transferrin were saturated with iron. Normally, transferrin is about 30% saturated, serum iron 70-150 mcg/dl and TIBC 300-450 mcg/dl.

Iron deficiency is the most common cause of anemia and is probably the most common dietary deficiency. Iron deficiency may develop from blood loss, decreased iron absorption, or increased iron supplements.

Iron excess in the body can also cause severe systemic diseases.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider iron, iron-binding capacity and transferrin tests medically reasonable and necessary for the following conditions:

- Diagnosis of hemochromatosis. Patients with this disease are often asymptomatic, however, may present with right upper quadrant abdominal pain, weakness, fatigue, joint pain, skin pigmentation, impotence, and loss of libido. The clinical findings associated with this disease include but are not limited to hepatomegaly, diabetes mellitus, bronze skin discoloration, inflammatory arthritis, and an increased suspectibility to infection.
- Distinguish between iron deficiency anemia and anemia of chronic disease.
- Evaluation of thalassemia. Thalassemias are inherited disorders characterized by hypochromic microcytic anemia caused by decreased synthesis of one of the globin chains. The symptoms and clinical findings associated with this disorder involve the hematologic system, skeletal abnormalities, hepatic changes, cardiopulmonary abnormalities, and other organs. The key signs and symptoms of thalassemias are pallor, fatigue, dark urine, anemia, jaundice, hepatosplenomegaly, Cooley's anemia facies (hypertrophy and expansion of erythroid marrow, maxilla is overgrown resulting in malocclusion of teeth), and cardiac failure/dilation.
- To determine response to iron therapy.
- Evaluate iron poisoning (toxicity) and overload in renal dialysis patients or patients with transfusion dependent anemias.

The ferritin level is normally performed in conjunction with iron to determine iron storage status.

HCPCS Section & Benefit Category
Pathology and Laboratory/Chemistry

HCPCS Codes

83540	Iron
83550	Iron-binding capacity
84466	Transferrin

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

275.0	Disorders of iron metabolism
280.0–289.9	Diseases of the blood and blood-forming organs
571.5	Cirrhosis of liver without mention of alcohol
572.8	Other sequelae of chronic liver disease
585	Chronic renal failure
790.4	Nonspecific elevation of levels of transaminase or lactic acid dehydrogenase LDH
790.5	Other nonspecific abnormal serum enzyme levels

Diagnoses that Support Medical Necessity
N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity
N/A

Diagnoses that DO NOT Support Medical Necessity
N/A

83540 - continued

Reasons for Denial
When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9-CM Code(s)
Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

Noncovered Diagnoses
N/A

Coding Guidelines
N/A

Documentation Requirements
Medical record documentation maintained by the performing provider must clearly indicate the medical necessity of the service being billed. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the office/progress notes, hospital notes, and/or laboratory results.

Documentation should support the criteria for coverage as set forth in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Utilization Guidelines
N/A

Other Comments
Terms Defined:
Anemia: a condition in which there is a reduction in number of circulating red blood cells or in hemoglobin, or in the volume of packed red cells per 100 ml. of blood or a combination of two or more of these factors.
Hemoglobin: the iron containing pigment of the red blood cells; its function is to carry oxygen from the lungs to the tissues.
Pernicious anemia: anemia due to Vitamin B-12 deficiency. Blood disease marked by progressive decrease in red blood corpuscles, muscular weakness, and gastrointestinal and neural disturbances.
Polycythemia: an excess of red blood cells.
Iron overload: excess iron storage in multiple organs. May be hereditary or acquired.
Hemochromatosis: a disease characterized pathologically by excess deposits of iron throughout the body (i.e., bronzed diabetes).
Thalassemia: a hereditary anemia due to a genetically-transmitted abnormality, with familial or racial incidence.

Sources of Information
Hurst, J. (1983). Medicine for the Practicing Physician. Boston: Butterworth Publishers.

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Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from the Pathology, Hematology, and Oncology specialties.

Start Date of Comment Period
N/A

Start Date of Notice Period
09/01/2000

Revision History

Revision Number: 2	PCR B2000-135
Start Date of Comment Period:	N/A
Start Date of Notice Period:	09/01/2000 Sep/Oct 2000 *Update!*
Revised Effective Date:	08/01/2000
Explanation of Revision:	Upon the development of an internal working document for this policy, it was determined that an indication needed to be added.
Start Date of Comment Period:	04/20/96
Start Date of Notice Period:	07/01/96 Jul/Aug 1996 *Update!*
Original Effective Date:	04/01/94
Revised Effective Date/Number:	08/19/96 1 PCR 96-185
Revision History:	Analysis of 1995 Medicare claims data for the state of Florida indicates that the Florida Carrier has allowed significantly more reimbursement for CPT code 83540 per 1,000 Medicare beneficiaries for the specialties of General Practice, Cardiology, Family Practice, Gastroenterology, Internal Medicine, Pathology, Pulmonary Disease, Rheumatology, Independent Laboratories and Hematology/Oncology than Medicare has paid nationally per 1,000 Medicare beneficiaries for these same specialties.
Start Date of Comment Period:	10/23/93
Start Date of Notice Period:	03/01/94
Original Effective Date:	04/01/94 PCR 94-140

Statistical data derived from a Focused Medical Review process has indicated that the billing for serum iron (83540) exceeds acceptable community practice standards as associated to the specialty of Independent Laboratories. The most commonly billed diagnosis were general symptoms and laboratory examination.

Advance Notice Statement
Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

Medical Policy Procedures: 84484

Policy Number
84484

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Troponin

AMA CPT Copyright Statement

HCFA National Coverage Policy
Program Memorandum AB 98-42

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
10/26/1998

Revision Effective Date
08/15/2000

Revision Ending Effective Date
08/14/2000

Policy Ending Date
N/A

LMRP Description
Troponin is a muscle protein that attaches to both actin and tropomyosin. It is concerned with calcium binding and inhibiting cross-bridge formation. Troponin is a complex of three proteins: troponin C, troponin I, and troponin T. The distribution of these isoforms varies between cardiac muscle and slow- and fast-twitch skeletal muscle. Their importance lies in the fact that the isoforms troponin I and troponin T show a high degree of cardiac specificity, and therefore, have an important role in the diagnostic evaluation of a patient presenting with symptoms suggestive of a cardiac origin.

Cardiac Troponin I (cTnI) is highly specific for myocardial tissue, is thirteen times more abundant in the myocardium than CK-MB on a weight basis, is not detectable in the blood of healthy persons, shows a greater proportional increase above the upper limit of the reference interval in patients with myocardial infarction and remains elevated for seven to ten days after an episode of myocardial necrosis. In addition, measurements of cTnI is useful to clarify which increases in CK-MB are due to myocardial injury and which ones reflect acute or chronic skeletal muscle abnormalities.

Troponin T, the tropomyosin-binding protein of the regulatory complex located on the contractile apparatus of cardiac myocytes, is also a sensitive and specific marker for myocardial necrosis. Damaged heart muscle releases the protein, troponin T, which increases in the bloodstream as early as 3 hours after the onset of chest pain and remains at an elevated level for 2 to 7 days.

Indications and Limitations of Coverage and/or Medical Necessity
Troponin levels are considered medically reasonable and necessary to rule out myocardial injury only under the following conditions:

- patient presents with signs and symptoms of an acute myocardial infarction (prolonged chest pain often described as squeezing, choking, stabbing, etc., usually spreading across chest to the left arm; dyspnea, diaphoresis) which is confirmed by an electrocardiogram (EKG, ECG);
- patient presents with vague or atypical symptoms suggestive of a cardiac origin, which is not confirmed by an electrocardiogram;
- patient evaluation reveals a normal creatine kinase MB isoenzyme (CK-MB), however, the EKG demonstrates new changes consistent with ischemia (e.g., flipped T waves, ST-segment depression); or
- to distinguish patients with unstable angina from those with a non-Q wave myocardial infarction.

Initially, it is expected that a qualitative Troponin level (procedure code 84512) is performed on a patient with suspected myocardial injury. If the results of the qualitative Troponin level is positive, then the quantitative level of Troponin I or Troponin T (procedure code 84484) is performed, usually with the same blood specimen, to determine if the symptoms are cardiac in nature. The Troponin C isoform is not useful in the management of myocardial infarction and it is not necessary to monitor both the T and I isoform.

The quantitative test is normally performed every 8-12 hours the first 24 hours. Once the determination is made whether myocardial injury has occurred, it is expected that a Troponin level will be performed only when the results are to be used in the active treatment of the patient.

Also, it is not necessary to use Troponin in addition to Creatine Kinase (procedure codes 82550-82554) in the management of patients with myocardial infarction.

HCPCS Section & Benefit Category
Pathology and Laboratory /Chemistry

HCPCS Codes
84484 Troponin, quantitative
84512 Troponin, qualitative

Not Otherwise Classified Codes (NOC)
N/A

84484 - continued

ICD-9-CM Codes that Support Medical Necessity

410.00-410.92	Acute myocardial infarction
411.1	Intermediate coronary syndrome
413.0-413.9	Angina pectoris
427.0-427.9	Cardiac dysrhythmias
785.0	Tachycardia, unspecified
786.03-786.09	Dyspnea and respiratory abnormalities
786.50-786.59	Chest pain
794.31	Abnormal electrocardiogram [ECG][EKG]

Diagnoses that Support Medical Necessity

N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity

N/A

Diagnoses that DO NOT Support Medical Necessity

N/A

Reasons for Denial

Troponin levels are not a covered service when performed as a routine screening procedure or in the absence of documentation of clinical findings in the patient's medical record indicating suspected myocardial injury.

When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9-CM Code(s)

Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

Noncovered Diagnoses

N/A

Coding Guidelines

One unit of troponin is equivalent to one order for 84484 or one order for 84512 regardless of the number or mix of isoforms provided. Therefore, regardless of the number of isoforms or mixture of isoforms provided, only one unit may be billed for each code.

Documentation Requirements

The medical records must document the medical necessity of the test including the test results. This information is usually found in the office/progress notes, emergency/hospital notes, and/or laboratory results.

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.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

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84484 - continued

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Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from the Florida Cardiology and Florida Emergency Medicine Societies.

Start Date of Comment Period
N/A

Start Date of Notice Period
09/01/2000

Revision History

Revision Number:	3	PCR B2000-147
Start Date of Comment Period:		N/A
Start Date of Notice Period:		09/01/2000 Sep/Oct 2000 *Update!*
Revised Effective Date:		08/15/2000
Explanation of Revision:		An evaluation in the use of both Troponin and CK-MB in the evaluation of patients warranted a revision to the indications section to better clarify the indications of coverage.
Start Date of Comment Period:		N/A
Start Date of Notice Period:		11/98 Nov/Dec '98 *Update!*
Original Effective Date:		10/26/98
Revision Date/Number:		10/26/98 2 (PCR B98-151)
Start Date of Comment Period:		N/A
Start Date of Notice Period:		
Original Effective Date:		10/26/98
Revision Date/Number:		10/26/98 1 (PCR B98-145) '99 ICD-9-CM update
Start Date of Comment Period:		11/01/97
Start Date of Notice Period:		09/98
Original Effective Date:		10/26/98 (PCR B98-140)

Advance Notice Statement
Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

Medical Policy Procedures: 90732

Policy Number
90732

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Pneumococcal Vaccinations

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Carriers Manual 2050.5.C.1, 2049.4

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
05/01/1993

Revision Effective Date
08/14/2000

Revision Ending Effective Date
08/13/2000

Policy Ending Date
N/A

LMRP Description
Pneumococcal vaccine is available to reduce the chances of developing pneumonia in patients considered to be at high risk of acquiring a pneumococcal infection. Typically, these vaccines are administered once in a lifetime except for persons considered at highest risk.

90732 - continued

Indications and Limitations of Coverage and/or Medical Necessity

Medicare reimburses initial vaccination with pneumococcal vaccine (90732) at 100% of the reasonable charge for persons considered to be at high risk of developing pneumococcal infection. Persons considered at high risk for whom an initial vaccine may be administered include, but are not limited to, the following:

- persons age 65 and 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/or
- 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 reimburses revaccination with pneumococcal vaccine (90732) for persons at highest risk of serious pneumococcal infection, provided that at least 5 years have passed since the previous pneumococcal vaccination. Persons considered to be at highest risk include, but are not limited to, the following:

- persons with functional or anatomic asplenia (e.g., sickle cell disease, splenectomy);
- persons with HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression such as organ or bone marrow transplantation, and those receiving immunosuppresive chemotherapy;
- individuals who have been shown to have a rapid decline in pneumococcal antibody levels.

Routine revaccination of people age 65 or older who are not at highest risk is not appropriate.

HCPCS Section & Benefit Category

Medicine/Immunizations

HCPCS Codes

90732	Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use
G0009	Administration of pneumococcal vaccine when no physician fee schedule service on the same day

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

N/A

Diagnoses that Support Medical Necessity

N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity

N/A

Diagnoses that DO NOT Support Medical Necessity

N/A

Reasons for Denial

When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Patient is not at high risk (definition determined from Indications and Limitations of Coverage).

Procedure code 90669 is not an FDA approved vaccine. Therefore, it is noncovered by Medicare of Florida.

Noncovered ICD-9-CM Code(s)

N/A

Noncovered Diagnoses

N/A

Coding Guidelines

Code administration of pneumococcal vaccine with G0009. Code pneumococcal vaccine with 90732.

Although ICD-9-CM code V03.82 is the appropriate diagnosis for the Pneumococcal Vaccinations, all diagnoses will be accepted. This is done because the goal of the program is to improve beneficiary health by the increased use of covered preventative services.

Documentation Requirements

Medical records must contain sufficient information to show the medical necessity of the service. See "Indications and Limitations of Coverage and/or Medical Necessity."

Effective August 14, 2000, Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Those administering the vaccine should not require the patient to present an immunization record prior to administering the pneumococcal vaccine, nor should they feel compelled to review the patient's complete medical record if it is not available. Instead, provided that the patient is competent, it is acceptable for them to rely on the patient's verbal history to determine prior vaccination status. If the patient is uncertain about their vaccination history in the past 5 years, the vaccine should be given. However, if the patient is certain that he/she was vaccinated in the last 5 years, the vaccine should not be given. If the patient is certain that the vaccine was given and that more than 5 years have passed since receipt of the previous dose, revaccination is not appropriate unless the patient is considered at highest risk (refer to "Indications and Limitations of Coverage and/or Medical Necessity").

Utilization Guidelines

Routine revaccination of people age 65 or older who are not at highest risk is not appropriate. Medicare reimburses revaccination with pneumococcal vaccine for persons at highest risk of serious pneumococcal infection, provided at least 5 years have passed since the previous pneumococcal vaccination.

90732 - continued

Other Comments
Reimbursement will not be made for the administration of a pneumococcal vaccine (G0009) if payment is not made for the vaccine (90732).

Sources of Information
N/A

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from numerous specialties.

Start Date of Comment Period
N/A

Start Date of Notice Period
09/01/2000

Revision History

Revision Number:	6	PCR B2000-129
Start Date of Comment Period:		N/A
Start Date of Notice Period:		09/01/2000 Sep/Oct 2000 *Update!*
Revised Effective Date:		08/14/2000
Explanation of Revision:		Based on HCFA Prof 574AB (Change Request)1237, the effective date has been changed to August 14, 2000.
Revision Number:	5	PCR B2000-123
Start Date of Comment Period:		N/A
Start Date of Notice Period:		09/01/2000 Sep/Oct 2000 *Update!*
Revised Effective Date:		07/01/2000
Explanation of Revision:		Revisions based on HCFA Profs 313B and 330B. Policy placed in new national format.
Start Date of Comment Period:		N/A
Start Date of Notice Period:		July/Aug '99 *Update!*
Original Effective Date:		05/01/1993
Revision Date/Number:		05/03/99 4 (PCR 99-092)
Start Date of Comment Period:		N/A
Start Date of Notice Period:		12/98
Original Effective Date:		05/01/1993
Revision Date/Number:		01/01/99 3 (PCR 99-022) '99 HCPCS
Start Date of Comment Period:		N/A
Start Date of Notice Period:		N/A
Original Effective Date:		05/01/1993
Revision Date/Number:		2 (PCR 96-139) 06/10/95 1 (PCR 95-073)
Original Effective Date:		05/01/1993 PCR 93-165

Advance Notice Statement
Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

Audiologist Services

The Medicare Carrier's Manual (MCM), Section 2070.3, provides Medicare coverage information regarding audiologist services. According to the MCM, there is limited coverage of diagnostic testing. However, no payment may be made for therapeutic services performed by privately practicing audiologists or audiologists on the staff of a clinic which is not physician-directed.

The following list of codes was developed as a guide for audiologists and represents those services that could be performed by an audiologist and potentially be covered by Florida Medicare.

CPT Codes for Use by an Audiologist:
92516, 92541-92547, 92552-92557, 92561-92565, and 92567-92588.

*HCPCS codes 92531-92534 are not paid separately; 92548 (Computerized Dynamic Posturography) is non-covered locally; and 92559, 92560, and 92589-92596 are nationally non-covered by Medicare. Therefore, these codes have not been included on the list of covered services.

93224: Electrocardiographic Monitoring for 24 Hours (Holter Monitoring)

Electrocardiographic monitoring can be performed on ambulatory patients over a set period of time (usually twenty four hours). The monitoring device (holter monitor) allows the patient to resume their normal lifestyle and activities while recording episodes of arrhythmia. This gives the physician documented episodes of arrhythmias or absence of arrhythmias to correlate with the patient's symptoms.

This coverage policy is being developed to clearly define the circumstances for which twenty-four hour continuous electrocardiographic monitoring is considered to be medically reasonable and necessary, and therefore covered, by Medicare Part B in Florida.

Policy Type

Local medical necessity policy

Indications and Limitations of Coverage and/or Medical Necessity

Medicare Part B in Florida will consider twenty-four hour electrocardiographic monitoring to be medically necessary in any of the following circumstances (see ICD-9-CM Codes That Support Medical Necessity):

- The patient complains of palpitations, and physical examination and standard EKG have not satisfactorily explained the patient's complaints.
- The patient has experienced an unexplained syncopal episode or the patient has experienced a transient episode of cerebral ischemia which is felt to possibly be secondary to a cardiac rhythm disturbance.
- The patient has been found to have a significant cardiac arrhythmia or conduction disorder (see list below) and holter monitoring is necessary as part of the evaluation and management of the patient:

  Complete Heart Block
  Second Degree AV Block
  New Left Bundle Branch Block
  New Right Bundle Branch Block
  Bifasicular Block
  Paroxysmal SVT
  Paroxysmal VT
  Atrial Fib/Flutter
  Ventricular Fib/Flutter
  Cardiac Arrest
  SA Node Dysfunction
  Frequent PAC's
  Frequent PVC's
  Wandering Atrial Pacemaker
  Unspecified Cardiac Arrhythmia

- The patient has a heart condition (see list below) associated with a high incidence of serious cardiac arrhythmia and/or myocardial ischemia, and holter monitoring is being done as part of the evaluation and management of the patient:

  Dressler's Syndrome
  History of Myocardial Infarction
  Angina Pectoris
  Prinzmetals's Angina
  Aneurysm of Heart Wall
  Chronic Ischemic Heart Disease
  Pericarditis
  Mitral Valve Disease
  Cardiomyopathy
  Anomalus AV Excitation
  Cardiomegaly
  Post Heart Surgery
  Prolonged QT Interval

- The patient has a cardiac arrhythmia or other cardiac condition and a cardiac medication which affects the electrical conduction system of the heart has been prescribed, and holter monitoring is necessary to evaluate the effect of the cardiac medication on the patient's cardiac rhythm and/or conduction system.
- The patient has a pacemaker and clinical findings (history or physical examination) suggest possible pacemaker malfunction.

Claims submitted for holter studies performed at unusually frequent intervals will be reviewed by Medicare to make certain that the services were medically reasonable and necessary.

HCPCS Codes

93224-93237	ECG monitoring for 24 hours

ICD-9-CM Codes That Support Medical Necessity

410.00-410.02	Acute myocardial infarction of anterolateral wall
410.10-410.12	Acute myocardial infarction of other anterior wall
410.20-410.22	Acute myocardial infarction of inferolateral wall
410.30-410.32	Acute myocardial infarction of inferoposterior wall
410.40-410.42	Acute myocardial infarction of inferior wall
410.50-410.52	Acute myocardial infarction of other lateral wall infarction
410.60-410.62	Acute myocardial infarction of true posterior wall infarction
410.70-410.72	Acute myocardial infarction of subendocardial infarction
410.80-410.82	Acute myocardial infarction of other specified sites
410.90-410.92	Acute myocardial infarction of unspecified site
411.0	Postmyocardial infarction syndrome
411.1	Intermediate coronary syndrome
411.81	Coronary occlusion without myocardial infarction
411.89	Other acute and subacute forms of ischemic heart disease
412	Old myocardial infarction
413.0-413.9	Angina pectoris
414.00	Coronary atherosclerosis of unspecified vessel
414.01	Coronary atherosclerosis of native coronary
414.02	Coronary atherosclerosis of autologous vein bypass graft
414.03	Coronary atherosclerosis of nonautologous biological bypass graft
414.10	Aneurysm of heart (wall)
414.11	Aneurysm of coronary vessels

93224 - continued

414.19	Other aneurysm of heart
414.8	Other specified forms of chronic ischemic heart disease
414.9	Chronic ischemic heart disease, unspecified
423.1	Adhesive pericarditis
423.2	Constrictive pericarditis
424.0	Mitral valve disorders
425.0-425.9	Cardiomyopathy
426.0	Artrioventricular block, complete
426.12	Mobitz (type) II atriioventricular block
426.13	Other second degree atrioventricular block
426.2	Left bundle branch hemiblock
426.4	Right bundle branch block
426.53	Other bilateral bundle branch block
426.7	Anomalous atrioventricular excitation
426.9	Conduction disorder, unspecified
427.0	Paroxysmal supraventricular tachycardia
427.1	Paroxysmol ventricular tachycardia
427.31	Atrial fibrillation
427.32	Atrial flutter
427.41	Ventricular fibrillation
427.42	Ventricular flutter
427.5	Cardiac arrest
427.61	Supraventricular premature beats
427.69	Other premature beats
427.81	Sinoatrial node dysfunction
427.89	Other specified cardiac dysrhythmias
427.9	Cardiac dysrhythmia, unspecified
429.3	Cardiomegaly
429.4	Functional disturbances following cardiac surgery
429.9	Heart disease, unspecified
780.2	Syncope and collapse
785.1	Palpitations
E942.0	Cardiac rhythm regulators
E942.1	Cardiotonic glycosides and drugs of similar action
V45.00	Unspecified cardiac device
V45.01	Cardiac pacemaker
V45.02	Automatic implantable cardiac defibrillator
V45.09	Other specified cardiac device
V67.51	Followup examination following treatment with high-risk medication, not elsewhere classified

HCPCS Section and Benefit Category
Medical

HCFA National Coverage Policy
CIM 50-15
MCM 7506.5G

Reasons for Denial
Screening tests performed on asymptomatic patients without medical problems, cannot be covered by Medicare Part B.

Noncovered ICD-9-CM Code(s)
N/A

Sources of Information
CPT
ICD-9-CM

Coding Guidelines
N/A

Documentation Requirements
Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of holter monitor studies covered by the Medicare program. Also, the results of holter studies covered by the Medicare program must be included in the patient's medical record.
If the provider of holter studies is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation along with copies of the ordering/referring physician's order for the study. When ordering holter studies from an independent physiological lab or other provider, the ordering/referring physician must state the reason for the holter study in his order for the test.

Other Comments
N/A

Rationale For Creating Policy
Analysis of 1993 Medicare claims data for the state of Florida indicates that the Florida Carrier has allowed significantly more reimbursement for electrocardiographic monitoring for twenty four hours; i.e., "Holter Studies" **(CPT code 93230)** per 1,000 Medicare beneficiaries, for several specialties (general practice, cardiology, family practice, internal medicine), than Medicare has paid nationally per 1,000 beneficiaries for these same specialties.

CAC Notes
This policy does not reflect the sole opinion of the Carrier or Carrier Medical Director. Conversely, this policy was developed in consultation with the medical community via the Carrier Advisory Committee on July 23, 1994, which includes representatives from the Cardiology Society.

Start Date of Comment Period:
Start Date of Notice Period:
Effective Date:
Revision Date/Number: 2

Revision History:

Start Date of Comment Period:		
Start Date of Notice Period:		
Effective Date:		
Revision Date/Number:	01/31/95	1
Start Date of Comment Period:	07/18/94	
Start Date of Notice Period:	10/31/94	
Effective Date:	12/01/94	
Revision Date/Number:	N/A	

Advance Notice Statement
Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

Medical Policy Procedures: 93875

Policy Number
93875

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Non-invasive Extracranial Arterial Studies

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Section 50-6
Coverage Issues Manual, Section 50-7
Coverage Issues Manual, Section 50-37

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
09/01/1994

Revision Effective Date
08/07/2000

Revision Ending Effective Date
08/06/2000

Policy Ending Date
N/A

LMRP Description
Non-invasive extracranial arterial studies involve the use of direct and occasionally indirect methods of ultrasound to evaluate and monitor the blood vessels that supply the brain. The direct methods of assessment are doppler and duplex ultrasound, whereas the indirect methods include techniques such as oculoplethysmography.

Doppler ultrasonography is used to evaluate hemodynamic parameters, specifically the velocity of blood flow and the pattern or characteristics of flow. The doppler ultrasound involves the evaluation of the supraorbital, common carotid, external carotid, internal carotid, and the vertebral arteries in the extracranial cerebrovascular assessment.

The second key component of vascular diagnostic ultrasound is the B-mode, or brightness-mode image. This real time imaging technique provides a two-dimensional gray-scale image of the soft tissues and vessels based on the acoustic properties of the tissues.

Duplex ultrasonography combines the direct visualization capabilities of B-mode ultrasonography and the blood-flow velocity measurements of doppler ultrasonography.

In addition to the direct methods of doppler and duplex ultrasonography to evaluate the cerebrovascular arterial system, indirect methods such as supraorbital doppler ultrasonography and oculoplethysmography are used as an adjunct to assess the carotid artery. Supraorbital doppler ultrasonography indirectly assesses blood flow from collateral branches of the internal carotid artery through the supraorbital vessels. This test is done by placing a directional doppler probe over a supraorbital artery and observing the flow with and without compression of neighboring arteries.
Oculoplethysmography indirectly measures blood flow in the ophthalmic artery by graphically recording ocular pulses obtained from corneal cups held in place by mild suction. Because the ophthalmic artery is the first major branch of the internal carotid artery, its blood flow accurately reflects carotid blood flow and ultimately that of cerebral circulation.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider non-invasive extracranial arterial studies medically reasonable and necessary under the following circumstances:

- To evaluate a patient with suspected occlusive cerebrovascular disease as demonstrated by the presence of transient ischemic attacks (TIA's), possible carotid bruit(s), diminished or absent pulses in the neck or arms, and/or a blood pressure difference in 2 arms of greater than 10mmHg.
- To evaluate a patient with signs/symptoms of subclavian steal syndrome. The symptoms usually associated with subclavian steal syndrome are a bruit in the supraclavicular fossa, unequal radial pulses, arm claudication following minimal exercise, and a difference of 20mmHg or more between the systolic blood pressures in the arms.
- To monitor a patient with known carotid stenosis. Patients demonstrating a diameter reduction of 30-50% are normally followed on an annual basis, whereas patients with a diameter reduction of greater than 50% are normally followed every six months. It is not necessary to monitor patients with a diameter reduction of less than 30%.
- To evaluate a patient with transient monocular blindness (amaurosis fugax). Normally a patient with this symptom is evaluated with an ocular pneumoplethysmography.
- To monitor patients who are post carotid endarterectomy. These patients are normally followed with duplex ultrasonography on the affected side at 6 weeks, 6 months, 1 year, and annually thereafter.
- To initially evaluate a patient presenting with an asymptomatic carotid bruit identified on physical examination. Routine monitoring of a patient with an asymptomatic carotid bruit without evidence of carotid stenosis is considered screening, and therefore, noncovered.
- To initially evaluate a patient who has had a recent stroke (recent is defined as less than six months) to determine the cause of the stroke.

93875 - continued

- To evaluate a patient presenting with an injury to the carotid artery.
- To evaluate a patient with a suspected aneurysm of the carotid artery. This is suspected in patients with swelling of the neck particularly if occurring post carotid endarterectomy.
- To preoperatively validate the degree of carotid stenosis of a patient whose previous duplex scan revealed a greater than 70% diameter reduction. The duplex is only covered when the surgeon questions the validity of the previous study and the repeat test is being performed in lieu of a carotid arteriogram.

Note: The current medical literature contains inconclusive information regarding the evaluation and monitoring of patients with asymptomatic carotid bruits. Even though the presence of bruit increases the likelihood of finding disease of extracranial carotid arteries, it does not necessarily indicate severe stenosis. Also, the predictive value of a bruit is questioned when severe disease is found in patients without a bruit.

In addition, the literature supports that the test of choice for all the above indications is the duplex scan, which is represented by procedure code 93880 and 93882.

Since the standard for the above indications is a color-duplex scan, portable equipment must be able to produce combined anatomic and spectral flow measurements.

HCPCS Section & Benefit Category

Non-invasive Vascular Diagnostic Studies/Medicine

HCPCS Codes

93875	Non-invasive physiologic studies of extracranial arteries, complete bilateral study (e.g., periorbital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis)
93880	Duplex scan of extracranial arteries; complete bilateral study
93882	unilateral or limited study

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

362.34	Transient arterial occlusion
433.10	Occlusion and stenosis of carotid artery without mention of cerebral infarction
433.11	Occulsion and stenosis of carotid artery with cerebral infarction
433.30	Occlusion and stenosis of multiple and bilateral precerebral arteries without mention of cerebral infarction
433.31	Occlusion and stenosis of multiple and bilateral precerebral arteries with cerebral infarction
434.00-434.91	Occlusion of cerebral arteries
435.0	Basilar artery syndrome
435.1	Vertebral artery syndrome
435.2	Subclavian steal syndrome
435.3	Vertebrobasilar artery syndrome
435.8	Other specified transient cerebral ischemias
435.9	Unspecified transient cerebral ischemia
436	Acute, but ill-defined, cerebrovascular disease
442.81	Other aneurysm of artery of neck
785.9	Other symptoms involving cardiovascular system (carotid bruit)
900.00	Injury to carotid artery, unspecified
900.01	Injury to common carotid artery
900.02	Injury to external carotid artery
900.03	Injury to internal carotid artery
V67.0	Follow-up examination following surgery

Diagnoses that Support Medical Necessity

N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity

N/A

Diagnoses that DO NOT Support Medical Necessity

N/A

Reasons for Denial

When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9-CM Code(s)

Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

Noncovered Diagnoses

N/A

Coding Guidelines

Vascular studies include patient care required to perform the studies, supervision of the studies and interpretation of study results with copies for patient records of hard copy output with analysis of all data, including bidirec tional vascular flow or imaging when provided. The use of a single hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be part of the physical examination of the vascular system and is not separately reimbursed under procedure codes 93875, 93880, or 93882.

Since a duplex scan of the extracranial arteries includes the combined capabilities of the B-mode and doppler ultrasonography, it is not expected that procedure code 93875 will be billed in addition to a duplex scan (93880 or 93882).

Documentation Requirements

Medical record documentation maintained by the ordering physician must clearly indicate the medical necessity of the services being billed. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the office/progress notes, hospital notes, and/or test results.

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.

93875 - continued

Utilization Guidelines

N/A

Other Comments

Terms Defined:

Amaurosis fugax - a sudden and brief loss of vision in one eye.
Bruit - an adventitious sound of venous or arterial origin heard on auscultation.
Carotid bruit - a murmur heard in the cervical area that does not disappear with venous compression, are maximal over the carotid bifurcation, and are not due to transmitted cardiac murmurs. The presence of asymptomatic carotid bruits increases with advanced age, but is not associated with increased risk for stroke in elderly patients. In addition, carotid bruits may spontaneously disappear without sequelae.
Cerebrovascular accident (CVA) - a focal neurological abnormality confined to one cerebral hemisphere which persists for more than 24 hours.
Subclavian Steal Syndrome - a shunting of blood, which was destined for the brain, away from the cerebral circulation. This occurs when the subclavian artery is occluded. Blood then flows from the opposite vertebral artery across to and down the vertebral artery on the side of the occlusion.
Transient Ischemic Attacks (TIAs) - a temporary interference with blood supply to the brain. The symptoms of neurological deficit may last for only a few moments or several hours (usually less than 24 hours). After the attack no evidence of residual brain damage or neurological damage remains. The neurological deficits may include such symptoms as contralateral weakness, speech alterations, visual disturbances, etc.

Sources of Information

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Advisory Committee Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from numerous societies.

Start Date of Comment Period

N/A

Start Date of Notice Period

09/01/2000

Revision History

Revision Number:	2	PCR B2000-133
Start Date of Comment Period:		N/A
Start Date of Notice Period:		09/01/2000 Sep/Oct 2000 *Update!*
Revised Effective Date:		08/07/2000
Explanation of Revision:		An evaluation was completed and it was determined to be appropriate to perform this study for diagnoses 433.30 and 433.31.
Start Date of Comment Period:		04/30/99
Start Date of Notice Period:		09/01/99 Sep/Oct 1999 *Update!*
Original Effective Date:		09/01/94
Revision Date/Number:		10/18/99 (PCR B99-110) Original Policy Struck Out
Start Date of Comment Period:		04/16/94
Start Date of Notice Period:		08/01/94
Original Effective Date:		09/01/94

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

Medical Policy Procedures: 93990

Policy Number
93990

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Duplex Scan of Hemodialysis Access

AMA CPT Copyright Statement

HCFA National Coverage Policy
Provider Reimbursement Manual 2710

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
10/20/1997

Revision Effective Date
10/01/2000

Revision Ending Effective Date
09/30/2000

Policy Ending Date
N/A

LMRP Description
Duplex scanning is an ultrasonic scanning procedure with display of both two-dimensional structure and motion with time and Doppler ultrasonic signal documentation with spectrum analysis and/or color flow velocity mapping or imaging. This technique allows sampling of a particular imaged blood vessel with analysis of the blood flow velocity.

Evaluation of endogenous arteriovenous fistulae and synthetic polytetrafluoroethylene (PTFE) grafts, which are the two principal means of creating permanent vascular access for hemodialysis, can be achieved by duplex scanning.

Indications and Limitations of Coverage and/or Medical Necessity
Limited coverage has been established for diagnostic duplex scanning of hemodialysis access sites in patients with end stage renal disease (ESRD). These procedures are medically necessary only in the presence of signs and symptoms of possible failure of the access site, and when the results of the procedures will permit medical intervention to address the problem. However, other diagnostic vascular services, such as venography, would be considered duplicative services and would not be covered by Medicare.

Appropriate indications for duplex scan of hemodialyis access site would include clear documentation in the dialysis record of signs of chronic (i.e., 3 successive dialysis sessions) abnormal function, including:

I. Clinical Indicators
- -difficult canulation by multiple personnel;
- -thrombus aspiration by multiple personnel;
- -prolonged bleeding after needle withdrawal;
- -pain in graft arm;
- -persistent swelling in graft arm;
- -elevated venous pressure greater than 200 mm Hg on a 200 cc/min. pump;
- -elevated recirculation time of 12 % or greater;
- -low urea reduction rate of less than 60%; or
- -shunt collapse, suggesting poor arterial flow.

II. Physical Findings by Examination of Graft
- -bruit is discontinuous, systolic only, harsh, high pitched;
- -thrill is at stenotic sites, possibly multiple, discontinuous, systolic only; and/or
- -pulse is water-hammer.

HCPCS Section & Benefit Category
Medicine /Non-invasive Vascular Diagnostic Studies

HCPCS Codes
93990 Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
996.73 Complications of surgical and medical care due to renal dialysis device, implant, and graft

Diagnosis that Support Medical Necessity
N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity
N/A

Diagnosis that DO NOT Support Medical Necessity
N/A

Reasons for Denial
When performed for indications other than those listed in the “Indications and Limitations of Coverage and/or Medical Necessity” section of this policy.

Noncovered ICD-9-CM Code(s)
Any diagnosis codes not listed in the “ICD-9-CM Codes That Support Medical Necessity” section of this policy.

Noncovered Diagnosis
N/A

93390 - continued

Coding Guidelines

The use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be a part of the physical examination of the vascular system and is not separately reported.

Doppler flow studies being used to monitor the hemodialysis access site are not covered as separately billable services. The professional component of these monitoring studies is included in the monthly capitation payment or other evaluation and management visits delivered to the patient. The technical component of monitoring procedures is included in the ESRD facility's composite payment rate.

Billing for monitoring of hemodialysis access using CPT codes for non-invasive vascular studies other than 93990 (e.g., 93922, 93923, 93924, 93925, 93926, 93930, 93931, 93965, 93970, 93971) is considered a misrepresentation of the service actually provided and will be considered for fraud investigation.

Documentation Requirements

Medical record documentation maintained by the physician must clearly indicate the medical necessity of the services being billed. The results of the study must be included in the medical record.

Utilization Guidelines

N/A

Other Comments

ESRD facilities are responsible as part of the dialysis treatment to monitor access. A number of ESRD facilities are monitoring hemodialysis access through flow studies. All such procedures are covered under the composite rate.

Sources of Information

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Advisory Committee Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from various societies.

Start Date of Comment Period

N/A

Start Date of Notice Period

09/01/2000

Revision History

Revision Number:	1	PCR B2000-132
Start Date of Comment Period:		N/A
Start Date of Notice Period:		09/01/2000
		Sep/Oct 2000 *Update!*
Revised Effective Date:		10/01/2000
Explanation of Revision:		HCFA released Transmittals AB-00-44 and AB-00-55.
Start Date of Comment Period:		04/19/97
Start Date of Notice Period:		09/01/97
Original Effective Date:		10/20/97
		PCR 97-107

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

Medical Policy Procedures: 94642

Policy Number
94642

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Aerosolized Pentamidine Isethionate

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Carrier's Manual 2049
Program Memorandum FQA-721 (3/30/90)

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
04/14/1997

Revision Effective Date
10/16/2000

Revision Ending Effective Date
10/15/2000

Policy Ending Date
N/A

LMRP Description
Pentamidine isethionate is an antiprotozoal agent. The drug, in its parenteral form, is used to treat *active* Pneumocystis carinii pneumonia. The aerosolized form of this drug, also known as NebuPent, is FDA approved for the *prevention* of Pneumocystis carinii pneumonia (PCP) in high risk, HIV-infected patients. The purpose of this policy is to define the conditions for coverage of the aerosolized form of Pentamidine isethionate.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider aerosolized Pentamidine isethionate, administered incident to a physician's services, medically reasonable and necessary for the following conditions:

1. For the prevention of P. carinii pneumonia in high risk HIV-infected patients defined by the following criteria:
   A history of one or more episodes of PCP, and/or
   A peripheral CD4+ (T4 helper/inducer) lymphocyte count less than or equal to 200 cells/mm3.
2. As an alternative regimen for the prevention of P. carinii pneumonia for organ transplant recipients intolerant of TMP-SMZ (cotrimoxazole).

Administration and dosage
The dosage of aerosolized Pentamidine isethionate is 300 mg by inhalation every 4 weeks. It is only to be administered via a device which is FDA approved to deliver this medication. The dose should be delivered until the nebulizer chamber is empty (approximately 30-45 minutes). The flow rate should be 5-7 L/min from a 40-50 pound per square inch (PSI) air or oxygen source. Pressure compressors providing less than 20 PSI should not be used.

In order to meet all the general requirements under the incident-to provision, an FDA approved drug or biological must be of a form that cannot be self-administered and must be furnished by a physician and administered by him/her or by auxiliary personnel employed by him/her under his/her supervision. The charge, if any, for the drug and biological must be included in the physician's bill, and the cost of the drug must represent an expense to the physician.

HCPCS Section & Benefit Category
Drugs and Biologicals
Pulmonary/Medicine

HCPCS Codes

94642	Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis
J2545	Pentamidine isethionate, inhalation solution, per 300 mg, administered through a DME

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

042	Human immunodeficiency virus [HIV] disease
136.3	Pneumocystosis
V42.0-V42.83	Organ or tissue replaced by transplant

Diagnoses that Support Medical Necessity
N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity
N/A

Diagnoses that DO NOT Support Medical Necessity
N/A

Reasons for Denial
When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

The use of aerosolized Pentamidine isethionate in excess of the administration/dosage described in this policy.

The self-administration of aerosolized Pentamidine isethionate.

Noncovered ICD-9-CM Code(s)
Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

94642 - continued

Noncovered Diagnoses
N/A

Coding Guidelines
The only place of service payable by the Carrier for procedure code(s) J2545 and 94642 is POS 11 (office).

HCPCS Level II code J2545 is intended to be used to represent the inhaled Pentamidine isethionate drug product. Systemic Pentamidine isethionate (Intravenous or Intramuscular) should be billed using HCPCS code J3490.

Documentation Requirements
Medical record documentation maintained by the treating physician must substantiate the medical necessity for use of aerosolized Pentamidine isethionate by clearly indicating the condition for which it is being given. If aerosolized Pentamidine isethionate is provided to an organ transplant recipient, documentation must support that the patient has undergone a Medicare approved transplant and the patient has an allergy to Sulfa. This documentation is usually found in the history and physical examination, the office/progress notes, and/or lab results.

Utilization Guidelines
N/A

Other Comments
Terms Defined:
Aerosol treatment - a solution of a drug which can be atomized into a fine mist for inhalation therapy

PCP – pulmonary infection due to pneumocystis carinii. PCP is the most common pneumonia in immunosuppressed patients with HIV infection.

Sources of Information
American Hospital Formulary Service Drug Information

Drug Facts and Comparisons®, August 1998.

George, R.B., Light, R.W., Matthay, M.A., Matthay, R.A. (Eds.). (1995). Chest medicine: Essentials of pulmonary and critical care medicine. (3rd ed.). Baltimore: Williams & Wilkins Company.

United States Pharmacopoeia Drug Information, 1999

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from the Florida Society of Allergy, Asthma and Immunology and the Florida Society of Otolaryngology.

Start Date of Comment Period
11/05/1999

Start Date of Notice Period
09/01/2000

Revision History

Revision Number: 2	PCR B2000-122
Start Date of Comment Period:	11/05/1999
Start Date of Notice Period:	09/01/2000 Sep/Oct 2000 *Update!*
Revised Effective Date:	10/16/2000
Explanation of Revision:	This policy was revised to add the drug used in the Nebulizer. The Carrier has jurisdiction for incident to services only.
Start Date of Comment Period:	08/21/98
Start Date of Notice Period:	
Original Effective Date:	04/14/97
Revision Date/Number :	01/01/99 1 (PCR B98-166)
Start Date of Comment Period:	09/20/98
Start Date of Notice Period:	03/12/97
Original Effective Date:	04/14/97 PCR B97-052

Advance Notice Statement
Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

95004: Allergy Skin Tests—Revision to Policy

The Allergy Skin Tests (95004) policy was published in the May/June 2000 *Medicare B Update!* (pages. 51-52). Since that time, the policy has been revised to reflect that procedure code 95004 (Percutaneous tests [scratch, puncture, prick] with allergenic extracts, immediate type reaction, specify number of tests) *is* covered for food allergy testing with ICD-9-CM codes 692.5, 693.1, and 995.60-995.69. However, food allergy testing continues to be noncovered for procedure codes 95010, 95015, 95024, 95027, 95028, and 95078.

Medical Policy Procedures: 95115

Policy Number
95115

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Allergen Immunotherapy

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Carriers Manual, Section 15050

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
10/16/2000

Revision Effective Date
N/A

Revision Ending Effective Date
N/A

Policy Ending Date
N/A

LMRP Description
Allergen immunotherapy (desensitization), also referred to as specific immunotherapy, is the subcutaneous introduction of increasing doses of allergens to which the patient is sensitive. Allergen immunotherapy is antigen-specific; thus the sensitivity of the patient must be known before formulating extracts for therapy. The antigenic cross-reactivity of extracts should be known by the physician to optimize use of the minimum number of separate extracts given per single injection. In this way, the maximum amount of protein antigen can be given.

This therapy is generally reserved for patients with significant relapsing, subacute to chronic symptoms, where the symptoms are likely caused by allergic pathology, and in situations where other means of conservative therapy (including avoidance) have failed to control the symptoms adequately, or avoidance of the relevant allergen (e.g., dust mites, pollen, mold) is impractical.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will provide coverage for allergen immunotherapy for patients with allergic rhinitis, allergic conjunctivitis, or asthma when *all four* of the following criteria are met:

1) the patient must have significant exposure to an allergen;
2) the patient must have demonstrated a significant level of sensitivity to the allergen;
3) the pattern of symptoms must conform to the pattern of exposure; and
4) other means of conservative therapy (including avoidance) have failed to control the symptoms, or avoidance of the relevant antigen (e.g., dust mites, pollen, mold) is impractical.

Generally, the course of allergen immunotherapy, if successful, should be continued until the patient has been symptom-free or has had substantially reduced symptoms for 1 to 2 years and in most cases from 3 to 5 years. If no response has occurred after 1 year at maintenance dose, the patient's sensitivities should be reviewed. All patients on immunotherapy should be encouraged to maintain environmental control and may have to use concomitant medication, such as antihistamines.

HCPCS Section & Benefit Category
Medicine/Allergy and Clinical Immunology

HCPCS Codes

95115	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection
95117	two or more injections
95165	Professional services for the supervision and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

372.05	Acute atopic conjunctivitis
372.14	Other chronic allergic conjunctivitis
477.0	Allergic rhinitis due to pollen
477.8	Allergic rhinitis due to other allergen
493.00-493.02	Extrinsic asthma (allergic asthma)
493.90-493.92	Asthma, unspecified (allergic bronchial asthma)

Diagnoses that Support Medical Necessity
N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity
N/A

Diagnoses that DO NOT Support Medical Necessity
N/A

Reasons for Denial
Allergen immunotherapy performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9-CM Code(s)
Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

Noncovered Diagnoses
N/A

95115 - continued

Coding Guidelines

Evaluation and Management services (99201-99215) are allowed in addition to 95115 or 95117 only when separately identifiable services are provided at the same time.

HCPCS codes 95115 and 95117 reflect the administration (injection) of the allergenic extract, when the extract is not included in the code descriptor. They do not include the provision or preparation of the extract. For example: An allergist provides a patient with an allergenic extract. The patient brings the extract to a family or primary care practitioner who administers the injection(s).

HCPCS code 95165 does not include the injection procedure(s). Therefore, when a physician prepares the allergenic extract(s) (same or different antigens), and administers the extract(s) using single or multiple injections, code 95165 should be reported in addition to either 95115 or 95117.

Code 95165 represents multiple dose vials of non-venom antigens. Some non-venom antigens cannot be mixed together (i.e., they must be prepared in separate vials). Therefore, some patients will be injected at one time from one vial (containing in one mixture all of the appropriate antigens), while other patients will be injected at one time from more than one vial.

A dose of code 95165 is the total amount of antigen to be administered to a patient during one treatment session, whether mixed or in separate vials. Therefore, if a physician mixes a 10 cc vial of mold and a separate 10 cc vial of pollen for a patient, and at each of 10 visits the plan is that the patient is to receive an injection from each vial, the physician has provided the patient with 10 doses of code 95165. Those 20 ccs together constitute 10 doses. Similarly, if a physician mixes for a patient 2 – 10 cc vials of mixed antigen and plans to administer those vials over 10 visits, this too would constitute 10 doses of code 95165. In cases where non-venom antigens cannot be mixed and dose adjustments lead to one vial lasting longer than the other, physicians may be reimbursed to prepare doses of the depleted antigen only up to the amount needed for administration with the remaining antigen. Although technically the catch-up antigen does not comprise doses of code 95165 for the particular patient (because it is not the total antigen to be administered to that patient during one visit), the physician may bill and be reimbursed for the "catch-up" antigen as doses of code 95165. For example, if there is mold antigen left to be administered over three visits, when the physician prepares pollen antigen to be administered over those same three visits, the physician may bill for three doses of pollen. Further antigen preparation and billing must return to the practice of 1 dose representing the total of what will be administered to the patient during one encounter.

HCPCS codes 95120–95134 represent complete services (i.e., services that include the injection services as well as the antigen and its preparation). These codes are not valid for Medicare purposes; therefore, no reimbursement will be provided.

Documentation Requirements

Medical record documentation maintained by the treating physician must clearly document the medical necessity to initiate allergen immunotherapy and the continued need thereof. The documentation should include:

- A history and physical that documents the following: a complete allergic history and physical examination; correlation of symptoms; occurrence of symptoms; exposure profile; documentation of allergic sensitization by accepted means and where attempts at avoidance have proven unsuccessful (or the impracticality of avoidance exists); and a copy of the sensitivity results.
- Progress notes that document physician management during the course of the allergic disease, anticipated length of treatment, and explanation of any deviations from normal treatment frequency.

Utilization Guidelines

N/A

Other Comments

Terms Defined:

Allergen: any substance that indicates a state of, or brings on manifestations of, allergy.
Allergy: an altered reaction of body tissues to a specific substance (allergen) which in nonsensitive persons will, in similar amounts, produce no effect.
Asthma: a reversible obstructive lung disorder characterized by increased responsiveness of the airways.
Immunotherapy: the production or enhancement of immunity.
Rhinitis: inflammation of the nasal mucosa.

Sources of Information

American Medical Association. (1996). Allergy immunotherapy update. cpt Assistant, (6)5, 1-2 and 11.

American Medical Association. (2000). Allergy immunotherapy – Provision of antigens. cpt Assistant, 10(4), 4.

Middleton, Jr., E., Reed, C., Ellis, E.F., Adkinson, Jr., N.F., Yunginger, J.W., and Busse, W.W. (Eds.). (1998). Allergy principles and practice. (Vol II). St. Louis: Mosby.

Theodoropoulos, D.S. & Lockey, R.F. (2000). Allergen immunotherapy: Guidelines, update, and recommendations of the World Health Organization. Allergy Asthma Proc. 2000, 21(3), 159-166.

Advisory Committee Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from numerous societies.

Carrier Advisory Committee held on May 13, 2000.

Start Date of Comment Period

05/05/2000

Start Date of Notice Period

09/01/2000

Revision History

Revision Number:	Original PCR B2000-150
Start Date of Comment Period:	05/05/2000
Start Date of Notice Period:	09/01/2000 Sep/Oct 2000 *Update!*
Original Effective Date:	10/16/2000

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

Medical Policy Procedures: 95934

Policy Number
95934

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
H-Reflex Study

AMA CPT Copyright Statement

HCFA National Coverage Policy
N/A

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
03/11/1994

Revision Effective Date
10/16/2000

Revision Ending Effective Date
10/15/2000

Policy Ending Date
N/A

LMRP Description
The H-reflex study is an electrodiagnostic nerve conduction study that provides information about the conduction of impulses through the proximal segments of a nerve. The study assesses sensory and motor nerve function and their connections in the spinal cord. This information is not obtainable by routine nerve conduction techniques.

The H-reflex represents the time required for a stimulus applied to a sensory nerve to travel to the spinal cord and return down the motor nerve (a type of late response). H-reflex studies usually involve assessment of the tibial motor nerve and the gastrocnemius/soleus muscle complex, although additional studies of other muscles are occasionally indicated. Generally, only one or two H-reflex studies are performed on a patient during a given encounter. The H-reflex is one of the few measures of afferent nerve conduction in proximal portions of sensory nerves and identifies dorsal root pathology when the H-reflex is prolonged in conjunction with normal F-wave response latency in the same nerve.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider the use of H-reflex studies to be medically reasonable and necessary when disease involving very proximal segments of a peripheral nerve is suspected (e.g., radiculopathies, neuropathies, and Guillain-Barré syndrome).

H-reflexes are almost always recorded from the gastrocnemius/soleus muscles of the leg. Therefore, procedure code 95934 represents the most common H-reflex study performed. Occasionally, complex clinical conditions require H-reflex testing in other muscles. Procedure code 95936 represents testing in these nonstandard muscles. An example of this would be

H-reflex testing in the upper limbs (flexor carpi radialis muscle) for conditions such as cervical radiculopathies or brachial plexopathies. Other muscles that rarely may be tested are the intrinsic small muscles of the hand and foot. Medical record documentation must support the use of testing in these other, nonstandard muscle groups.

HCPCS Section & Benefit Category
Medicine/Neurology and Neuromuscular Procedures

HCPCS Codes

95934	H-Reflex, amplitude and latency study; record gastrocnemius/soleus muscle
95936	record muscle other than gastrocnemius/soleus muscle

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

250.60-250.63	Diabetes with neurological manifestations
356.0-356.9	Hereditary and idiopathic peripheral neuropathy
357.0-357.9	Inflammatory and toxic neuropathy
722.80-722.83	Postlaminectomy syndrome
723.4	Brachial neuritis or radiculitis NOS
724.3	Sciatica
724.4	Thoracic or lumbosacral neuritis or radiculitis, unspecified

Diagnoses that Support Medical Necessity
N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity
N/A

Diagnoses that DO NOT Support Medical Necessity
N/A

Reasons for Denial
When performed for indications other than those listed in the “Indications and Limitations of Coverage and/or Medical Necessity” section of this policy.

Noncovered ICD-9-CM Code(s)
Any diagnosis codes not listed in the “ICD-9-CM Codes That Support Medical Necessity” section of this policy.

95934 - continued

Noncovered Diagnoses
N/A

Coding Guidelines
Procedure codes 95934 and 95936 represent unilateral procedures and are reported per study. Documentation should support the bilateral study, if performed and should be billed with modifier –50 (Bilateral procedure).

Documentation Requirements
Medical record documentation maintained by the performing physician must clearly indicate the medical necessity of the service being billed. There should be evidence in the medical record that the test results were noted and influenced or contributed to the patient's course of treatment. In addition, documentation that the service was performed must be included in the patient's medical record. This documentation should include a printed recording of the test results. This information is normally found in the office/progress notes, hospital notes, and/or procedure notes.

Documentation should support the criteria for coverage as set forth in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

For bilateral procedures, medical record documentation should support the rationale as addressed in the "Coding Guidelines" section of this policy.

Utilization Guidelines
N/A

Other Comments
N/A

Sources of Information

American Medical Association. (1996). New codes for H-reflex and F-wave studies. cpt Assistant,6 (1), 1-4

Adams, R., & Victor, M. (1993). Principles of neurology (5th edition). New York: McGraw-Hill.

Bussy, R.K. (Ed.). (1995). Merritt's textbook of neurology (9th edition). Baltimore: Williams & Wilkins.

Sabbahi, M, & Khalil, M. (1990). Segmental H-reflex studies in upper and lower limbs of patients with radiculopathy. Archives of Physical Medicine Rehabilitation, 71 (3), 223-7.

Thomas, C. (Ed.). (1993). Taber's cyclopedic medical dictionary. Philadelphia: F.A. Davis Company

Wiebers, D., Dale, A., Kokmen, E., & Swanson, J. (Eds.). (1998). Mayo Clinic examinations in neurology. St. Louis: Mosby.

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from the Florida Neurological Society.

Carrier Advisory Committee meeting held on May 13, 2000.

Start Date of Comment Period
05/05/2000

Start Date of Notice Period
09/01/2000

Revision History

Revision Number:	5	PCR B2000-142
Start Date of Comment Period:		05/05/2000
Start Date of Notice Period:		09/01/2000 Sep/Oct 2000 *Update!*
Revised Effective Date:		10/16/2000
Explanation of Revision:		CAC revision to clarify procedure description as well as indications and limitations for the service. Original policy to be deleted.
Start Date of Comment Period:		N/A
Start Date of Notice Period:		09/10/96
Original Effective Date:		03/11/94
Revision Date/Number:		10/21/96 (PCR 96-227) 4
Start Date of Comment Period:		N/A
Start Date of Notice Period:		07/08/96
Original Effective Date:		03/11/94
Revision Date/Number:		08/19/96 (PCR 96-179) 3
Start Date of Comment Period:		N/A
Start Date of Notice Period:		03/08/96
Original Effective Date:		03/11/94
Revision Date/Number:		04/15/1996 (PCR 96-006A) 2
Start Date of Comment Period:		N/A
Start Date of Notice Period:		01/12/96
Original Effective Date:		03/11/94
Revision Date/Number:		01/01/1996 (PCR 96-006) '96 HCPCS 1
Start Date of Comment Period:		09/09/1993
Start Date of Notice Period:		11/01/1993
Original Effective Date:		03/11/1994 PCR 94-059

Advance Notice Statement
Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

ELECTRONIC MEDIA CLAIMS

Filing Medicare Claims Electronically

Electronic Media Claims (EMC) filing was created to enable providers' and suppliers' claims to be received by Medicare the same day of transmission. Due to an increasing volume of claims being filed to Medicare Part B, increasing EMC submissions is an ongoing effort to expedite payments and 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 and communications software (if necessary) is all it takes.

Service Bureaus, Billing Services, and Clearinghouses - These types of companies specialize in sending claims electronically to Medicare.

Claims may be submitted seven days a week, 24 hours a day. The only charges incurred are for any long-distance telephone charges that apply (Note that some clearinghouses may charge a per-claim fee that may be dependant on participation status. Contact your clearinghouse for more information).

Types of claims that may be submitted electronically include:

Most physicians' claims, plus:

- Ambulance
- Ambulatory Surgical Centers
- Anesthesia
- Chiropractic
- Dialysis
- Extended Care Facility/Skilled Nursing Facility
- Hospital (Inpatient & Outpatient)
- Independent Laboratory
- Injectable Drugs
- Medicare Secondary Payer claims
- Nursing Home
- Ophthalmologists
- Optometrists
- Physical Therapy
- Podiatry
- Portable X-ray
- Psychiatric
- Radiology

Some claims for surgical procedures may be sent electronically. Additionally, claims with unlisted procedure codes may be sent via EMC, if the service can be described in the narrative record (281 characters or less, including spaces), *and* documentation is not required. An example might be an unlisted injectable drug where the name, strength, and dosage fit in the narrative record. Contact Provider Customer Service at (904) 634-4994 to find out if a specific service may be submitted electronically.

Please call Provider Electronic Services Marketing at (904) 791-8767 for information and assistance in implementing electronic filing of your Medicare claims. ❖

Electronic Funds Transfer

Electronic Funds Transfer (EFT) is a payment option offered to all providers that allows for direct deposit of Medicare Part B payments. There are no requirements to meet in order to have this capability. Payments are deposited within 24-48 hours of the check date (depending on the provider's bank distribution procedures).

Providers who elect EFT still receive the paper remittance data showing payment information (Electronic Remittance Notification, or ERN, allows providers to receive this information electronically as well).

Providers who are interested in this or any other electronic application should contact Provider Electronic Services Marketing at (904) 791-8767. ❖

Electronic Remittance Notification

Manually posting Medicare B Payments is not necessary. It is possible to receive Medicare remittance notification data electronically. Electronic Remittance Notification (ERN) allows providers' offices to receive finalized (paid and denied) claims information electronically for automatic posting to an accounts receivable system.

To receive Electronic Remittance Notification, please contact Provider Electronic Services Marketing at (904) 791-8767. Providers can ask their EMC vendor if ERN is a software application they currently support. If a vendor does not support this function, specifications may be accessed on the World Wide Web:

National specifications may be found at: **www.hcfa.gov/medicare/edi/edi3.htm**

Florida-specific specifications may be accessed at: **www.floridamedicare.com**

A paper copy of the specifications may be obtained by calling Provider Electronic Services Marketing. ❖

GENERAL INFORMATION

FRAUD AND ABUSE

Reassignment of Benefits

Prevention of fraud, waste, and abuse in the Medicare program is not only the responsibility of the federal government; its agencies and contractors, all health care providers, and recipients must share responsibility in ensuring the integrity of the Medicare program. Health care providers should note that although they may conduct their practice in a legitimate manner, there may be instances when they may fall victim to fraudulent or inappropriate activities, and consequently may subject themselves to possible scrutiny by the federal government. The following information outlines one particular scheme and the protective measures that may be used to avoid such an activity.

In general, Medicare makes payment to the actual individual or entity who furnishes a service or item. However, payment may be made to another entity or organization (such as a medical group or professional association) on behalf of the individual or entity who actually furnishes the service or item. This is known as "reassignment of benefits," and requires that certain applications and forms be completed and submitted to Medicare. The reassignment of benefits allows an entity to bill for and receive payment on behalf of the individual who furnishes the service or item.

A number of physicians and non-physician practitioners in Florida have fallen prey to the following scheme involving "reassignment of benefits." The physicians and practitioners are employed by or contract with a group to whom they reassign their benefits. They are either paid a salary or per diem for the services and items they furnish. Although the physicians and practitioners do furnish services and items for the group, the group then bills for other services and items using the physicians' or practitioners' Medicare provider number; however, the physicians or practitioners do not furnish those other services or items. In addition, the services and items were either not furnished at all or they are not covered but are reported as covered.

In most cases, the physicians and practitioners are not aware that their Medicare provider numbers are being used to bill for these fraudulent claims — they do not see nor review the statements sent from Medicare for the claims filed on their behalf. Although these physicians and practitioners may not be aware of these activities, they may be held accountable for the inappropriate payments.

Physicians and non-physician practitioners who *do* reassign their benefits to a group or other entity should consider using the following safeguards to ensure the integrity of the claims filed on their behalf:

- One of the terms of employment or contracting with a group or entity should allow the physician or practitioner access to all medical records and any financial records pertaining to the services and items they furnish.
- The physician or practitioner should be allowed to periodically review claims and statements from Medicare for services that are submitted on their behalf.
- The physician or practitioner should ensure that procedure codes, diagnostic codes or other information furnished by the physician or practitioner used for filing claims are not changed or altered without their knowledge and consent.
- The physician or practitioner should be kept informed of all correspondence or communications that pertain to the claims submitted on their behalf.
- As physicians or practitioners leave or terminate employment with a particular group or entity, they should ensure that the Medicare contractor is notified *in writing* of their termination of employment. If this is not done, the group or entity could continue using their Medicare provider number to file false claims.

Physicians and non-physician practitioners who suspect that their Medicare provider numbers are being used to file inappropriate claims should promptly notify Medicare, the Office of the Inspector General, or a health care attorney. ❖

FINANCIAL SERVICES

Medicare Checks Must Be Cashed Timely

In accordance with the Medicare Carriers Manual (CAR1 4940) and the Code of Federal Regulations (42 CFR 424.352), First Coast Service Options, Inc. (Florida Medicare) will not reissue provider checks that are older than one year. Providers should monitor any payments due their offices. If it is determined that a check has been lost, stolen, defaced, destroyed or mutilated, please write to:

Medicare Part B
P.O.Box 2360
Jacksonville, FL 32231

Written requests are preferred; however, providers may also call (904) 634-4994.

Payment will be reissued, provided the request is received within one year from the date the check was originally issued. ❖

Overpayment Interest Rate

Medicare assesses interest on overpaid amounts that are not refunded timely. Interest will be assessed if the overpaid amount is not refunded within 30 days from the date of the overpayment demand letter. The interest rate on overpayments is based on the higher of the private consumer rate (PCR) or the current value of funds (CVF) rate.

Effective August 1, 2000, the interest rate applied to Medicare overpayments is **13.875** percent, based on the new revised PCR rate. Previous interest rates may be found in past issues of the *Medicare B Update!* on our provider website, **www.floridamedicare .com**. ❖

MEDIGAP/CROSSOVER

Filing Medigap Crossovers

Florida Medicare is working hard to reduce claim filing errors. Errors cause rework for the provider, and can result in thousands of lost revenue dollars annually. Additionally, rework costs the Medicare program when claims must be re-filed or re-processed. Our goal is to have all claims submitted and processed right the first time.

The purpose of this article is to highlight the top two Medigap claim-filing errors and provide educational instructions to ensure that all crossovers are successful.

The Medigap Crossover process is a financial benefit available to Participating Physicians and Suppliers. With a single claim filing, a provider can receive both the primary and secondary claim payments. The crossover process is not automatic. In order for the crossover to be successful, all of the Medigap insurer information must be accurate, complete and submitted in the specified format. If information is not complete or information is omitted, the claim will not be crossed over to the Medigap insurer. It is likely if a provider files just one incorrect Medigap claim, this common billing error may potentially affect his or her entire practice.

Examine the billing instructions below to ensure that all crossover information is submitted correctly. These instructions apply to both paper and electronic claims.

Billing Error	Billing Instruction
Submitting an invalid Medigap ID #, or omitting the 5 digit assigned Medigap ID number.	Each Medigap insurer is assigned a unique 5-digit ID number. When providing the 5-DIGIT MEDIGAP ID #, you must also include the complete name of the MEDIGAP INSURER When providing both the 5 DIGIT MEDIGAP ID # and the complete name of the MEDIGAP INSURER, it is not necessary to include the full street, city, or zip code address information. The patient's MEDIGAP POLICY # is mandatory.
Providing incomplete Medigap address information and the Medigap ID #is either invalid or omitted.	If the valid 5 DIGIT MEDIGAP # is omitted, Medicare must have the complete NAME, ADDRESS, CITY, STATE AND ZIP OF THE MEDIGAP INSURER. The patient's MEDIGAP POLICY # is mandatory.
Providing only the patient's Medigap policy # and omitting the 5 digit Medigap ID # and/or the complete name and address of the Medigap insurer.	Submitting only the patient's Medigap policy # will not allow the Medicare carrier to cross the claim to the Medigap insurer. Refer to the situations above to ensure all of the required information is submitted correctly.

For more information on all crossovers, visit the Medicare Part B Medigap area of our provider website **www.floridamedicare.com**. This area contains the "Crossover Information" document, which is designed to help providers understand the circumstances under which Medicare Part B will crossover Medicare payment data to various insurers. An up-to-date Medigap insurer listing is also available to view, print, or download. ❖

Crossover Updates

The following updates have been performed to the Medicare Part B of Florida Crossover Insurers list. These changes can be viewed in the Part B Medigap Section on our provider website - **www.floridamedicare.com.** This area contains the "Crossover Information" document, and an up-to-date Medigap insurer listing that is available to view, print, or download.

Automatic Crossover

- **New Crossover Insurer**

  The following private insurer has been added to our list of Automatic Crossover Insurers.

  CareFirst BCBS, Washington DC

- **Updates to Crossover Insurers**

  Union Fidelity

  Union Fidelity has moved the administration of claims for Union Fidelity, Harvest Life, and Federal Home Life to Wakely and Associates. Wakely and Associates uses Health Data Management (HDM) as their clearinghouse. HDM's update follows.

  Health Data Management Corporation (HDM)

  Added the Following Plans for Wakely and Associates:

  Union Fidelity
  Harvest Life
  Federal Home Life

Medigap Crossover

- **Address Change**

Number	Insurer Name/Address
59048	Security Health Plan PO Box 8000 Marshfield WI 54449

- **Name Change**

  Florida Medicare has been advised that United General Life Insurance Company has merged with Conseco Senior Health Insurance Company. New identification cards, billings, and correspondence will be in the name of Conseco Senior Health Insurance. The mailing addresses and telephone numbers will remain the same.

  The Medigap insurer list has been updated to reflect this change:

Number	Former Name	New Name
19795	United General Life Insurance Company	Conseco Senior Health Insurance Company

- **Exempt Non-Medigap Insurers**

  The following insurers do not offer and/or process Medicare Supplemental plans and are exempt from the Medigap crossover process.

  The Medigap insurer list has been updated to change each insurer identification number listed below to an exempt status. Each number listed is inactive and payment information will not be crossed over to these insurers.

Number	Insurer Name
19197	Capital Health Plan PO Box 13267 Tallahassee FL 32317
23101	Mutual of New York 500 Park Blvd Itasca IL 60143
53076	Mutual of NY 12720 Hillcrest Rd Dallas TX 75230
53051	Texas Eastern PO Box 2521 Houston TX 77252

❖

MEDICARE REGISTRATION

Returned Provider Applications

The Medicare Registration Department is experiencing an increase in incomplete and/or incorrect applications being submitted. Applications submitted that are incomplete or incorrect are returned to the provider.

Listed below, in order of highest occurrence, are some of the most common reasons an application is returned to a provider, and some solutions on how to avoid returns.

Individual Reassignment of Benefits Application (HCFA 855R)

Section 7 (Attestation Statement) was not signed, was not an original signature, or was not signed by an authorized representative.

An authorized representative must sign section 7 of the HCFA 855R. The authorized representative must be an officer, chief executive officer, senior or majority partner, president, vice-president, secretary, treasurer, director (board of directors), owner, or someone who can obligate and commit the individual or entity to Medicare laws and regulations. Unacceptable signatures may include office manager, medical director, enrollment specialist, agent, manager, credentialing specialist, insurance specialist, consultant, receptionist, administrator, etc.

All signatures must be original signatures. It is helpful if applications are signed in a color other than black.

Section 5 (Reassignment of Benefits Statement) was not an original signature, was not signed by the individual reassigning benefits, or the legal business name of the entity was not listed correctly.

The legal business name must be given in this section and must match the name that is on file with the Internal Revenue Service (IRS).

The individual that is reassigning their benefits must sign this section. The signature must be an original signature. It is helpful if applications are signed in a color other than black.

Section 3 (Practice Location) contains a practice location that the legal business has not yet enrolled.

When a provider submits a HCFA 855R, the address given in section 3 must have been submitted on a HCFA 855 by the legal business. The legal business may submit the HCFA 855 simultaneously with the HCFA 855R.

Section 2 (Individual Identification) did not indicate if the individual is a W-2 employee, 1099 contractor, 1065-K1 or other. In some cases, more than one block was checked.

One of these blocks must be checked when submitting a HCFA 855R indicating what type of relationship the individual has with the legal business. No more than one block may be checked.

A provider must be actively enrolled when submitting a HCFA 855R. If the provider does not have an active Medicare Part B provider number or has not utilized their provider number within the last year, a General Enrollment Application (HCFA 855) must also be submitted.

General Enrollment Application (HCFA 855)

The most common reason for returning a HCFA 855 is due to the enrolling provider not submitting a HCFA 855R when needed. If payment will be generated in a name that is different than the enrolling provider, a HCFA 855R must be submitted. The name in which reimbursement will be generated is dependent on what the Internal Revenue Service (IRS) has on file for the tax identification number given on the enrollment application. If the name of the individual enrolling is John Smith, MD and the name on file with IRS is John Smith MD PA, completion of a HCFA 855R is required.

Many applications are being returned due to Section 6 (Practice Location) being incomplete. Providers should list ***ALL*** addresses at which they practice, when they started practicing at that address, where records are stored for services rendered at that location, who the managing/directing employee(s) is for that location, what mailing address should be used for that location etc. Ensure all blocks are completed in their entirety.

Section 8 (Ownership Information) is often not completed or blocks of information are left blank. This section should contain information pertaining to the owner(s) of the organization, corporation, partnership, etc. Block 8E requests specific information regarding any adverse legal actions that may have been imposed against the owner. Information must be provided in each block.

Section 18 (Certification Statement) is often not signed by an authorized representative or is not an original signature. If the enrollment application is being submitted for assignment of a group provider number, an authorized representative must sign the application. Examples are given above of who can and can not sign as an authorized representative. If an individual is applying for a provider number, the applicant must sign this section. It is helpful if applications are signed in a color other than black.

Section 5 (Exclusion/Sanction Information) is often omitted. This section requests specific information regarding any legal actions taken against the applicant. If the applicant has never had any adverse legal actions, the applicant should check the “none of these” box. In addition, the applicant should indicate whether he/she has any outstanding criminal fines and/or restitution orders.

Section 9 (Managing/Directing Employees) is often blank or incomplete. This section should be completed with information regarding each managing/directing employee. Each block in this section should contain either information or NA if not applicable. If an individual is given in section 6 of the application as the managing/directing employee for a particular location, information regarding that managing/directing employee should be given in section 9.

Medicare Registration - continued

Change Of Address Information

Requests to change address information should be submitted on the Change of Information Application (HCFA 855C). If changing a physical address, the new physical address should be given in Section 3D. Section 3A requests the new mailing address and section 3B requests the new "pay to" address. The current Florida Medicare Part B provider file does not allow different mailing and pay to address. Therefore, when requesting address changes, please give the physical address in section 3D and the pay to address in section 3B. **Please do not provide a different mailing and pay to address.**

Applications (HCFA 855, HCFA 855R and HCFA 855C) may be obtained by contacting the Provider Customer Service Department at (904) 634-4994 or downloaded from **www.floridamedicare.com** under "Forms" in the "Shared" section.

Completed applications should be mailed to:

Medicare Registration
P O Box 44021
Jacksonville, FL 32231-4021

Providers Reassigning To An ASC

The Medicare Registration Department has received several enrollment applications requesting that an individual provider be allowed to reassign his/her benefits to an ambulatory surgical center (ASC). As long as the individual provider meets the reassignment criteria (is a W2 employee of the ASC reassigning to or renders services on the premises of the ASC reassigning to), reassignment will be allowed. If the ASC has already been approved by the Agency for Health Care Administration (AHCA), completion of a HCFA 855 by the ASC is not required. A group provider number will be assigned to the ASC and the provider reassigning will be added as a group member. If the ASC has not been approved by the AHCA, they should contact the AHCA at (850) 487-2717 or write to:

Agency for Health Care Administration
Fort Knox Bldg. 1, Hospital Section
2727 Mahan Dr.
Tallahassee, FL 32308

If the individual provider has net yet received a Medicare Part B provider number, he/she should submit a HCFA 855 and a HCFA 855R. See article above for information regarding obtainment and submission of enrollment applications. ❖

GENERAL INFORMATION

"Do Not Forward" Initiative—Clarification

Information regarding this initiative was published in the May/June 2000 *Medicare B Update!* (page 57) and in the July/August *Update!* (page 69). This clarification concerns appropriate use of Form HCFA 855C.

Beginning August 14, 2000, Medicare carriers implemented the "Do Not Forward" (DNF) initiative for Medicare checks that could not be delivered to providers. With this initiative, carriers use "Return Service Requested" envelopes to prevent the forwarding of Medicare checks to locations other than those recorded on the Medicare provider files.

When a check is returned, if applicable, the U. S. Postal Service will provide Medicare with a new address or reason for nondelivery. However, if a new address is supplied with the returned check, Medicare cannot automatically change the address of the provider or re-mail the check to the provider. The provider must complete a Change of Address Form HCFA-855C or other written notification.

Note: entities receiving their provider number after May 1, 1996 must submit a HCFA 855 or HCFA 855C to update their address, a request on letterhead is not acceptable.

The form or written notification must bear an original signature from an authorized representative of the entity that completed the original registration form. No copies, faxes, or stamps are acceptable. For purposes of this process, the most important address is the "Pay To" address. If the provider does not furnish the "Pay To" address on Form HCFA-855C or the written notification, it will be returned and the address will not be updated.

To obtain copies of Form HCFA-855C, providers may call Florida Medicare's Provider Customer Service department at (904) 634-4994, or log on to our provider website, **www.floridamedicare.com**. Addresses *cannot* be changed based on telephone calls; written notification as described above is required. ❖

Is Your Patient Really Entitled to Medicare?

The single most important information necessary to process a Medicare claim is the patient's complete and accurate Health Insurance Claim (HIC) number. Florida Medicare realizes providers face challenges in maintaining accurate and current health insurance information on all of their patients. Circumstances such as the death of a spouse, remarriage, part-time Florida residents, and enrollment in other health insurance plans can affect patient eligibility. When incomplete or invalid patient information is submitted and eligibility cannot be validated, Medicare claims may be delayed or denied. This leads to both physician and patient frustration.

Eligibility must be validated before any Medicare program payment may be made. The official red, white, and blue Medicare card reflects the accurate and complete name of the patient maintained through the Social Security Administration (SSA). Patients may use nicknames or other common names that do not match the official SSA records. **When filing the Medicare claim it is important that both the HIC number and the patient's *complete* name match exactly the way it is printed on the red, white, and blue Medicare card.**

Tips For Maintaining Complete and Accurate Health Insurer Eligibility

- Maintain a photocopy of all insurance cards in patients' files.
- Routinely discuss insurance coverage changes with patients and make sure to obtain copies of all insurance cards.
- When referring patients to other providers for diagnostic tests and services, it is important to provide both health insurer *and* patient diagnosis information. Remember that these providers are providing laboratory and diagnostic test results information that allows you to effectively treat your patients. Remember, they need to be reimbursed too!
- Providers who receive referrals from primary physicians, must constantly reinforce the importance in receiving accurate health insurer information.
- Ensure that the staff submitting Medicare claims uses patients' names and HIC numbers as they appear on the red, white, and blue Medicare cards.

Maintaining accurate patient health insurance eligibility information is an on-going process. When valid and up-to-date patient eligibility records are maintained it; eliminates rework, reduces physician and beneficiary frustration, and greatly increases the likelihood of program reimbursement without the hassle of denials. ❖

Religious Nonmedical Health Care Institutions—Clarification

Information pertaining to billing for services provided to beneficiaries who have elected to receive Medicare benefits in religious nonmedical health care institutions (RNHCIs – formerly known as Christian Science Sanitoria) was provided in the May/June 2000 *Medicare B Update!* (page 62). Since that time, clarification has been received regarding what is considered an "excepted" or "nonexcepted" service.

A beneficiary who has elected coverage in a RNHCI has attested that the he or she is conscientiously opposed to acceptance of nonexcepted medical treatment and that his or her acceptance of such treatment would be inconsistent with his or her sincere religious beliefs.

Examples of nonexcepted medical care could include but are not limited to the following:

- A beneficiary receiving medical diagnosis and/or treatment for persistent headaches and/or chest pains.
- A beneficiary in an RNHCI who is transferring to a community hospital to have radiological studies and the reduction of a fracture.
- A beneficiary with intractable back pain receiving medical, surgical, or chiropractic services.

Examples of excepted medical care include, but are not limited to the following:

- A beneficiary that receives vaccinations required by a state or local jurisdiction. This is compliant behavior to meet government requirements and not considered as voluntarily seeking medical care or services; or
- A beneficiary who is involved in an accident and receives medical attention at the accident scene, or in transport to the hospital, or at the hospital before being able to make their beliefs and wishes known; or
- A beneficiary who is unconscious and receives emergency care and is hospitalized before regaining consciousness or being able to locate his or her legal representative.

Effective August 14, 2000, Florida Medicare will review allowable services for beneficiaries enrolled in the RNHCI benefit election when the date of service(s) is within their election period. The diagnosis, procedure code(s), related history claims, and provider of service will be used in determining if the services rendered were excepted or non-excepted medical care. This review process will not alter the payment determination of the claim; however, determinations of non-excepted medical care will result in a revocation of the beneficiary's RNHCI benefit election. ❖

EDUCATIONAL RESOURCES

Provider Education and Training Advisory Meeting

Medicare Education and Outreach cordially invites you to attend our quarterly Part A and Part B Provider Education and Training Advisory Meeting on **September 27, 2000** in Jacksonville.

First Coast Service Options, Inc. is excited about offering a forum to encourage open dialogue between the Medicare contractor and representatives from state medical societies, specialty associations, provider organizations, practitioners, consultants, billing staffs, and others.

During this session the contractor will share important information about Medicare initiatives, trends, aberrancies, other significant issues.

With the help of individuals like you we have proven that partnership works to help us make operational improvements. We are seeking your help to:

- Recommend areas for additional policy clarifications/provider training
- Assist in the improvement of our *Medicare A Bulletin* and *Medicare B Update!*
- Enhance our customer service ARU system
- Recommend topics for special curriculum development
- Evaluate the value and effectiveness of educational sessions attended
- Alert First Coast Service Options to claim processing/system irregularities effecting provider billing

How to prepare for this meeting:

1. Note your recommendations or topics of concern in the space provided below (additional pages are welcome)
2. Fax your registration and comments no later than September 15, 2000
3. Be prepared to discuss your ideas in an open and relaxed forum

_____

_____

_____

Please come and spend an exciting and informative half day with us! Your contributions are vital to the success of your carrier/ intermediary. You will not be disappointed.

Register Today! Seating is limited

FOR MORE INFORMATION CALL (904) 791-8299

REGISTRATION FORM

for Quarterly Medicare Part A and Part B
Provider Education and Training Advisory Meeting

Please complete one form per person

Registrant's Name:_____

Registrant's Title/Position:_____

Provider's Name:_____

Specialty Association Name:_____

Medicare Billing Provider Number:_____

Address:_____

City, State, ZIP Code:_____

Phone: ( )_____ Fax: ( )_____

Cost: ***FREE!!***

Please fax your registration form to: (904) 791-6035

Location: **First Coast Service Options, Inc.**
Blue Cross Blue Shield Building
532 Riverside Avenue
Jacksonville, FL 32202

Directions to our building will be faxed with your confirmation

Mark your calendar! **September 27, 2000**
8:30 a.m. - 12:30 a.m.

Please RSVP 10 days prior to the event

www.floridamedicare.com — Florida Medicare's Provider Website

The following outlines the types of information that is available as of August 2000 on the First Coast Service Options, Inc. (FCSO) Florida Medicare provider website.

What's New

Including "***Hot! Topics***" — Provides a brief introduction to recent additions to specific areas of the site. Also provides items of immediate interest to providers.

Part A

- ***PPS*** - (Prospective Payment System) Includes Florida Special Issue newsletters and links to helpful information on the HCFA website (www.HCFA.gov) such as satellite broadcasts, hospital outpatient PPS reference guide, home health PPS main web page, and more.
- ***Reason Codes*** - A listing of codes used by Part A to explain actions taken on line items/claims.
- ***Draft and Final LMRPs*** - FCSO's final and draft Part A Local and Focused Medical Review Policies (LMRPs/FMRPs).
- ***Fraud & Abuse*** - Articles of interest concerning fraud, abuse, and waste in the Medicare program.
- ***Publications*** - *Medicare A Bulletins* from 1997 through the present.

Part B

- ***Draft and Final LMRPs*** - FCSO's final and draft Part B Local and Focused Medical Review Policies (LMRPs/FMRPs).
- ***Fraud & Abuse*** - Articles of interest concerning fraud, abuse and waste in the Medicare program.
- ***MEDIGAP Insurer Listing*** - Information about claim crossovers (e.g., list of auto-crossovers, etc.).
- ***Publications*** - *Medicare B Updates!* from 1997 through the present.

Shared (information shared by Part A and Part B)

- ***Education*** - Medicare Educational resources and a Calendar of Events.
- ***Fee Schedules***
- ***UPIN Directory***
- ***MEDPARD Directory***
- ***Forms*** - Various enrollment applications and materials order forms (e.g., HCFA Form 855, claim review request, etc.).

EDI (Electronic Data Interchange)

- ***Forms*** - Various EDI applications' enrollment forms such as EMC, ERN, electronic claims status, etc.
- ***Specs*** - Florida specific format specification manuals for programmers.
- ***HCFA*** - Link to HCFA website for ANSI specification manuals
- ***Other*** - EDI Vendor List and other important news and information.

Extra

- ***Site Help***
- ***Contact Us*** - Important telephone numbers and addresses for Medicare Part A and Part B and website design comment form (to Webmaster).
- ***Links*** - Helpful links to other websites (e.g., HCFA, Medicare Learning Network, etc.).

Search

Enables visitors to search the entire site or individual areas for specific topics or subjects.

www.fcsomedicare.com - First Coast Service Options' Medicare Gateway

Florida Medicare's provider website may also be accessed through FCSO's Medicare Gateway. Additonal sites available through the gateway are: FCSO's Florida beneficiary website, FCSO's Corporate site, and, after September 22, 2000, FCSO's Connecticut Medicare provider and beneficiary (combined) site. ❖

Third party Web sites. *This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites, and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.*

Health Care Financing Administration

FIRST COAST SERVICE OPTIONS, INC.
A HCFA Contracted Carrier & Intermediary

ORDER FORM – PART B MATERIALS

The following materials are available for purchase. To order these items, please complete and submit this form along with your check/money order payable to First Coast Service Options, Inc. with the account number listed by each item. PLEASE NOTE: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
❑	***Medicare B Update!* Subscription –** One copy of the *Update!* is sent free of charge to individual providers and Professional Association (PA) groups who bill at least one claim to Medicare Part B of Florida for processing during the twelve months prior to the release of each issue. Non-provider entities or providers who need additional copies at other office locations may purchase an annual subscription. This subscription includes all issues published for calendar year 2001 (back issues sent upon receipt of order).	756245	$75.00
❑	**2000 Fee Schedule –** One copy of the *Medicare Part B Physician and Non-Physician Practitioner Fee Schedule* is sent free of charge in mid-November to individual providers and Professional Association (PA) groups who bill at least one claim to Medicare Part B of Florida for processing during the preceding twelve months. The Fee Schedule contains calendar year 2000 payment rates for all Florida localities. These fees apply to services performed between January 1 and December 31, 2000. These items include the payment rates for injectable drugs, but *do not* include payment rates for clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the *Medicare B Update!* Non-provider entities or providers who need additional copies at other office locations may purchase additional copies.	756250	$20.00

Subtotal $ _____

Tax (6.5%) $ _____

Total $ _____

Mail this form with payment to:

First Coast Service Options, Inc.
Medicare Publications
P.O. Box 45280
Jacksonville, FL 32232-5280

Contact Name: _____

Provider/Office Name: _____

Phone : _____ FAX Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Please make check/money order payable to: BCBSFL- FCSO Account # (fill in from above)

(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)

ALL ORDERS MUST BE PREPAID - DO NOT FAX - PLEASE PRINT

IMPORTANT ADDRESSES

CLAIMS SUBMISSIONS

Routine Paper Claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating Providers
Medicare Part B Participating 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 B Claims 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 B Financial 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

Provider Participation and Group Membership Issues; Written Requests for UPINs, Profiles & Fee Schedules:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider Change of Address:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32231-1109

Provider Education:
For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:
Medicare Part B
Medicare Education and Outreach
P. O. Box 2078
Jacksonville, FL 32231-0048

For Seminar Registration:
Medicare Part B
Medicare Education and Outreach
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

Medicare Claims for Railroad Retirees:
MetraHealth RRB Medicare
P. O. Box 10066
Augusta, GA 30999-0001

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

PHONE NUMBERS

BENEFICIARY

Outside Duval County (in Florida):
(800) 333-7586
Duval County (or outside Florida):
(904) 355-3680
Hearing Impaired:
(800) 754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this service by providers is not permitted and may be considered program abuse.

PROVIDERS

Express Line/ARU Status Inquiries:
(904) 353-3205
Specialty Customer Service Reps:
(904) 634-4994

EMC

Format Issues & Testing:
(904) 354-5977
Start-Up & Front-End Edits/Rejects:
(904) 791-8767
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
(904) 791-6895
PC-ACE Support:
(904) 355-0313
Help Desk
(Confirmation/Transmission):
(904) 791-9880

OCR

Printer Specifications/Test Claims:
(904) 791-8132

DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare
(803) 735-1034

WEBSITES

PROVIDER

Florida
www.floridamedicare.com
Health Care Financing Administration
www.hcfa.gov

BENEFICIARY

Florida
www.medicarefla.com
Health Care Financing Administration
www.medicare.gov

A

B

C

C (continued)

D

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

D continued

E

F

G

H

I

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

I continued

L

M

M (continued)

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

M continued

N

O

P

P continued

R

S

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

S continued

T

U

V

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X

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Modifiers

Procedure Codes

HCPCS Codes

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

HCPCS Codes (continued)

Anesthesia/Surgery, 00100-69979

Diagnostic Tests 70010-89399

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

Diagnostic Tests continued

Diagnostic Tests (continued)

Medicine, 90281-99199

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

Medicine (continued)

Evaluation and Management, 99201-99499

* Special *Updates!*

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

MEDICARE B UPDATE!

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