

In This Issue...

Implementation Provider Payment for the Year 2000

Submitting, Processing, and Paying Medicare Claims in the Year 2000 page 5

Billing for Influenza and Pneumococcal Vaccinations

Including "Fact Sheet" and Roster Billing Forms page 6

Final Medical Review Policies

33223, 53850, 86706, 88230, 93875, J0585, J1561, J1950 and PAINREH page 18

Final Rule for Medicare Ambulance Policy

Important Information for All Providers page 44

FREE National Education Programs

Computer Based Training and Satellite Broadcast page 50

Features

From the Medical Director	3
Administrative	4
General Information	5
Fraud and Abuse	17
Local and Focused Medical Policies	18
Coverage	44
Electronic Data Interchange	46
Skilled Nursing Facilities	48
Educational Resources	50
Index	57



Please share the *Medicare A Bulletin* with appropriate members of your organization.

Routing Suggestions:

- ☐ Medicare Manager
- ☐ Reimbursement Director
- ☐ Chief Financial Officer
- ☐ Compliance Officer
- ☐ Y2K Officer
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Table of Contents

In This Issue	1
From the Intermediary Medical Director, "The 1999/2000 Flu and Pneumococcal Vaccination Campaign is Under Way! Mobilize to Immunize!"	3

Administrative

About the Medicare A Bulletin	4
-------------------------------------	---

General Information

Year 2000

Submitting, Processing, and Paying Medicare Claims in the Year 2000	5
Y2K Readiness for PC-ACE™ Software ...	6

General Information

Billing Guidelines for Influenza and Pneumococcal Pneumonia Vaccines	6
1999 Medicare Influenza Virus Vaccine Benefit	7
1999 Medicare Influenza Vaccine Benefit Questions & Answers	7
1999 Medicare Pneumococcal Vaccine (PPV) Benefit	11
1999 Medicare Pneumococcal Vaccine (PPV) Benefit Questions & Answers	12
Overpayment Interest Rate	16
Claim Processing Requirement Modifications	16
Addition to List of Approved Liver Transplant Centers	16

Fraud and Abuse

Floridians Can Help Fight Medicare Fraud and Abuse	17
---	----

Medical Policy

Medical Policy Table of Contents	18
General Information About Medical Policies	18

Final Medical Policies

33223: Implantation of Automatic Defibrillators	19
53850: Prostate Treatments	20
86706: Hepatitis B Surface Antibody and Surface Antigen	23
88230: Cytogenetic Studies	27
93875: Noninvasive Extracranial Arterial Studies	29
J0585: Botulinum Toxin Type A (Botox) ...	32
J1561: Intravenous Immune Globulin	35
J1950: Leuprolide Acetate	39
PAINREH: Pain Rehabilitation	41

Coverage

Revision and Clarification of Final Rule on Ambulance Services	44
48554: Revision to Pancreas Trans- plantation Coverage	45
G0102-G0103: Coverage for Prostate Cancer Screening	45

Electronic Data Interchange

Adoption of Standard Electronic Health Care Transaction Formats	46
--	----

Skilled Nursing Facilities

Clarification of Dialysis Coverage for Skilled Nursing Facility Residents	48
--	----

Educational Resources

FREE Medicare Training Courses and Satellite Broadcasts	50
Medicare Online	51
Florida Electronic Bulletin Board System (BBS)	51
Order Form — 1999 Part A Materials	53
"LET'S TALK" Session (October 21)	54
1999 Medicare Influenza Vaccine Roster	55
1999 Medicare Pneumococcal Vaccine Roster	56

Other Information

Index to <i>Medicare A Bulletin</i>	57
Phone Numbers	Back Cover

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Publications Staff

Millie C. Pérez
Carol McCrossin
Pauline Crutcher
Shari Bailey
Bill Angel

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Questions concerning this publication or its contents may be directed in writing to:

**Medicare Part A
Publications**
P.O. Box 2078
Jacksonville, FL
32231-0048

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A PHYSICIAN'S FOCUS

The 1999/2000 Flu and Pneumococcal Vaccination Campaign is Under Way! Mobilize to Immunize!

The Health Care Financing Administration is working with its national partners, the National Centers for Disease Control and Prevention (CDC), and the National Coalition for Adult Immunization (NCAI), to promote influenza and pneumococcal immunizations to 39 million Medicare beneficiaries.

You as a health care provider are an important partner in promoting the benefits of influenza and pneumonia vaccination. Research shows that a health care provider's recommendation is the most influential factor in a patient's decision to be immunized against flu and pneumonia. Advising beneficiaries to receive the once-in-a-lifetime pneumonia vaccination and an annual flu shot is a vital part of effective preventive health care.

Influenza and pneumonia claims the lives of as many as fifty thousand Americans a year— more than all other vaccine-preventable diseases combined. ***More than ninety percent of these deaths occur in the Medicare population.***

The flu season is not far away. Patients should be told about the benefits of influenza and pneumonia vaccines now. Seventy percent of flu shots are given during October, and seventy percent of pneumococcal vaccines are given during October, November, and December. Initiate *your* 2000 flu and pneumococcal vaccination campaign by considering and establishing some systematic procedures, such as:

- Tracking each patient's immunization status
- Tracking the percentage of *all* immunized patients
- Displaying posters in your facility showing the benefits of immunization
- Giving flu and pneumococcal shots at the time of the patients' hospitalization
- Distributing immunization information to patients and health care professionals.

These are proven techniques to achieve the joint goal of promoting patient quality of health care.

We thank you for advocating this important preventive health care benefit to your Medicare patients. We thank you and your patients will, too.

Sincerely,

Sidney R. Sewell, M. D.
Medicare Medical Director



About *The Medicare A Bulletin*

The *Medicare A Bulletin* is a comprehensive, bimonthly magazine for all Florida Part A providers. It is published six times annually (every two months), plus the annual HCPCS special issue. The schedule for the remainder of 1999 is:

- October/November 1999
- December 1999/January 2000
- HCPCS 2000 Special Issue (late December)

The *Bulletin* is mailed during the first half of the first month of publication (e.g., early August for the August/September issue).

Who Receives the *Bulletin*?

If you were previously receiving individually distributed Part A bulletins, you will now receive the comprehensive *Medicare A Bulletin*. Please remember that Medicare Part A (First Coast Service Options, Inc.) uses the same mailing address for all correspondence. No issue of the *Bulletin* may be sent to a specific person/department within an office. To ensure continued receipt of all Medicare correspondence, providers must keep their mailing addresses current.

What Is in the *Bulletin*?

The *Bulletin* is divided into general and facility-specific sections.

The publication begins with an article by the contractor's Medical Director. Following is the Administrative section, containing general information for all facilities and Part A providers, including Year 2000 information, ARU upgrades, Medicare secondary payer, cost reports, and interest rates. Next is the General Coverage section, with coverage guidelines applicable to all facilities and Part A providers.

Following Medical Policy are sections specific to facility types. These will appear in the *Bulletin* only when an article in that category is published (for example, if no CORF/ORF information is in the issue, that section will be omitted.) Also, as needed, Electronic Data Interchange (EDI) and Fraud and Abuse sections will appear, as well as educational resource material, such as Medifest schedules, Medicare Online BBS (the contractor's online bulletin board system), and reproducible forms. (Section order may vary from issue to issue.) An index to the *Bulletin* and important phone numbers are in the back.

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

Articles included in each *Medicare A Bulletin* represent formal notice that specific coverage policies have or will take effect on the date given. Providers who receive each issue are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines. Medicare Part A (First Coast Service Options, Inc.) maintains the mailing lists for each issue; 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.

Do You Have Comments?

The publications staff welcomes your feedback on the *Bulletin* and appreciates your continued support. Please mail comments to:

Medicare Publications Department
Editor, *Medicare A Bulletin*
P.O. Box 2078
Jacksonville, FL 32231-0048

In response to reader comments, the Medical Policy section in the center of the *Bulletin* may be removed separately, without disturbing the rest of the articles.

YEAR 2000

Submitting, Processing, and Paying Medicare Claims in the Year 2000

The following Health Care Financing Administration (HCFA)-generated article is published at the direction of HCFA.

Implementation of Provider Payment Updates and Related Issues

AHCFA's top priority between now and January 1, 2000, is to make sure that Medicare computer systems are Y2K compliant so that Medicare beneficiaries' care is uninterrupted and that providers' claims are paid in a timely fashion. At the same time, HCFA wants to meet statutory deadlines for making routine payment updates for providers, and I'm pleased that we're now on track to meet both goals."

—Nancy-Ann DeParle, HCFA Administrator

Because of its significant progress in preparing for systems challenges in the year 2000 (Y2K), the Health Care Financing Administration (HCFA) and First Coast Service Options Inc. (FCSO), anticipate the timely and accurate processing of Medicare claims to continue into the new millennium, including provider, supplier, and other payment updates. The following article summarizes HCFA's Y2K activities, delineates the schedule for implementation of provider payment and other annual updates, and instructs you, as Medicare providers and suppliers, how to handle and expedite the processing of your claims during the century rollover.

Summary of Y2K Activities

Following the recommendation of its Y2K expert consultant (known as an independent verification and validation (IV&V) contractor), HCFA announced last summer that provider payment updates might have to be delayed to minimize computer system changes during final Y2K testing and monitoring. However, after reviewing the status of the renovation and testing of systems with its IV&V contractor, HCFA has now determined that the substantial progress made on Y2K preparations should allow provider payment updates to occur in a timely manner. In the words of Ms. DeParle: "We've made excellent progress on Y2K readiness, and our success means we can make the provider payment updates without jeopardizing our systems."

Throughout the fall, First Coast Service Options (FCSO) and HCFA will continue to test and retest their computer systems. All HCFA and FCSO systems will undergo an extensive recertification process.

Schedules for the Implementation of Provider Payment and Other Updates

Statutory Requirements. By law, Medicare payment rate updates for Part A providers, including inpatient hospitals, skilled-nursing facilities, home-health agencies and hospices, are to occur on October 1 of each year, except for the payment rate update for swing bed hospitals, which is to occur on January 1 of each year. Payment rate updates for physicians and other Part B providers and suppliers are to occur on January 1 of each year.

Part A Provider Payment Updates. HCFA plans to make October statutory Part A payment updates on October 1, 1999.

The statutory swing bed hospital payment rate update will be handled as for other January annual updates, a process described below.

No Changes to ICD-9-CM Codes. To minimize system complexity at this critical time for Y2K testing, there will be no changes in ICD-9-CM codes (International Classification of Diseases, 9th Revision, Clinical Modification) for fiscal year 2000.

Part B Provider Payment and Other January Annual Updates. HCFA plans to make Part B provider/supplier payment and other January annual updates on January 17, 2000, but will apply the updates retroactively to all claims for services provided on or after January 1. HCFA is waiting until January 17 to make this change to reduce the risk of systems problems impacting the year 2000 rollover. The updates which will be put into production are listed below:

Updates to be in Production January 17, 2000

- All Part A and Part B Coinsurance and Deductible Amounts
- Clinical Diagnostic Laboratory Fee Schedule
- Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule
- HCFA Common Procedure Coding System (HCPCS)*
- Inherent Reasonableness
- Medicare Physician Fee Schedule
- Reasonable Charge (Ambulance Services, Certain DME Supplies, Blood Supplies/Transfusion Medicine)
- Rural Health Clinic /Federally Qualified Health Center Annual Upper Payment Limit
- Screening Mammography Limit
- Swing Bed Rate

*More information will be sent later in the year regarding the use of CPT and HCPCS codes in the year 2000.

Submitting and Processing Claims in the Year 2000

Claims With Year 2000 Service Dates. Beginning January 1, 2000, you may file claims as usual, but Medicare contractors will hold all claims with dates of service of January 1 or later until January 17 in order to correctly apply the year 2000 payment and other annual updates, including any changes in beneficiary coinsurance and deductibles. You will not need to take any action, other than submitting a millennium compliant claim, to receive the correct payment amount.

By law, electronic clean claims must be held for at least 14 calendar days but no longer than 30 calendar days before payment can be made. The period of time from receipt of year 2000 claims will count toward these requirements. Beginning on January 17, all claims for services in the year 2000 will be released for processing, and claims are expected to be finalized for payment very quickly. Therefore, holding claims with year 2000 service

dates until January 17 should only minimally affect their date of payment, if at all (because of the statutory requirement to hold claims payment for at least 14 calendar days).

Claims With Service Dates Prior to Year 2000. From January 1 until 17, claims having dates of service only occurring during the calendar year 1999 or a previous year will continue to be processed and paid using the appropriate payment rates. However, because of the way our system functions, any claim received from January 1 until January 17, 2000, that includes services occurring during calendar year 2000 and previous years will be held in its entirety until January 17. Providers having a claim with dates of service occurring both in 2000 and in a previous year, and not wishing the entire claim held until January 17, must send in two separate claims: one for year 1999 (or earlier) services, and one for year 2000 services. In this way, the processing of the claims for year 1999 (or earlier) services will not be held.

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.

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Using CPT and HCPCS Codes in the Year 2000. More information will be published in the future regarding the use of CPT and HCPCS codes in the year 2000.

For More Information

Please contact Medicare Part A Customer Service for more information about this article or about Y2K issues in general at (904)355-8899, or access the Medicare Online bulletin board system (BBS). For information regarding the BBS, call (904) 791-8384. For Y2K questions and concerns, you may also contact either of the following:

The HCFA Y2K outreach line:
1-800-958-HCFA (4232)

or

The HCFA Y2K Web site:
www.hcfa.gov/y2k

Y2K Readiness for PC-ACE™ Software

The EMC software (PC-ACE™) that is distributed by Florida Medicare has been successfully tested regarding its Y2K readiness. Providers that use the PC-ACE™ software bear the responsibility of determining and ensuring the Y2K readiness of their hardware. ♦

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GENERAL INFORMATION

Billing Guidelines for Influenza and Pneumococcal Pneumonia Vaccines

The following information on influenza and pneumococcal pneumonia vaccines was prepared by the Health Care Financing Administration (HCFA) to assist health care providers in encouraging and educating Medicare beneficiaries on the benefits of influenza and pneumonia immunizations. The material includes fact sheets highlighting Medicare policies on influenza and pneumococcal pneumonia vaccines, as well as a question/answer series for each policy.

The Health Care Financing Administration, the American Health Care Association, and the American Association of Homes and Services for the Aging are coordinating efforts to promote influenza and pneumococcal pneumonia vaccination to Medicare beneficiaries.

Influenza virus vaccine is administered annually, usually from October through December; however, the pneumococcal pneumonia vaccine is generally a once-in-a-lifetime vaccination and may be administered at any time. The Advisory Committee on Immunization Practices (ACIP) recommends vaccination if a person's pneumococcal pneumonia vaccination status is unknown. The ACIP also recommends that persons at higher risk of serious pneumococcal infection receive a second vaccination. However, vaccination of those 65 and older who are

not at highest risk is unnecessary, unless the prior vaccination was before age 65 and at least five years earlier.

What's New for 1999

Three new procedure codes for influenza vaccine and PPV. Influenza virus vaccine must be billed using CPT codes 90657, 90658, or 90659. These codes are for the vaccines only and do not include administration. Administration of the influenza virus vaccine continues to be billed using HCPCS code G0008.

One new code for polyvalent pneumococcal conjugate vaccine (90669); however, it is currently not FDA-approved and is therefore noncovered under the Medicare program. PPV is billed using CPT code 90732. Administration of PPV continues to be billed using HCPCS code G0009.

1999 Medicare Influenza Virus Vaccine Benefit

Coverage

- Coverage of the vaccine and its administration is available only under Medicare Part B, regardless of the setting in which it is furnished.
- Medicare beneficiaries who get the vaccine do not pay the usual coinsurance or deductible amounts. Medicare pays those amounts, along with an amount for the vaccine and the person who administers the shot.
- Typically, these vaccines are administered once a year in the fall or winter.
- Medicare does not require, for coverage purposes, that the vaccine be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order or supervision.

Diagnosis Coding

Influenza virus vaccine is billed using diagnosis code V04.8.

HCPCS Coding

- Influenza virus vaccine is billed using HCPCS codes 90657, 90658 or 90659. These codes are for the vaccines only and do not include administration.
- Administration of influenza virus vaccine is billed using HCPCS code G0008.

Revenue Code Reporting

- Providers other than independent rural health clinics (RHCs) and freestanding federally qualified health centers (FQHCs) bill for the influenza virus vaccine and its administration on Form HCFA-1450 using revenue code 636 for the vaccine and 771 for the administration of the vaccine in conjunction with the diagnosis and HCPCS codes.
- Independent RHCs and freestanding FQHCs do not include charges for the vaccine or its administration on the HCFA-1450. They bill in accordance with Section 614 of the RHC/FQHC manual.

Simplified Billing (Roster)

- Effective for services furnished on or after October 1, 1994, the simplified billing process was expanded to other providers that bill carriers and intermediaries, with the exception of independent RHCs and freestanding FQHCs.
- To qualify for roster billing, public health clinics (PHCs) and other properly-licensed individuals and entities may use the simplified process if they: (1) conduct mass immunization programs (at least 5 beneficiaries on the same day is required except as noted below); and (2) agree to accept assignment for influenza vaccination claims when billing carriers.

NOTE: The five immunizations per day requirement is waived for hospitals providing flu/PPV shots to Medicare inpatient beneficiaries.

- Hospitals that roster bill the flu/PPV for their inpatients may report the actual date of service instead of the discharge date.
- For simplified billing, intermediaries use HCFA-1450 form and carriers use HCFA-1500 form with preprinted standardized information relative to the provider/supplier.
- Mass immunizers attach a standard roster to a single pre-printed HCFA-1500 or HCFA-1450 that contains variable claims information necessary for processing each claim.
- A stamped signature on file is acceptable on a roster claim to qualify as an actual signature, providing that the provider has a signed authorization on file to bill Medicare for services rendered.
- Providers/suppliers that do not mass immunize should continue to bill for the influenza vaccine using the normal billing method, i.e., submission of a HCFA-1450, HCFA-1500 or electronic billing for each beneficiary.

For a sample roster that may be photocopied, see page 55.

1999 Medicare Influenza Vaccine Benefit Questions & Answers

Coverage Policy

Q What individuals and entities may bill Medicare for the influenza vaccine and its administration?

A For the purpose of the influenza vaccine benefit, any individual or entity meeting state licensure requirements may qualify to have payment made for furnishing and administering influenza vaccine to Medicare beneficiaries enrolled under Part B.

Q Does a physician have to be present when the influenza vaccine is administered?

A Medicare does not require a physician to be present. However, the law in individual states may require a physician presence.

Q Is a physician order (written or verbal), plan of care, or any other type of physician involvement required for Medicare coverage of influenza vaccinations?

A No. However, individual state law may require a physician order or other physician involvement.

Q There has been some confusion about how often a beneficiary can receive an influenza vaccination and have it covered by Medicare. If a beneficiary receives an influenza vaccination more than once in a 12-month period, will Medicare still pay for it?

A Generally, Medicare pays for one influenza vaccination per influenza season. This may mean that a beneficiary may receive more than one influenza vaccination in a 12-month period. For example, a beneficiary may receive an influenza vaccination in December 1998 for the 1998/99 influenza season and another influenza vaccination in October 1999 for the 1999/2000 influenza season. In this case, Medicare pays for both shots because the beneficiary received only one influenza shot per season.

Q What if a beneficiary needs more than one influenza shot in an influenza season?

A Medicare will pay for more than one influenza vaccination per influenza season if it is reasonable and medically necessary.

Q Is a person with only Part A coverage entitled to receive the influenza vaccination and have it covered under Part B?

A No. The influenza vaccine and its administration are a Part B covered service only.

Q What types of providers may bill the intermediary for the influenza and pneumococcal vaccines?

A The following providers of services may bill intermediaries for this benefit:

- Hospitals
- Skilled Nursing Facilities (SNFs)
- Religious Non-Medical Health Care Institutions
- Rural Primary Care Hospitals (RPHs)
- Home Health Agencies (HHAs);
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Outpatient Physical Therapy (OPT) providers
- Independent Renal Dialysis Facilities (RDFs)

Payment Policy

Q Are a coinsurance amount and deductible required for the influenza vaccine benefit?

A No. Medicare pays 100 percent of the Medicare approved charge or the submitted charge, whichever is lower. Neither the \$100 annual deductible nor the 20 percent coinsurance apply. Therefore, if a beneficiary receives an influenza vaccination from a physician, provider, or supplier that agrees to accept assignment (i.e., agrees to accept Medicare payment as payment in full), there is no cost to the beneficiary. If a beneficiary receives an influenza vaccination from a physician, provider, or supplier that does not accept assignment, the physician may collect his or her usual charge.

Q May providers, physicians, and suppliers charge and collect payment from Medicare beneficiaries for the influenza vaccination?

A Nonparticipating physicians, providers, and suppliers that do not accept assignment may collect payment from the beneficiary, but they must submit an unassigned claim on the beneficiary's behalf.

Participating institutional providers and physicians, providers, and suppliers that accept assignment must bill Medicare if they charge a fee to cover any or all costs related to the provision and/or administration of the influenza vaccine. They may not collect payment from beneficiaries.

Q Why can't Medicare pay one rate, nationwide, for influenza shots?

A The way in which Medicare pays for a given item or service is determined by statute. It would require congressional legislation for Medicare to pay a nationwide rate.

Q May a physician, provider, or supplier charge a Medicare beneficiary more for an immunization than he or she charges a non-Medicare patient?

A No.

Q If a beneficiary receives both the influenza vaccine and the pneumococcal vaccine on the same day, will Medicare pay for both administration fees?

A Yes.

Q May a physician, provider, or supplier collect payment for an immunization from a beneficiary and instruct the beneficiary to submit the claim to Medicare for payment?

A No. Medicare law requires that physicians, providers, and suppliers submit a claim for services to Medicare on the beneficiary's behalf.

Billing Medicare for the Influenza Benefit

Q What information is needed on the HCFA-1450 and HCFA-1500 to bill for the influenza virus vaccine?

A All data fields that are required for any Part B claim are required for the vaccine and its administration. Providers should bill in accordance with the bill completion instructions in the various provider manuals. Additionally, coding specific to these benefits is required.

Q What specific codes must be used?

A The following codes are used:

HCPCS Code	Description
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, split virus, whole virus, for intramuscular or jet injection use
G0008	Administration of Influenza Virus Vaccine

The following code is used if the sole purpose for the visit is to receive the influenza vaccine.

Diagnosis Code	Description
V04.8	Influenza Vaccination

Q Who bills for the influenza vaccine when it is furnished to a dialysis patient of a hospital or hospital-based renal dialysis facility?

A Regardless of where the vaccine is administered to a dialysis patient of a hospital, the hospital bills the intermediary using bill type 13X.

Q What bill types are applicable for this benefit?

A Applicable bill types are: 13X, 22X, 23X, 34X, 42X, 52X, 71X (provider-based RHCs only), 72X, 73X (provider-based FQHCs only), 74X, 75X, 83X and 85X.

Q Independent RHCs are required to use revenue code 521 in order to bill. How should they show the charge for the vaccine and its administration on the HCFA-1450?

A RHCs follow guidelines in section 614 of the RHC/FQHC Manual. They do not include charges for the vaccine or its administration on the HCFA-1450. Payment is made at cost settlement.

Q Are providers allowed to use therapy revenue codes on the influenza vaccine claim?

A Providers bill for the vaccine using revenue code 636 and for the administration using revenue code 771. If therapy services are also provided, they may be reflected on the same claim with the vaccine and its administration.

Q Should Part A shared systems maintainers allow condition code A6 or special program indicator 06 on vaccine claims?

A Yes. Condition code A6 is used to indicate services not subject to deductible and coinsurance.

Q For inpatient hospital and inpatient skilled nursing facilities, what revenue code is used for the administration?

A All providers that bill the intermediary for the vaccine report the administration under revenue code 771.

Q What bill type do hospitals and skilled nursing facilities report for inpatients who receive this benefit?

A Medicare hospitals bill for the vaccine under bill type 13X for their inpatients and skilled nursing facilities bill for the vaccine under bill type 22X.

Q May other charges be listed on the same bill with the influenza vaccine?

A Other charges may be listed on the same bill as influenza vaccine. However, there must be separate coding for the additional charge(s).

Q May certified Part A providers submit claims to a carrier?

A No. With the exception of hospice providers, certified Part A providers must bill their intermediary for this Part B benefit. Hospice providers bill the carrier.

Q How should nonparticipating provider facilities (e.g., nursing homes) bill Medicare?

A Non-Medicare-participating provider facilities bill their local carrier.

Q May HHAs that have a Medicare-certified component and a non-Medicare certified component elect to furnish the influenza benefit through the noncertified component and bill the Part B carrier?

A Yes.

Claims Processing

Q There has been some concern about the confusion caused by providers advertising influenza vaccination as “free.” When patients later receive the Medicare summary notices, they contact the carrier to report fraudulent billing. Should providers advertise this as a free service?

A Physicians, providers, and suppliers that accept assignment may advertise that there will be no charge to the beneficiary, but they should make it clear that a claim will be submitted to Medicare on their behalf.

Physicians, providers, and suppliers that do not accept assignment should never advertise the service as free, since there will be an out-of-pocket expense for the beneficiary after Medicare has paid at 100 percent of the Medicare-allowed amount.

Edits

Q Are there influenza edits in place in the Common Working File (CWF)?

A There are no influenza edits in CWF. Contractors have edits in their systems so that claims for more than one influenza vaccination in an influenza season can be screened for medical necessity.

Q Are claims for influenza vaccine and administration subject to CWF Medicare Secondary Payer (MSP) edits?

A CWF waives MSP development on all carrier processed influenza claims when the only service on the claim is for the influenza virus vaccine and/or its administration. CWF also waives MSP development on roster billed intermediary-processed claims. However, if a provider knows that a particular group health plan covers the influenza virus vaccine and its administration and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed.

Questions of Special Interest to Mass Immunizers

Note: Although these questions primarily concern mass immunizers they may apply to any entity immunizing Medicare beneficiaries.

Q What is a mass immunizer?

A As used by HCFA, the term “mass immunizer” is defined in the following manner:

A mass immunizer generally offers influenza vaccinations to a large number of individuals (the general public or members of a specific group, such as residents of a retirement community).

Often the influenza shots are offered during a special “influenza program” or “influenza clinic.”

A mass immunizer may be a traditional Medicare provider or supplier (such as a hospital outpatient department) or may be a nontraditional provider or supplier (such as a senior citizen center or a public health clinic).

A mass immunizer submits claims for immunizations on roster bills.

Mass immunizers must accept assignment.

Q May providers, physicians, and suppliers submit claims for the influenza benefit to Medicare if they provide the benefit free of charge or on a sliding fee scale to other patients?

A *Nongovernmental entities* (providers, physicians, or suppliers) that provide immunizations free of charge to all patients, *regardless of their ability to pay*, must provide the benefit free of charge to Medicare beneficiaries and may not bill Medicare. (See Medicare Carriers Manual, Part 3, section 2306.)

However, a *nongovernmental entity* that does not charge patients who are unable to pay or reduces its charge for patients of limited means (sliding fee scale) but does expect to be paid if a patient has health insurance that covers the items or services provided, may bill Medicare and receive Medicare program payment.

State and local government entities (such as public health clinics) may bill Medicare for immunizations given to beneficiaries, even if they provide immunizations free to all patients, regardless of their ability to pay.

Q Historically, some entities that have provided mass immunization programs have not charged patients the full cost of the influenza vaccine and/or its administration because they have subsidized part of the cost from their budgets. Instead, they have requested a specific dollar donation that covers part of the cost of the influenza vaccination. These entities do not then submit a claim to Medicare on behalf of the beneficiary. Is this an acceptable practice?

A No. Since the influenza benefit does not require any beneficiary coinsurance or deductible, a Medicare beneficiary has a right to receive this benefit without incurring any out-of-pocket expense. In addition, the entity is required by law to submit a claim to Medicare on behalf of the beneficiary.

The entity may bill Medicare for the amount that is not subsidized from its budget. For example, an entity that incurs a cost of \$7.50 per influenza shot and pays \$2.50 of the cost from its budget may bill the carrier the \$5.00 cost that is not paid out of its budget.

Q Sometimes an entity receives donated influenza vaccine or receives donated services for the administration of the vaccine. In these cases, may the provider bill Medicare for the portion of the influenza vaccination that was not donated?

A Yes.

Billing Using Simplified Billing Procedures (Roster Billing)

Q May an individual or entity providing both PPV and influenza virus vaccinations to the beneficiaries submit a single HCFA-1450 or HCFA-1500 that contains the information for both the PPV and influenza vaccinations and a single roster bill that contains the names of the beneficiaries who received both vaccinations?

A No. Individuals and entities submitting claims for PPV and influenza virus vaccinations must submit a separate preprinted HCFA-1450 or HCFA-1500 for each type of vaccination. Each HCFA-1450 or HCFA-1500 must have an attached roster bill listing the beneficiaries who received that type of vaccination. Each roster bill must also contain all other information required on a roster bill.

Q Is electronic billing available for roster billed claims?

A Providers may use the Direct Data Entry (DDE) system to submit roster billing electronically.

Q How many beneficiaries per day must be vaccinated in order for the roster billing procedure to be used?

A Generally, five beneficiaries per day must be vaccinated in order to roster bill. However, this requirement is waived for inpatient hospitals that mass immunize and utilize the roster billing method.

Q May hospitals and other entities that bill intermediaries use the signature on file designation on a roster bill?

A Yes. Inpatient/outpatient departments of hospitals and outpatient departments of other providers may use a signature on file stamp or notation if they have access to a signature on file in the beneficiary's record.

1999 Medicare Pneumococcal Vaccine (PPV) Benefit

Coverage

- Coverage of the vaccine and its administration is available only under Medicare Part B, regardless of the setting in which it is furnished.
- Medicare beneficiaries who get the vaccine do not pay the usual coinsurance or deductible amounts. Medicare pays those amounts, along with an amount for the vaccine and the person who administers the shot.
- Typically, these vaccines are administered once in a lifetime to persons at high risk of pneumonia infection. Considered at risk are persons 65 years of age and older; immunocompetent adults who are at increased risk of pneumonia infection or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks), and individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, HIV infection, nephrotic syndrome, sickle cell disease, or organ transplantation).
- Medicare requires for coverage purposes that the vaccine to be ordered by a doctor of medicine or osteopathy. However, a physician does not have to be present to meet the physician order requirement, if a previously written physician order (standing order) is on hand and it specifies that for any person receiving the vaccine
 - the person's age, health and vaccination status must be determined
 - a signed consent must be obtained
 - the vaccine may be administered only to persons at high risk of pneumococcal disease who have not been previously vaccinated
 - a record of vaccination must be provided.
- Typically, PPV is administered once in a lifetime. Claims are paid for beneficiaries who are at high risk of pneumonia infection and have not received PPV within the last five years or are revaccinated because they are unsure of their vaccination status.

Diagnosis Coding

Pneumococcal vaccine is billed using diagnosis code V03.82.

HCPCS Coding

- Pneumococcal vaccine is billed using HCPCS code 90669 or 90732. These codes are for the vaccine only and do not include administration.
- Administration of pneumococcal vaccine is billed using HCPCS code G0009.

Revenue Code Reporting

- Providers other than independent rural health clinics (RHCs) and freestanding federally qualified health centers (FQHCs) bill for the pneumococcal vaccine and its administration on Form HCFA-1450, using revenue code 636 for the vaccine and 771 for the administration of the vaccine in conjunction with the diagnosis and HCPCS codes.
- Independent RHCs and freestanding FQHCs do not include charges for the vaccine or its administration on the HCFA-1450. They bill in accordance with Section 614 of the RHC/FQHC manual.

Simplified Billing (Roster)

- Effective for services furnished on or after November 1, 1996, the simplified billing process was expanded to include the pneumococcal vaccination. Providers that bill carriers and intermediaries (with the exception of independent RHCs and free-standing FQHCs) may roster bill for the pneumococcal vaccination.
- In response to providers' requests to expedite the provider enrollment process, Medicare has developed simplified instruction for the HCFA-855, Provider/Supplier Enrollment application. This enrollment process currently applies only to entities that will bill the carrier; use roster bills and bill only for pneumococcal vaccinations. The Part B carrier will provide the HCFA-855.
- To qualify for roster billing, Public Health Clinics PHCs and other properly-licensed individuals and entities may use the simplified process if they: conduct mass immunization programs (at least five beneficiaries on the same day is required, except as noted below) and agree to accept assignment for pneumococcal vaccination claims when billing carriers.

NOTE: The five immunizations-per-day requirement is waived for hospitals providing PPV shots to their inpatients.

- Hospitals that roster bill a PPV for their inpatients may report the actual date of service instead of the discharge date.
- For simplified billing, carriers use Form HCFA-1500 and intermediaries use Form HCFA-1450 with preprinted standardized information relative to the provider/supplier.
- Mass immunizers attach a standard roster to a single preprinted HCFA-1500 or HCFA-1450 that contains variable claims information necessary for processing each claim.
- A stamped signature on file is acceptable on a roster claim to qualify as an actual signature providing that the provider has a signed authorization on file to bill Medicare for services rendered.
- For more information, mass immunizers can contact their local carrier or intermediary.
- Providers/suppliers that do not mass immunize should continue to bill for PPV using the normal billing method, i.e., submission of a HCFA-1450, HCFA-1500 or electronic billing for each beneficiary.
- Note the following warning that must be printed on the PPV roster bill form:

WARNING: Ask beneficiaries if they have been vaccinated with PPV.

- Rely on patients' memory to determine prior vaccination status.
- If patients are uncertain whether they have been vaccinated within the past five years, administer the vaccine.
- If patients are certain that they have been vaccinated within the past five years, **do not revaccinate.**

For a sample roster that may be photocopied, see page 56.

1999 Medicare Pneumococcal Vaccine (PPV) Benefit Questions & Answers

Coverage Policy

Q Does a physician have to be present when PPV is administered?

A Medicare does not require a physician to be present but does require a standing order. (See Q3) However, the law in individual states may require a physician presence.

Q What individuals and entities may bill Medicare for PPV and its administration?

A For the purpose of the PPV benefit, individuals and entities that meet state licensure requirements may qualify to have payment made for furnishing and administering PPV to Medicare beneficiaries enrolled under Part B, as long as certain Medicare requirements are met. (See Q3)

Q Is a physician order (written or verbal), plan of care, or any other type of physician involvement required for Medicare coverage of PPV?

A Yes. Unless PPV is administered under the supervision of a physician, Medicare requires either a prescription written specifically for the beneficiary who is receiving PPV or a previously written physician order (standing order). (See Q4 for an explanation of the term "standing order.") The standing order must specify that the individual or entity providing PPV must:

- Determine the person's age, health, and vaccination status;
- Obtain a signed consent;
- Administer an initial dose of PPV only to persons at high risk of pneumococcal disease (see Q7 for the definition of a high risk individual);
- Revaccinate only persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels (see Q9 for the definition of a highest-risk individual), provided that at least five years have passed since receipt of a previous dose of PPV; and
- Provide a record of vaccination to the patient.

Q What is a standing order?

A A standing order is a prescription written in advance by a responsible, identifiable physician to cover certain common treatment situations.

Q May a physician write a standing order that covers an entire group of patients?

A Yes. However, the standing order **must** specify the items listed in Q3. For example, a physician who is the director of a clinic may write a standing order that covers all individuals who come into the clinic and request PPV, or a hospital physician may write a standing order that covers all hospital inpatients.

Q Does a beneficiary have to provide something in writing to show his/her vaccination status? Is it necessary for the provider to review the beneficiary's medical records?

A No. Individuals and entities providing PPV to Medicare beneficiaries may rely on a verbal account of vaccination status provided by a competent beneficiary.

Q What is meant by a "high risk" individual?

A Persons at high risk of pneumococcal disease who should receive an initial dose of the vaccine include all individuals aged 65 or over immunocompetent adults 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).

Q How often should high-risk individuals receive PPV?

A High-risk individuals need PPV only once in a lifetime. Revaccination of persons 65 and older who are not at highest risk (see Q10) is not appropriate.

Q What if a high-risk individual (i.e., an individual not at highest risk) is revaccinated? Will Medicare pay for the revaccination?

A If a beneficiary who is not at highest risk is revaccinated because of uncertainty about his/her vaccination status, Medicare will cover the revaccination.

Q What individuals are considered at highest risk and should be revaccinated?

A Individuals for whom revaccination may be appropriate include adults at highest risk of serious pneumococcal infection and those who have been shown to have a rapid decline in pneumococcal antibody levels. This group includes persons with functional or anatomic asplenia (e.g., sickle cell disease, splenectomy), congenital immunodeficiency, 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.

Q Is a person with only Part A coverage entitled to receive PPV and have it covered under Part B?

A No. PPV and its administration are a Part B-covered service only.

Q What types of providers may bill the intermediary for PPV?

A The following providers of services may bill intermediaries for this benefit:

- Hospitals
- Skilled Nursing Facilities (SNFs)
- Religious Non-Medical Health Care Institutions
- Rural Primary Care Hospitals (RPCBs)
- Home Health Agencies (HHAs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Outpatient Physical Therapy (OPT) providers
- Independent Renal Dialysis Facilities (RDFs)

Payment Policy

Q Are a coinsurance amount and deductible required for the PPV benefit?

A No. Medicare pays 100 percent of the Medicare approved charge or the submitted charge, whichever is lower. Neither the \$100 annual deductible nor the 20 percent coinsurance apply. Therefore, if a beneficiary receives PPV from a physician, provider, or supplier that agrees to accept assignment (i.e., agrees to accept Medicare payment as payment in full), there is no cost to the beneficiary. If a beneficiary receives PPV from a physician, provider, or supplier that does not accept assignment, the physician may collect his or her usual charge.

Q May providers, physicians, and suppliers charge and collect payment from Medicare beneficiaries for PPV?

A Nonparticipating physicians, providers, and suppliers that do not accept assignment may collect payment from the beneficiary, but they must submit an unsigned claim on the beneficiary's behalf.

Participating institutional providers and physicians, providers, and suppliers that accept assignment must bill Medicare if they charge a fee to cover any or all costs related to the provision and/or administration of PPV. They may not collect payment from beneficiaries.

Q Why can't Medicare pay one rate, nationwide, for PPV?

A The way Medicare pays for a given item or service is determined by statute. It would require congressional legislation for Medicare to pay a nationwide rate.

Q May a physician, provider, or supplier charge a Medicare beneficiary more for an immunization than he or she charges a non-Medicare patient?

A No.

Q If a beneficiary receives both the flu vaccine and PPV on the same day, will Medicare pay twice for the administration fee?

A Yes.

Q May a physician, provider, or supplier collect payment for an immunization from a beneficiary and instruct the beneficiary to submit the claim to Medicare for payment?

A No. Medicare requires that physicians, providers, and suppliers submit a claim for services to Medicare on the beneficiary's behalf.

Billing Medicare for the Pneumococcal Pneumonia Vaccine Benefit

Q What information is needed on the HCFA-1450 and HCFA-1500 to bill for PPV?

A All data fields that are required for any Part B claim are required for the vaccine and its administration. Providers should bill in accordance with the bill completion instructions in the various provider manuals. Additionally, coding specific to these benefits is required.

Q What are the specific codes that must be used?

A The following codes are used.

HCPCS

Code	Description
90669	Pneumococcal conjugate vaccine, polyvalent, for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use
G0009	Administration of pneumococcal vaccine

The following code is used if the sole purpose for the visit is to receive PPV:

Diagnosis

Code	Description
V03.82	Pneumococcal Vaccination

Q Who bills for PPV when it is furnished to a dialysis patient of a hospital or hospital-based renal dialysis facility?

A Regardless of where the vaccine is administered to a dialysis patient of a hospital, the hospital bills the intermediary using bill type 13X.

Q What bill types are applicable for this benefit?

A Applicable bill types are: 13X, 22X, 23X, 34X, 42X, 52X, 71X (provider-based RHCs only), 72X, 73X (provider-based FQHCs only), 74X, 75X, 83X, and 85X.

Q Independent RHCs are required to use revenue code 521 in order to bill. How should they show the charge for the vaccine and its administration on the HCFA-1450?

A RHCs follow guidelines in section 614 of the RHC/FQHC manual. They do not include charges for the vaccine or its administration on the HCFA-1450. Payment is made at cost settlement.

Q Are providers allowed to use therapy revenue codes on the PPV claim?

A Providers bill for the vaccine using revenue code 636 and for the administration using revenue code 771. If therapy services are also provided, they may be reflected on the same claim with the vaccine and its administration.

Q Should Part A shared systems maintainers allow condition code "A6" or special program indicator 06 on vaccine claims?

A Yes. Condition code A6 is used to indicate services not subject to deductible and coinsurance.

Q For inpatient hospital and inpatient skilled nursing facilities, what revenue code is used for the administration?

A All providers that bill the intermediary for the vaccine report the administration under revenue code 771.

Q What bill type do hospitals and skilled nursing facilities report for inpatients who receive this benefit?

A Medicare hospitals bill for the vaccine under bill type 13X for their inpatients and skilled nursing facilities bill for the vaccine under bill type 22X.

Q May other charges be listed on the same bill with the pneumococcal vaccine?

A Other charges may be listed on the same bill as PPV. However, there must be separate coding for the additional charge(s).

Q How should nonparticipating provider facilities (e.g., nursing homes) bill Medicare?

A Non-Medicare-participating provider facilities bill their local carrier.

Q May HHAs that have a Medicare-certified component and a non-Medicare-certified component elect to furnish the PPV benefit through the noncertified component and bill the Part B carrier?

A Yes

Claims Processing

Q There has been some concern about the confusion caused by providers advertising PPV shots as **Afree**.[®] When patients later receive the Medicare summary notice, they contact the carrier to report fraudulent billing. Should providers advertise this as a free service?

A Physicians, providers, and suppliers that accept assignment may advertise that there will be no charge to the beneficiary, but they should make it clear that a claim will be submitted to Medicare on their behalf.

Physicians, providers, and suppliers that do not accept assignment should never advertise the service as free since there will be an out-of-pocket expense for the beneficiary after Medicare has paid at 100 percent of the Medicare-allowed amount.

Edits

Q Are there PPV edits in place in the Common Working File (CWF)?

A No.

Q Are claims for PPV and its administration subject to CWF Medicare Secondary Payer (MSP) edits?

A CWF waives MSP development on all carrier-processed PPV claims when the only service on the claim is for PPV and/or its administration. CWF also waives MSP development on roster-billed intermediary-processed claims. However, if a provider knows that a particular group health plan covers PPV and its administration, and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed.

Questions of Special Interest to Mass Immunizers

Note: Although these questions primarily concern mass immunizers, they may apply to any entity immunizing Medicare beneficiaries.

Q What is a mass immunizer?

A As used by HCFA, the term **A mass immunizer**[®] is defined in the following manner:

- A mass immunizer generally offers influenza and/or PPV shots to a large number of individuals (the general public or members of a specific group, such as residents of a retirement community).
- Often the PPV shots are offered as part of a special immunization program or clinic.
- A mass immunizer may be a traditional Medicare provider or supplier (such as a hospital outpatient department) or may be a nontraditional provider or supplier (such as a senior citizen center or a public health clinic).
- A mass immunizer submits claims for immunizations on roster bills.
- Mass immunizers must accept assignment.

Q May providers, physicians, and suppliers submit claims for the pneumococcal vaccine benefit to Medicare if they provide the benefit free of charge or on a sliding fee scale to other patients?

A **Nongovernmental entities** (providers, physicians, or suppliers) that provide immunizations free of charge to all patients, **regardless of their ability to pay**, must provide the benefit free of charge to Medicare beneficiaries and may not bill Medicare.

However, a **nongovernmental entity** that does not charge patients who are unable to pay or reduces its charge for patients of limited means (sliding fee scale), but does expect to be paid if a patient has health insurance that covers the items or services provided, may bill Medicare and receive Medicare program payment.

State and local government entities (such as public health clinics) may bill Medicare for immunizations given to beneficiaries, even if they provide immunizations free to all patients, regardless of their ability to pay.

Q Historically, some entities that have provided mass immunization programs have not charged patients the full cost of vaccines and/or their administration, because they have subsidized part of the cost from their budgets. Instead, they have requested a specific dollar “donation” that covers part of the cost of the vaccinations. These entities do not then submit a claim to Medicare on behalf of the beneficiary. Is this an acceptable practice?

A No. Since the pneumococcal vaccine benefit does not require any beneficiary coinsurance or deductible, a Medicare beneficiary has a right to receive this benefit without incurring any out-of-pocket expense. In addition, the entity is required by law to submit a claim to Medicare on behalf of the beneficiary.

The entity may bill Medicare for the amount that is not subsidized from its budget. For example, an entity that incurs a cost of \$12 per PPV shot and pays \$5 of the cost from its budget may bill the carrier the \$7 cost not paid out of its budget.

Q Sometimes an entity receives donated PPV or receives donated services for the administration of the vaccine. In these cases, may the provider bill Medicare for the portion of the PPV shot that was not donated?

A Yes.

Billing Using Simplified Billing Procedures (Roster Billing)

Q May an individual or entity providing both PPV and influenza virus vaccinations to beneficiaries submit a single HCFA-1450 or HCFA-1500 that contains the information for both the PPV and influenza vaccinations and a single roster bill that contains the names of the beneficiaries who received both vaccinations?

A No. Individuals and entities submitting claims for PPV and influenza virus vaccinations must submit a separate preprinted HCFA-1450 or HCFA-1500 for each type of vaccination. Each HCFA-1450 or HCFA-1500 must have an attached roster bill listing the beneficiaries who received that type of vaccination. Each roster bill must also contain all other information required on a roster bill.

Q Are the roster bills used for flu vaccinations and PPV identical?

A No. Since a standing order is required for PPV, the following reminder to providers *must* be printed on the PPV roster bill:

WARNING: Ask beneficiaries if they have been vaccinated with PPV.

- Rely on patients= memory to determine prior vaccination status.
- If patients are uncertain whether they have been vaccinated within the past five years, administer the vaccine.
- If patients are certain they have been vaccinated within the past five years, **do not revaccinate.**

Q Is electronic billing available for roster billed claims?

A Providers may use the Direct Data Entry (DDE) system to submit roster billing electronically.

Q How many beneficiaries per day must be vaccinated for the roster billing procedure to be used?

A Generally, five beneficiaries per day must be vaccinated in order to roster bill. However, this requirement is waived for inpatient hospitals that mass immunize and utilize the roster billing method.

Q What information must be submitted on a patient roster form that will be attached to a preprinted HCFA-1450 or HCFA-1500 under the simplified roster billing procedure?

A The following should be included on the roster form: patient name and address; health insurance claim number; date of birth; sex; date of service; signature or stamped “signature on file” (see following question); and provider name and identification number.

The format of the beneficiary roster may be modified to meet the needs of individual providers. It is the responsibility of the carrier to develop suitable roster formats that meet provider and carrier needs and contain the minimum data necessary to satisfy claims processing requirements for these claims.

Q Are there circumstances in which a signature is not required on a roster bill submitted to a carrier or intermediary? For example, what if an entity is unable to obtain a beneficiary’s signature because he/she is incompetent?

A A “signature on file” stamp or notation qualifies as a signature on a roster claim form in cases where the provider has access to a signature on file in the beneficiary’s record (e.g., when the vaccine is administered in a physician’s office).

Q May hospitals and other entities that bill intermediaries use the “signature on file” designation on a roster bill?

A Yes. Inpatient/outpatient departments of hospitals and outpatient departments of other providers may use a signature on file stamp or notation if they have access to a signature on file in the beneficiary’s record.

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 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 4, 1999, the interest rate applied to Medicare overpayments is **13.25** percent based on the new revised PCR rate. The following table lists previous interest rates. ❖

Period	Interest Rate
May 05, 1999 - August 03, 1999	13.375%
February 01, 1999 - May 04, 1999	13.75%
October 23, 1998 - January 31, 1999	13.50%
July 31, 1998 - October 22, 1998	13.75%
May 13, 1998 - July 30, 1998	14.00 %
January 28, 1998 - May 12, 1998	14.50%
October 24, 1997 - January 27, 1998	13.875%
July 25, 1997 - October 23, 1997	13.75%
April 24, 1997 - July 24, 1997	13.50%
January 23, 1997 - April 23, 1997	13.625%
October 24, 1996 - January 22, 1997	13.375%

Claim Processing Requirement Modification

Effective October 1, 1999, the following edits have been activated in the contractor's system to ensure proper billing and accurate claim processing.

• FS3125 FIX OCCURRENCE DATE CHECKING

The logic has been modified to validate the dates associated with any particular occurrence code entered on claim page 2 to the same occurrence code when the correction is entered on page 7 (remarks field). The dates associated with any occurrence codes entered on claim page 7 (remarks) must be entered in the following format (i.e. A1=01011953).

The reason codes associated with this change are 31201 thru 31230.

• MA2124S1 INFLUNZA VACCINE AND DX CODE V048

The current logic has been modified for reason code 31498 to edit as follows:

If the influenza vaccine is billed alone, or the administration is billed alone, or the influenza vaccine and the administration are the only services being billed, then diagnosis code V048 must be present. If diagnosis code V048 is not present under one of the above three conditions, then reason code 31498, should be received.

Addition to List of Approved Liver Transplant Centers

The following facility has been added to the list of approved liver transplant centers that was published in the Medicare Part A Bulletin G-368 page 2 published March 15, 1999:

Name and Address	Effective Date
Tampa General Hospital 409 Bayshore Boulevard Tampa, Florida 33606	August 3, 1999

FRAUD AND ABUSE

Floridians Can Help Fight Medicare Fraud and Abuse

Medicare fraud drains money from the Medicare program. The current national estimate for Medicare fraud, waste, and abuse is *\$12.6 billion*. This represents *7.1 percent of all claims processed*. Floridians should care about this fraud, because it drives health care costs higher, and it may affect the quality of patient care. Medicare recipients and providers can protect their Medicare dollars by partnering with Medicare to help fight fraud and abuse.

Fraud means knowingly and willfully attempting to defraud the Medicare program of its benefit dollars for claims that are deceptively filed. Most times, Medicare fraud involves payment in some form, resulting from inappropriately filed claims or other documents. However, other types of fraudulent activities—or “scams”—not specifically affecting Medicare payments *can* directly affect Medicare *beneficiaries* and Medicare *providers*. The following information describes two “scams:”

“Refunds from Medicare”

Recently, many Medicare beneficiaries throughout the United States have received notices from a private company (not affiliated with Medicare or the federal government). These notices advise Medicare beneficiaries that they may be eligible for a “refund” on their Medicare premiums from the Medicare program. The notices include instructions on how to obtain the so-called “refund.”

- The beneficiaries are instructed to call a “900” telephone service (at \$4.95 per minute).
- The message on the “900” service again tells beneficiaries that they may be eligible to receive refunds, and it further instructs them to call the Social Security Administration “800” telephone number.
- Further instructions suggest that callers send \$20 to a certain address, to receive information concerning “changes” in the Medicare program.

Unfortunately, this entire activity is a scam. There are no refunds of beneficiary premiums.

In limited situations, certain individuals may qualify for a discount; but there are *no refunds*. In addition, the information that a beneficiary may have paid \$20 for is nothing more than the *Medicare handbook*—which is *free to all Medicare recipients*.

As mentioned above, this particular scam does not involve *direct* payments from the Medicare program. However, the victims of this fraud are often Medicare beneficiaries. Be alert! Don’t get “taken.”

“Seminar Attendance is Required”

A private consulting firm (not affiliated with the Medicare program) is advertising to physicians about *its own* Medicare seminars. This is not illegal. No regulations prohibit private organizations from conducting seminars or providing information about the Medicare program.

However, this organization has misrepresented itself as “Medicare” and has advised physicians that attendance at the firm’s seminars is *mandatory*. The advertising also suggests that physicians could lose their Medicare participation status if they do not attend the consulting firm’s seminars. And, as with most scams, money is involved. Physicians must pay a fee to attend the “mandatory” seminars.

There are no regulations that require attendance at Medicare seminars; nor are there any punitive actions if a provider does not attend one. Attendance at any seminar is *voluntary*, whether the seminar is sponsored by a Medicare contractor or a private company.

How to Help

Health care providers and Medicare beneficiaries should exercise caution when responding to advertising regarding the Medicare program. If there is a question about the information’s legitimacy, the Medicare contractor may be contacted for assistance. If false or fraudulent activities are suspected, these should be reported to the Medicare contractor or to the Office of the Inspector General’s fraud hot line at 1-800-HHS-TIPS.

MEDICAL POLICIES

This section of the Medicare A Bulletin features new and revised medical policies. The Health Care Financing Administration's (HCFA's) instructions regarding development of Local Medical Review Policy (LMRP) are addressed in the Medicare Intermediary Manual (HCFA Publication 13-3, Section 3911), which indicates, "Medical review policy is a composite of statutory provisions, regulations, nationally published Medicare coverage policies, and Local Medical Review Policies (LMRPs)." In the absence of statute, regulations, or national coverage policy, Medicare contractors (intermediaries and carriers) are instructed to develop LMRPs to describe when and under what circumstances an item or service will be covered. LMRPs are also developed to clarify or to provide specific detail on national coverage guidelines and are the basis for medical review decisions made by the Medicare contractor's medical review staff.

Medical review initiatives are designed to ensure the appropriateness of medical care and to ensure that medical policies and review guidelines developed are consistent with the accepted standards of medical practice.

LMRP Format

Each LMRP is written in a standard format designed to convey pertinent information about an item or service in an organized and concise manner. The format is divided into distinct sections, many of which contain information the provider must know to ensure compliance. The LMRPs are reproduced in that standard format in the Bulletin.

Effective Dates

The final LMRPs were previously published to the provider community for "notice and comment." Subsequently, comments received during the 45-day notice and comment period were reviewed and considered for incorporation into the final policies. In accordance with the Health Care Financing Administration's (HCFA) guidelines, a minimum 30-day advance notice is required when initially implementing all final Medicare Part A LMRPs. Based on the publication of this final notice, these LMRPs will be effective approximately 30 days from the date of this bulletin. Therefore, the policies contained in this section are effective for claims processed **November 15, 1999**, and after, unless otherwise noted.

Medical Policy Table of Contents

Final Medical Policies

33223: Implantation of Automatic Defibrillators	20
53850: Prostate Treatments	21
86706: Hepatitis B Surface Antibody and Surface Antigen	24
88230: Cytogenetic Studies	28
93875: Non-Invasive Extracranial Arterial Studies	30
J0585: Botulinum Toxin Type A (Botox)	33
J1561: Intravenous Immune Globulin	36
J1950: Leuprolide Acetate	40
PAINREH: Pain Rehabilitation	42

Medicare Part A Medical Policy Procedures

Medical Policy may be applied to Medicare claims on either a pre-payment or post-payment basis. Medicare participating providers are accountable for compliance with published policy application. This includes Medicare coverage/policy information published via national HCFA Manual Transmittals, or fiscal intermediary publication of Local Medical Review Policy (LMRP).

Maintaining Local Medical Review Policies For Reference

Providers are encouraged to maintain all published Medical Policy Procedures on file (i.e., the policies published in this document); perhaps placing them in a manual/binder where they may be accessed/referenced by facility staff. In response to reader comments, the Medical Policy section may be removed separately, without disturbing the rest of the articles.

All final LMRPs are available in their entirety on the Medicare Online BBS. Please refer to page 31 for information about accessing the BBS. ❖

33223: Implantation of Automatic Defibrillators

Description

The implantable automatic defibrillator is an electronic device designed to detect and treat life threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating.

Type of Bill

Hospital -13x
Skilled Nursing Facility - 21x

Revenue Code

361 Minor Surgery

Indications and Limitations of Coverage and/or Medical Necessity

Effective for services performed on or after January 24, 1986 through July 1, 1991, Medicare considers the implantation of an automatic defibrillator a covered service only when used as a treatment of last resort for patients who have had a documented episode of life threatening ventricular tachyarrhythmia or cardiac arrest not associated with myocardial infarction. Patients must also be found, by electrophysiologic testing, to have an inducible tachyarrhythmia that proves unresponsive to medication or surgical therapy (or be considered unsuitable candidates for surgical therapy). It must be emphasized that unless **all** of the above-described conditions and stipulations are met in a particular case, **including the inducibility of tachyarrhythmia, etc.**, implantation of an automatic defibrillator may not be covered.

Effective for services performed on or after **July 1, 1991**, Medicare considers the implantation of an automatic defibrillator a covered service for patients who have had a documented episode of life-threatening ventricular tachyarrhythmia or cardiac arrest not associated with myocardial infarction.

Effective for services performed on or after **July 1, 1999**, Medicare considers the implantation of an automatic defibrillator a covered service for patients with the following conditions:

1. A documented episode of cardiac arrest due to ventricular fibrillation not due to a transient or reversible cause;
2. Ventricular tachyarrhythmia, either spontaneous or induced, not due to a transient or reversible cause; or,
3. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmias such as long QT syndrome or hypertrophic cardiomyopathy.

HCPCS Codes

33223	Revision or relocation of skin pocket for implantable cardioverter-defibrillator
33240	Insertion or replacement of implantable cardioverter-defibrillator pulse generator only
33241	Removal of implantable cardioverter-defibrillator pulse generator only
33242	Repair of implantable cardioverter-defibrillator pulse generator and/or leads

33243	Removal of implantable cardioverter-defibrillator pulse generator and/or lead system; by thoracotomy
33244	by other than thoracotomy
33245	Implantation or replacement of implantable cardioverter-defibrillator pads by thoracotomy, with or without sensing electrodes;
33246	with insertion of implantable cardioverter-defibrillator pulse generator
33247	Insertion or replacement of implantable cardioverter-defibrillator lead(s), by other than thoracotomy;
33249	with insertion of cardio-defibrillator pulse generator

ICD-9-CM Codes That Support Medical Necessity

425.1	Hypertrophic obstructive cardiomyopathy
425.4	Other primary cardiomyopathies
427.1	Paroxysmal ventricular tachycardia
427.5	Cardiac arrest
794.31	Abnormal electrocardiogram [ECG][EKG] (long QT syndrome)

HCPCS Section and Benefit Category

Cardiovascular System/Surgery

HCFA National Coverage Policy

Coverage Issues Manual, Section 35-85

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.

Sources of Information

N/A

Coding Guidelines

N/A

Documentation Requirements

Medical record documentation maintained by the performing 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 operative report.

Other Comments

N/A

CAC Notes

N/A

Start Date of Comment Period:	07/06/1999
Start Date of Notice Period:	October/November 1999 <i>Bulletin</i>
Original Effective Date:	11/15/1999

53850: Prostate Treatments

Revision Overview—The indications for transurethral microwave thermotherapy (TUMT) have been revised to include the criteria common to both FDA-approved devices: the Prostatron and the Targis system (also known as the T3 system).

Description

The prostate gland is located below the internal urethral orifice, behind the symphysis pubis and close to the rectal wall. The gland averages 4 cm in width at its base, 3 cm from top to bottom, 2 cm from front to back, and 20 g in weight.

Clinically, the prostate gland is important because of its affinity for congestive, inflammatory, hyperplastic, and malignant diseases. Since the prostate gland is close to the rectal wall, it is easily palpable by rectal examination, and this makes diagnosis of problems at an early stage possible. Because of the anatomic relationship of the prostate gland to the urethra, most prostatic diseases present as urinary tract symptoms.

Benign prostatic hyperplasia (BPH), the most common benign neoplasm in the aging human male, has a high prevalence that increases progressively with age. The prevalence of histologically identifiable BPH for 60 year old males is greater than 50 percent. By age 85, the prevalence is approximately 90 percent.

BPH is fundamentally a disease that causes morbidity through the urinary symptoms with which it is associated. While a minority of men undergo prostatectomy for absolute indications such as recurrent or refractory urinary retention, urinary tract infections, obstructive uropathy or severe hematuria, the majority of men undergo an operation to relieve bothersome urinary symptoms such as frequency, urgency and sensation of incomplete emptying and to improve their quality of life. For many years prostatectomy, particularly transurethral prostatectomy, has been the standard treatment for symptomatic BPH. More recently, however, a plethora of competing therapies is being used to treat patients with symptomatic BPH. These treatments include transurethral incision for the prostate, laser prostatotomy, balloon dilation, hyperthermia, insertion of prostatic stents, α -adrenergic blocking drugs and hormonal therapy. In addition, a "watchful waiting" approach can be followed.

This policy addresses two treatment options for BPH: **Transurethral Microwave Thermotherapy (TUMT)**, and Transurethral Radiofrequency Thermotherapy.

Type of Bill

Hospital - 13x
Skilled Nursing Facility - 21x
Rural Health Clinic - 71x

Revenue Codes

361 Minor Surgery

Indications and Limitations of Coverage and/or Medical Necessity

Transurethral Microwave Thermotherapy (TUMT):

TUMT provides simultaneous microwave heating of the prostate with temperatures of 45-55 °C and conductive cooling of the urethra. This treatment results in high-power microwave application deep in the lateral lobes, leading to irreversible cell damage of prostatic tissue

without damaging the urethra. TUMT effectively maintains temperatures in the urethra sphincter, and rectum at physiologically safe temperatures while targeting heat deep within the prostate transition zone. This is accomplished by combining the use of a water-cooled catheter with microwave radiation to the prostate lobes.

The treatment of symptomatic BPH with microwave thermotherapy is indicated and covered when the treatment is performed using an FDA device approved for this specific indication and the patient meets the following criteria:

- Prostatic lengths between 30-50 mm as determined by ultrasound;
- American Urology Association (AUA) symptom greater than or equal to 9 or Madsen symptom index greater than 8;
- Free peak uroflow rate (PFR) less than 15cc/sec with a voided volume greater than or equal to 150cc;
- Post void residual (PVR) less than 350cc.

Contraindications

1. Peripheral arterial disease with intermittent claudication or Leriche's syndrome (e.g., claudication of the buttocks and perineum).
2. Clinical or histological evidence of prostatic cancer or bladder cancer.
3. Severe urethral stricture preventing catheterization.
4. Presence of an active cardiac pacemaker, an implantable defibrillator, or a metallic implant in the region of the hip or pelvis.

Note: The use of the device must be prescribed and administered under the direct supervision of a qualified and trained physician, after appropriate urologic evaluation of the patient. The treating physician should be present at all times during the treatment.

HCPCS Codes

53850 Transurethral destruction of prostate tissue; by microwave thermotherapy

ICD-9-CM Codes That Support Medical Necessity

600 Hyperplasia of prostate

Transurethral Radiofrequency Thermotherapy:

Thermotherapy for BPH is based on the principle that heating the adenoma (greater than 45°) causes necrosis of obstructing tissue and leads to relief of prostatic obstruction. Transurethral Radiofrequency Thermotherapy uses radiofrequency (RF) energy (460-490kHz) for prostatic heating. Normally, the RF signal that is generated is carried into the prostate via needles. Thermal energy is generated through inductive heating of water molecules and by friction. The amount of heat energy produced and the subsequent thermal effect are determined by the amount of the tissue contact (length of the needle) and by

the wattage energy. These physical properties allow RF energy to achieve: target tissue ablation; precision tissue ablation allowing for the preservation of adjacent tissues and organs; and customized tissue ablation.

The treatment of BPH with radiofrequency thermotherapy is indicated and covered when the treatment is performed using an FDA device approved for this specific indication and the patient meets the following criteria:

- Diagnosis of symptomatic BPH with duration of symptoms greater than 3 months;
- American Urology Association (AUA) symptom score value greater than or equal to 13;
- Peak urine flow rate (Qmax) less than 15cc/sec on a voided volume of greater than 125cc;
- Prostate size greater than 15 grams; and
- Post Void Residual (PVR) less than 350cc.

Contraindications

1. Active Urinary Tract Infection
2. Prostate or bladder malignancy
3. Prominent median lobe BPH
4. Neurogenic bladder
5. Previous prostate surgery

Note: The use of the device must be prescribed and administered under the direct supervision of a qualified and trained physician, after appropriate urologic evaluation of the patient. The treating physician should be present at all times during the treatment.

HCPCS Codes

53852 Transurethral destruction of prostate tissue; by radiofrequency thermotherapy

ICD-9-CM Codes That Support Medical Necessity

600 Hyperplasia of prostate

HCPCS Section and Benefit Category

Surgery/Urinary System

HCFA National Coverage Policy

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.

Sources of Information

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Coding Guidelines

N/A

Documentation Requirements

Medical records maintained in the patient's file must document the patient's prostatic length and/or size, BPH symptoms, AUA symptoms or Madsen symptom index, the peak flow rate and post void residual. In addition, a description of the thermotherapy procedure must be documented. This information is usually found in the office/progress notes, history and physical, and/or procedure note.

Other Comments

N/A

CAC Notes

This policy does not express the sole opinion of the carrier or Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee, which includes representatives from the Florida Urological Society.

Start Date of Comment Period:	N/A
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Original Effective Date:	01/21/1999
Revision Date/Number:	11/15/1999

The indications were revised to incorporate information received on another device used for TUMT.

Revision History:

Start Date of Comment Period:	07/17/1998
Start Date of Notice Period:	12/07/1998
Original Effective Date:	01/21/1999

86706: Hepatitis B Surface Antibody and Surface Antigen

Description

Hepatitis refers to inflammation of the liver. Approximately 50 percent of all acute viral hepatitis cases in the United States are type B. Hepatitis B is caused by the hepatitis B virus (HBV) which is spread by blood and serum-derived fluids through direct contact with these body fluids (such as transmission through parenteral, sexual and perinatal modes). The incubation period for hepatitis B can be six weeks to six months with a slow onset. The most frequent presenting symptoms of acute viral hepatitis are low-grade fever, anorexia, fatigue, myalgia, and nausea followed one to two weeks later by jaundice. Dark urine and clay colored stools present several days before jaundice. After the onset of jaundice, the liver enlarges and becomes tender. About 5% of patients infected with the hepatitis B virus develop what is coined the “serum-sickness syndrome”. The syndrome includes the symptoms of jaundice, fever, rash and arthralgia. Hepatitis B may be quite mild, while a few patients could rapidly progress to death suffering from acute necrosis of the liver. Some patients with hepatitis B (approximately 6%-10%) may progress to a persistent carrier status confirmed by the consistently present hepatitis B surface antigen in their blood. These patients are highly likely to transmit hepatitis B. Each case of hepatitis B is treated symptomatically.

Hepatitis B surface antigen (HBsAg) is the earliest indicator of an acute hepatitis B infection. It can be detected one to seven weeks before liver enzyme elevation or the onset of clinical symptoms. The serology of 50% of affected patients will be positive three weeks after acute onset, while at the seventeen week mark only 10% will remain positive. There is evidence of a “window” stage where the hepatitis B surface antigen has become negative and the patient has not yet developed the hepatitis B surface antibody. The chronic carrier state is indicated by the persistence of hepatitis B surface antigen over six months and longer (even years) while never seroconverting to hepatitis B surface antibody. The reference range is negative. The detection of the hepatitis B surface antigen establishes the presence of infection and implies infectivity.

Hepatitis B surface antibody (HbsAb or anti-HBs) is present in the serum of patients who have resolved a previous hepatitis B infection or have been vaccinated against hepatitis B. The disappearance of hepatitis B antigen with the appearance of hepatitis B antibody signals recovery from the hepatitis B infection, the status of noninfectivity and protection from recurrent hepatitis B infection. Hepatitis B surface antibody can be detected several weeks to several years after Hepatitis B antigen can no longer be detected. It may persist for life after the acute infection has been resolved. Since there are different serologic subtypes of the hepatitis B virus, it is possible for a patient to have an antibody for one subtype and be infected with another. Transfused individuals or hemophiliacs receiving plasma components may have false positive tests. Individuals vaccinated with HBV vaccine will have antibodies. The appearance of the

hepatitis B antibody following vaccination signals successful vaccination against hepatitis B. The detection of hepatitis B surface antibody in the patient’s serum can be performed by either the radioimmunoassay (RIA) or enzyme immunoassay (EIA) method. The reference range varies with the clinical circumstance.

Type of Bill

Hospital - 12x, 13x, 14x
 Skilled Nursing Facility - 21x, 22x, 23x
 Rural Health Clinic - 71x
 End Stage Renal Dialysis Facility - 72x

Revenue Code

302 Laboratory Immunology (Hepatitis B surface antibody)
 306 Laboratory Microbiology (Hepatitis B surface antigen)

Indications and Limitations of Coverage and/or Medical Necessity Hepatitis B Surface Antibody

Medicare of Florida will consider coverage for the **Hepatitis B surface antibody** (86706) for any of the following indications:

- To confirm the resolution of a recent hepatitis B infection. The HBsAb is drawn one month after the diagnosis of acute hepatitis B is made. This test may be repeated monthly while seeking the disappearance of HBsAg and the appearance of HBsAb indicating immunity and recovery. If the HBsAg is still evident at the end of six months of testing, the patient is considered a persistent hepatitis B carrier. No further HBsAb would be considered reasonable and necessary.
- After percutaneous or mucosal exposure to blood and/or serum-derived fluids when the SOURCE is HBsAg-Positive and the previously vaccinated exposed person is either a known responder or the response to vaccination is unknown, in order to determine adequate antibody response. One test would be sufficient to make this determination. EXCEPTION- Vaccinated persons who have not been tested within the past 24 months should undergo testing to determine immunity.
- After percutaneous or mucosal exposure to blood and/or serum-derived fluids when the SOURCE is Not Tested or Unknown and the previously vaccinated exposed person’s response to the vaccination is unknown, in order to determine adequate antibody response. One test would be sufficient to make this determination.
- Following the administration of the Hepatitis B vaccine series in order to determine adequate antibody response. Coverage for this indication is limited to two instances:

1. To determine the antibody response of vaccination due to prophylaxis treatment following percutaneous and/or mucosal exposure or
2. To determine the antibody response of vaccination following a Medicare reimbursed vaccination furnished to a beneficiary who is at high or intermediate risk of contracting hepatitis B. See Intermediary Manual section 3157 for more information regarding this benefit.

It is recommended this testing occur between one to six months following the completion of the series. If the patient was given Hepatitis B immunoglobulin (HBIG) during this time period, the testing should be delayed until four to six months after the HBIG administration. Those beneficiaries who do not respond to the initial vaccination series, can receive up to three additional doses of vaccine at one to two month intervals. Serologic testing can occur following each dose.

- To determine the serological status of a hemodialysis, intermittent peritoneal dialysis, or continuous cycling peritoneal dialysis patient upon entry into a Medicare dialysis facility in accordance with HCFA National coverage policy. Further testing is dependent upon the initial result and the vaccination status. Please refer to the following table from the Coverage Issues Manual section 50-17.

Vaccination and Serologic Status	Freq. of HBsAb Surveillance
Unvaccinated	
Susceptible	Semiannually
HBsAg Carrier	None
HBsAb positive (*)	Annually
Vaccinated	
HBsAb positive (*)	Annually
HBsAb of 9 or less SRUs by RIA	Semiannually

* At least 10 sample ratio units (SRUs) by radioimmunoassay or positive by enzyme immunoassay. Antibody titers 10 mIU/ml are recognized as conferring protection against hepatitis.

ESRD patients who are in the process of receiving the hepatitis B vaccine, but have not completed the series, should be followed as susceptible. Between one and six months following the final vaccine dose, all patients should be tested for HBsAb response to the vaccine. Once the response is confirmed as positive, there is no further need to perform semiannual HBsAb tests. If, during future annual HBsAb testing, it is determined that the SRUs drop below 10 or the result by EIA is negative, a booster dose of hepatitis B vaccine should be given. A booster dose, otherwise known as re-vaccination, requires the complete three-injection-series be repeated. Once again, between one and six months following the final vaccine dose, all patients should be tested for HBsAb response to the vaccine.

HCPCS Codes

86706 Hepatitis B surface antibody (HBsAb)

ICD-9-CM Codes That Support Medical Necessity

070.20-070.23	Viral hepatitis B with hepatic coma
070.30-070.33	Viral hepatitis B without mention of hepatic coma
585	Chronic renal failure
V01.7	Contact with or exposure to communicable diseases, other viral diseases (viral hepatitis)
V05.3	Need for other prophylactic vaccination and inoculation against single diseases, Viral hepatitis
V45.1	Renal dialysis status
V67.59	Follow-up examination, other treatment [Hepatitis B Vaccination]

Note: Billing for Hepatitis B Surface Antibody for ESRD beneficiaries requires dual diagnoses. Please submit codes 585 and V45.1 to report the approved indication.

Hepatitis B Surface Antigen

Medicare of Florida will consider coverage for the Hepatitis B surface antigen (87340) for any of the following indications:

- To aid in the differential diagnosis of hepatitis when the patient presents with signs and symptoms of acute viral infection. If the initial HBsAg test is positive with the Anti-HBc-IgM being negative, both of these tests are repeated in two weeks. The results of the repeat tests aid in the differential diagnosis of acute HBV infection vs. chronic HBV carrier status. If the initial HBsAg test is positive with the Anti-HBc-IgM being positive, HBV infection is confirmed. The hepatitis B surface antigen test can be repeated monthly until negative. If, at the end of six months, the hepatitis B surface antigen remains positive, the beneficiary is diagnosed as a chronic HBV carrier and further hepatitis B surface antigen testing would not be reasonable or necessary.
- To evaluate patients with chronic elevations (6 months or longer) of the following serum liver enzyme levels: alanine aminotransferase (ALT) and aspartate aminotransferase (AST) to rule out the diagnosis of Hepatitis B. It is expected that only **one** HBsAg test will be required in this clinical situation (ICD-9-CM code 790.4).
- To evaluate patients with polyarteritis nodosa to determine if the illness is associated with replicating hepatitis B. In this instance HBsAg and HBeAg would be evaluated. It is expected that only **one** HBsAg test will be required (ICD-9-CM code 446.0)
- To determine the serological status of a hemodialysis, intermittent peritoneal dialysis, or continuous cycling peritoneal dialysis patient upon entry into a Medicare

dialysis facility in accordance with HCFA National coverage policy. Further testing is dependent upon the initial result as well as the vaccination status. Please refer to the following table from the Coverage Issue Manual section 50-17.

Vaccination and Serologic Status	Freq. of HBsAg Surveillance
----------------------------------	-----------------------------

Unvaccinated

Susceptible	Monthly
HbsAg Carrier	Annually
HbsAb positive (*)	None

Vaccinated

HbsAb positive (*)	None
HbsAb of 9 or less SRUs by RIA	Monthly

* At least 10 sample ratio units (SRUs) by radioimmunoassay or positive by enzyme immunoassay. Antibody titers 10 mIU/ml are recognized as conferring protection against hepatitis B.

ESRD patients who are in the process of receiving the hepatitis B vaccine, but have not completed the series, should be followed as susceptible. Between one and six months following the final vaccine dose, all patients should be tested for HBsAb response to the vaccine. Once the response is confirmed, there is no further need to perform monthly HBsAg tests. If, during future annual HBsAb testing, it is determined that the SRUs drop below 10 or the result by EIA is negative, a booster dose of hepatitis B vaccine should be given. Monthly HBsAg can resume while awaiting the antibody response to this booster. Once the antibody titer confirms protection, no further HBsAg testing would be necessary.

HCPCS Codes

87340 Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; hepatitis B surface antigen (HBsAg)

ICD-9 Codes-CM That Support Medical Necessity

070.20-070.23	Viral hepatitis B with hepatic coma
070.30-070.33	Viral hepatitis B without mention of hepatic coma
070.6	Unspecified viral hepatitis with hepatic coma
070.9	Unspecified viral hepatitis without mention of hepatic coma (fulminant hepatic failure)
446.0	Polyarteritis nodosa
570	Acute and subacute necrosis of liver
573.1	Hepatitis in viral diseases classified elsewhere
573.2	Hepatitis in other infectious diseases classified elsewhere
573.3	Hepatitis, unspecified
585	Chronic renal failure
719.40-719.49	Pain in joint (arthralgia)
729.1	Myalgia and myositis, unspecified
774.4	Perinatal jaundice due to hepatocellular damage
780.6	Fever (of unknown origin)

780.79	Other malaise and fatigue
782.1	Rash and other nonspecific skin eruption
782.4	Jaundice, unspecified, not of newborn
783.0	Anorexia
787.02	Nausea alone
789.1	Hepatomegaly
790.4	Nonspecific elevation of levels of transaminase or lactic acid dehydrogenase [LDH]
791.9	Other nonspecific findings on examination of urine (urobilin or urochrome)
792.1	Nonspecific abnormal findings in stool contents
V01.7	Contact with or exposure to other viral diseases (viral hepatitis)
V02.61	Hepatitis B carrier
V45.1	Renal dialysis status

Note: Billing for Hepatitis B Surface Antigen for ESRD beneficiaries requires dual diagnoses. Please submit codes 585 and V45.1 to report the approved indication.

HCPCS Section and Benefit Category

Pathology and Laboratory

HCFA National Coverage Policy

Coverage Issues Manual 50-17
Hospital Manual 160B12, E205.
Intermediary Manual 3157
Renal Dialysis Facility Manual 207.3
Skilled Nursing Facility Manual 260.7

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.

Sources of Information

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Coding Guidelines

Hepatitis B surface antigen and antibody tests are separately billable lab tests for hemodialysis, intermittent peritoneal dialysis and continuous cycling peritoneal dialysis patients. Payment for these tests are not part of the composite rate of reimbursement.

To identify End Stage Renal Dialysis patients, bill **both** 585 and V45.1 on the Medicare claim form. If both ICD-9 codes are not on the claim, the services will be denied as lacking medical necessity.

Documentation Requirements

For someone suspected of having been recently exposed to the hepatitis B virus, the medical record documentation must contain information regarding the beneficiary's vaccination status, and the suspected incident including an assessment of current signs and symptoms. It is expected that the initial and, if needed, subsequent hepatitis B lab test results (e.g., HBsAg, HBsAb, and/or Anti-HBc-IgM) be contained within the medical record. This information is usually found in the history and physical, office notes, test results, and/or progress notes.

Medical record documentation for ESRD beneficiaries receiving services through Medicare dialysis facilities must contain information regarding the method of dialysis, their hepatitis B vaccination status and the results of their initial admission serology testing and all subsequent hepatitis B surface antigen and antibody tests.

If the provider of 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 test(s). The physician must state the beneficiary's vaccination status as well as the clinical indication/medical necessity for the study in his order for the test(s).

Other Comments

Terms defined:

Chronic hepatitis—persistently abnormal liver enzymes for at least six months duration.

End Stage Renal Disease (ESRD)—the term as defined by HCFA reads the "stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life."

Person infected with HBV—the blood of this individual contains the hepatitis B surface antigen.

Person immune to HBV—the blood of this individual contains the hepatitis B antibody.

Person susceptible to HBV—the blood of this individual contains neither hepatitis B surface antigen nor antibody.

CAC Notes

This policy does not express the sole opinion of the carrier or the Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee which includes representatives from the Florida Gastroenterologic Society, Florida Society of Nephrology and the Clinical Laboratory Management Association.

Start Date of Comment Period:	08/26/1998
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88230: Cytogenetic Studies

Description

Cytogenetics is the study of chromosomes by light microscopy. Cytogenetic testing is used to study an individual's chromosome makeup. The term karyotyping refers to the arrangement of cell chromosomes in order from the largest to the smallest to analyze their number and structure. Cytogenetic testing involves the determination of chromosome number and structure; variations in either can produce numerous abnormalities. With cytogenetic testing, the total chromosome count is determined first, followed by the sex chromosome complement and then by any abnormalities. A normal karyotype of chromosomes consists of a pattern of 22 pairs of autosomal chromosomes and a pair of sex hormones; XY for the male, and XX for the female. A plus (+) or minus (-) sign indicates, respectively, a gain or loss of chromosomal material.

Specimens for cytogenetic analysis can be obtained for routine analysis from the peripheral blood, in which case T lymphocytes are examined; from amniotic fluid for culture of amniocytes; from trophoblastic cells from the chorionic villus; from bone marrow; and from cultured fibroblasts, usually obtained from a skin biopsy. Enough cells must be examined so that the chance of missing a cytogenetically distinct cell line (a situation of mosaicism) is statistically low. For most clinical indications, 20 mitoses are examined and counted under direct microscopic visualization, and two are photographed and karyotypes are prepared. Observation of aberrations usually prompts more extended scrutiny and in many cases further analysis of the original culture.

Type of Bill

Outpatient Hospital: 12x, 13x, 14x
Skilled Nursing Facility: 21x, 22x, 23x
Rural Health Clinic: 71x

Revenue Code

301 Chemistry
311 Cytology

Indications and Limitations of Coverage and/or Medical Necessity

Medicare considers cytogenetic studies (88230-88299) to be medically reasonable and necessary for the diagnosis and treatment of the following conditions:

Effective for services on or after October 1, 1979

- Genetic disorders (e.g., mongolism) in a fetus; (758.0-758.9)
- Failure of sexual development; or (259.0)
- Chronic myelogenous leukemia. (205.10-205.11)

Effective for services performed on or after July 16, 1998

- Acute leukemias lymphoid (FAB L1-L3), Acute leukemias myeloid (FAB M0-M7), and Acute leukemias unclassified; or (204.00-204.01, 205.00-205.01, 208.00-208.01)
- Myelodysplasia. (238.7)

HCPCS Codes

88230 Tissue culture for non-neoplastic disorders; lymphocyte
88233 skin or other solid tissue biopsy
88235 amniotic fluid or chorionic villus cells

88237	Tissue culture for neoplastic disorders; bone marrow, blood cells
88239	solid tumor
88240	Cryopreservation, freezing and storage of cells, each cell line
88241	Thawing and expansion of frozen cells, each aliquot
88245	Chromosome analysis for breakage syndromes; baseline Sister Chromatid Exchange (SCE), 20-25 cells
88248	baseline breakage, score 50-100 cells, count 20 cells, 2 karyotypes (eg, for ataxia telangiectasia, Fanconi anemia, fragile X)
88249	score 100 cells, clastogen stress (eg, diepoxybutane, mitomycin C, ionizing radiation, UV radiation)
88261	Chromosome analysis; count 5 cells, 1 karyotype, with banding
88262	count 15-20 cells, 2 karyotypes, with banding
88263	count 45 cells for mosaicism, 2 karyotypes, with banding
88264	analyze 20-25 cells
88267	Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, 1 karyotype, with banding
88269	Chromosome analysis, in situ for amniotic fluid cells, count cells from 6-12 colonies, 1 karyotype, with banding
88271	Molecular cytogenetics; DNA probe, each (eg, FISH)
88272	chromosomal in situ hybridization, analyze 3-5 cells (eg, for derivatives and markers)
88273	chromosomal in situ hybridization, analyze 10-30 cells (eg, for microdeletions)
88274	interphase in situ hybridization, analyze 25-99 cells
88275	interphase in situ hybridization, analyze 100-300 cells
88280	Chromosome analysis; additional karyotypes, each study
88283	additional specialized banding technique (eg, NOR, C-banding)
88285	additional cells counted, each study
88289	additional high resolution study
88291	Cytogenetics and molecular cytogenetics, interpretation and report
88299	Unlisted cytogenetic study

ICD-9-CM Codes That Support Medical Necessity

204.00-204.01	Acute lymphoid leukemia
205.00-205.01	Acute myeloid leukemia
205.10-205.11	Chronic myeloid leukemia (Chronic myelogenous leukemia)
208.00-208.01	Acute leukemia of unspecified cell type
238.7	Neoplasm of uncertain behavior of other lymphatic and hematopoietic tissues (Myelodysplastic syndrome)
259.0	Delay in sexual development and puberty, not elsewhere classified
758.0-758.9	Chromosomal anomalies

HCPCS Section and Benefit Category

Pathology and Laboratory

HCFA National Coverage Policy

Medicare Coverage Issues Manual, Section 50-29

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.

Sources of Information

Fauci, A., Braunwald, E., Isselbacher, K., Wilson, J., Martin, J., Kasper, D., Hauser, S., and Longo, D. (eds.) (1998). *Harrison's Principles of Internal Medicine*. (14th Edition). New York: McGraw-Hill.

Jacobs, D., Demott, W., Grady, H., Horvat, R., Huestis, D., and Kasten, B. (1996). *Laboratory Test Handbook*. Hudson: Lexi-Comp, Inc.

Tierney, L., McPhee, S., & Papadakis, M. (1998). *Current Medical Diagnosis & Treatment*. Stamford: Appleton & Lange.

Coding Guidelines

N/A

Documentation Requirements

Medical record documentation 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. This information is usually found in the history and physical, office/progress 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 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 the study in his order for the test.

Other Comments

N/A

CAC Notes

This policy does not express the sole opinion of the carrier or the Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee which includes representatives from numerous societies.

Start Date of Comment Period:	07/06/1999
Start Date of Notice Period:	October/November 1999 <i>Bulletin</i>
Original Effective Date:	11/15/1999

93875: Noninvasive Extracranial Arterial Studies

Description

Noninvasive 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.

Type of Bill

Hospital - 12x, 13x, 14x

Skilled Nursing Facility - 21x, 22x, 23x

Rural Health Clinic - 71x

Revenue Code

921 Peripheral Vascular Lab, Other Diagnostic Services

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida 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 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.
- 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 Codes

- 93875 Non-invasive physiologic studies of extracranial arteries, complete bilateral study (eg, 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

ICD-9 Codes-CM That Support Medical Necessity

- 362.34 Transient arterial occlusion
- 433.10 Occlusion and stenosis of carotid artery without mention of cerebral infarction
- 433.11 Occlusion and stenosis of carotid artery 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

HCPCS Section and Benefit Category

Non-Invasive Vascular Diagnostic Studies/Medicine

HCFA National Coverage Policy

Coverage Issues Manual, Section 50-6
 Coverage Issues Manual, Section 50-7
 Coverage Issues Manual, Section 50-37
 Hospital Manual, Section 443
 Intermediary Manual 3, Section 3631

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.

Sources of Information

Blakeley, D., Oddone, E., Hasselblad, V., Simel, D., & Matchal, D. (1995). Noninvasive Carotid Artery Testing. *Annals of Internal Medicine*, 122(5), 360-367.

Davies, K., & Humphrey, P. (1994). Do carotid bruits predict disease of the internal carotid arteries? *Postgrad Med J*, 70(824), 433-435.

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Fisher, M. (Ed.). (1995). *Stroke Therapy*. Boston: Butterworth-Heinemann.

Hill, S., Holtzman, G., Berry, R., & Arnold, J. (1997). The Appropriate Use of the Duplex Scan in Carotid Arterial Disease. *The American Surgeon*, 63, 720-725.

Holdworth, R., McCollom, P., Stonebridge, P., Bryce, J., & Harrison, D. (1996). What are the Indications for a Carotid Duplex Scan? *Clinical Radiology*, 51, 801-803.

Hood, D., Mattos, M., Mansour, A., Ramsey, D., Hodgson, K., Barkmeier, L., & Sumner, D. (1996). Prospective evaluation of new duplex criteria to identify 70% internal carotid artery stenosis. *Journal of Vascular Surgery*, 23(2), 254-262.

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Mansour, M., Mattos, M., Faught, W., Hidgson, K., Barkmeier, L., Ramsey, D., & Sumner, D. (1995). The natural history of moderate (50% to 79%) internal carotid artery stenosis in symptomatic, nonhemispheric, and asymptomatic patients. *Journal of Vascular Surgery*, 21(2), 346-357.

Ouriel, K., & Green, R. (1995). Appropriate Frequency of Carotid Duplex Testing Following Carotid Endarterectomy. *The American Journal of Surgery*, 170, 144-147.

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Tabers Cyclopedic Medical Dictionary (17th ed.). (1989). Philadelphia: F. A. Davis Company.

Taylor, R. (Ed.). (1994). *Family Medicine Principles and Practice* (14th ed.). New York: Springer.

Tierney, L., McPhee, S., & Papadakis, M. (Eds.). (1998). *Current Medical Diagnosis & Treatment* (37th ed.). Stamford: Appleton & Lange.

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 bidirectional 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.

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, is 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 (TIA's)—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.

CAC Notes

This policy does not express the sole opinion of the carrier or the Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee which includes representatives from numerous societies.

Start Date of Comment Period:	07/06/1999
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J0585: Botulinum Toxin Type A (Botox)

Revision Overview—Type of Bill 28x has been removed from the policy. Descriptor for diagnosis code 478.75 and procedure code 67345 have been corrected under the "Coding Guidelines" section of the policy.

Description

Botulinum toxin is a complex protein produced by the anaerobic bacterium *Clostridium botulinum*. Botulinum Toxin Type A injections can be used to treat various focal muscle spastic disorders and excessive muscle contractions such as dystonias, spasms, etc.

Botulinum toxin type A blocks neuromuscular conduction by binding to receptor sites on motor nerve terminals, entering the nerve terminals, and inhibiting the release of acetylcholine. When injected intramuscularly or subcutaneously at therapeutic doses, botulinum toxin type A produces a localized chemical denervation muscle paralysis. The resulting chemical denervation of muscle produces local paresis or paralysis and allows individual muscles to be weakened selectively. It has the advantage of being a potent neuromuscular blocking agent with good selectivity, duration of action, with the smallest antigenicity, and fewest side effects.

Type of Bill

Hospital: 13x

Skilled Nursing Facility: 21x, 23x

Rural Health Clinic: 71x

Comprehensive Outpatient Rehabilitation Facility: 75x

Revenue Codes

250 General Classification-CORF Providers Only

636 Drug Requiring Detailed Coding

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider Botulinum Toxin Type A (Botox) (J0585) to be medically reasonable and necessary for the treatment of blepharospasm, cranial nerve aberrant regeneration, strabismus, hemifacial spasm, facial spasm, achalasia, spasmodic dysphonia, spasmodic torticollis, laryngeal dystonia, and for other dystonias (e.g., writer's cramp, focal task-specific dystonias) and limb spasticity.

Botulinum Toxin Type A can be used to reduce spasticity or excessive muscular contractions to relieve pain; to assist in posturing and walking; to allow better range of motion; to permit better physical therapy; to reduce severe spasm in order to provide adequate perineal hygiene.

Botox can also be used in the treatment of achalasia. It should not be used for all patients with this disorder, but it can be considered individually in patients who have one or more of the following:

- have failed conventional therapy
- are at high risk of complications of pneumatic dilatation or surgical myotomy
- have failed a prior myotomy or dilation
- have had a previous dilation induced perforation
- have an epiphrenic diverticulum or hiatal hernia both of which increase the risk of dilation-induced perforation

Due to the uncommonness, one would not expect to see the diagnosis of organic writer's cramp (333.84) billed frequently.

There may be patients who require electromyography in order to determine the proper injection site(s). The electromyography procedure codes specified under the HCPCS section of this policy may be covered if the physician has difficulty in determining the proper injection site.

Medicare of Florida will allow payment for one injection per each functional muscle group (e.g., elbow flexors or elbow extensors) regardless of the number of injections made into each group or the muscles that compose it.

Note: It is expected that a patient will not receive continued injections of Botox if treatment failure occurs after 2 consecutive injections, using maximum dose for the size of the muscle.

HCPCS Codes

The following HCPCS codes are to be reported for the injection of Botulinum Toxin A:

J0585 Botulinum Toxin Type A, per unit

The following procedure codes are to be reported with the respective listed covered ICD-9-MC diagnosis codes: (See Coding Guidelines for correct reporting of services)

31513	Laryngoscopy, indirect (separate procedure); with vocal cord injection
31570	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic
31571	with operating microscope
64612	Destruction by neurolytic agent (chemodenervation of muscle endplate); muscles innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)
64613	cervical spinal muscles (e.g., for spasmodic torticollis)
64640	Destruction by neurolytic agent; other peripheral nerve or branch
67345	Chemodenervation of extraocular muscle
92265	Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report
95860	Needle electromyography, one extremity with or without related paraspinal areas
95861	Needle electromyography, two extremities with or without related paraspinal areas
95863	Needle electromyography, three extremities with or without related paraspinal areas
95864	Needle electromyography, four extremities with or without related paraspinal areas
95869	Needle electromyography; thoracic paraspinal muscles
95870	other than paraspinal (eg, abdomen, thorax)

ICD-9-CM Codes That Support Medical Necessity (J0585 Only)

333.6	Idiopathic torsion dystonia
333.7	Symptomatic torsion dystonia
333.81-333.89	Fragments of torsion dystonia
351.8	Other facial nerve disorders
378.00-378.87	Strabismus and other disorders of binocular eye movements
478.75	Laryngeal spasm
530.0	Achalasia
723.5	Torticollis, unspecified
728.85	Spasm of muscle

HCPCS Section and Benefit Category

Drugs and Biologicals

HCFA National Coverage Policy

Medicare Carrier Manual, section 2049

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.

Botulinum Toxin Type A used for the treatment of anal spasm, irritable colon, biliary dyskinesia or any other spastic conditions not listed as covered in this policy are considered investigational and therefore, noncovered by Medicare of Florida.

Cosmetic for the removal of wrinkles.

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.

Sources of Information

Drug Information for the Health Care Professional. (17th ed.). (1997). Taunton: The U.S. Pharmacopeial Convention, Inc.

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Tsui, J., Bhatt, M., Calne, S., and Calne, D. Botulinum Toxin in the Treatment of Writer's Cramp: A Double-Blind Study. *Neurology.* (1993). 184(43): 183-185.

Coding Guidelines

Botulinum Toxin Type A injection should be billed with revenue code 636. The following Type of Bill must also include the applicable HCPCS code: Hospital - 13X.

CORF providers must identify the applicable HCPCS codes in addition to Revenue Code 250.

When billing for injections of Botulinum Toxin Type A for covered conditions/diagnoses, the following guidelines should be used. Failure to report this procedure according to these guidelines may result in a denial of a claim.

Correct procedure code		Correct ICD-9 code	
31513	laryngoscopy, indirect; diagnostic with vocal cord injection	478.75	laryngeal spasm
31570	therapeutic laryngoscopy with vocal cord injection		
31571	with operation microscope		
64612	destruction by neurolytic agent; muscles enervated by facial nerve	333.81	blepharospasm
		333.82	oral facial dyskinesia (oral mandibular dystonia)
		351.8	hemifacial spasm
64613	destruction by neurolytic agent; cervical spinal muscles	333.83	spasmodic torticollis
		723.5	torticollis, unspecified
64640	Destruction by neurolytic agent; other peripheral nerve or branch	333.6	idiopathic torsion dystonia
		333.7	symptomatic torsion dystonia
		333.84	writer's cramp
		333.89	other torsion dystonia
		478.75	laryngeal spasm
		530.0	achalasia
		728.85	spasm of muscle
67345	Chemodenervation of extraocular muscle	378.00-378.87	strabismus

Due to the short life of the botulinum toxin, Medicare will reimburse the unused portion of this drug, only when the vial is not split between patients. However, documentation must show in the patient's medical record the exact dosage of the drug given and the exact amount of the discarded portion of the drug.

Electromyography guidance (CPT codes 92265, 95860-95864, 95869-95870) may be covered if the physician has difficulty in determining the proper injection site(s). However, electromyography is not required for every patient.

Only one electromyography guidance procedure per injection site should be billed.

Documentation Requirements

Documentation (e.g., history and physical, office/progress notes) must be maintained on file and should include the following elements in the event of a postpayment review:

- support for the medical necessity of the Botulinum Toxin A injection
- a covered diagnosis
- a statement that traditional methods of treatment have been tried and proven unsuccessful
- dosage and frequency of the injections
- support for the medical necessity of electromyography procedures
- support of the clinical effectiveness of the injections
- specify the site(s) injected

Other Comments

Terms Defined:

Achalasia—The inability of a muscle to relax.

Blepharospasm—A twitching or spasmodic contraction of the orbicularis oculi muscle due to habit spasm, eyestrain, or nervous irritability.

Chemodenervation—Nerve destruction by a clinical neurolytic agent.

Dysphonia—Defective production of vocal sounds in speech, caused by disease or damage to the larynx or to the nerve supply to the laryngeal muscles.

Dystonia—Abnormal muscle rigidity, causing painful muscle spasms, unusually fixed postures, or strange movement patterns. Dystonia may affect a localized area of the body, or it may be more generalized.

Spasmodic Dysphonia—Dysphonia due to spasmodic contraction of all of the muscles involved with speech production.

Spasmodic Torticollis—Recurrent stiff neck caused by spasmodic contraction of neck muscles drawing the head to one side with the chin pointing to the other side.

Strabismus—A visual disorder in which one eye cannot align with the other.

CAC Notes

This policy does not express the sole opinion of the carrier or Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee, which includes representatives from the Ophthalmology Society.

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Revision Date/Number:	11/15/1999

Revision History:

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Start Date of Notice Period:	October/November 1999 <i>Bulletin</i>
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Revision Date/Number:	11/15/1999 1

Start Date of Comment Period:	11/01/1997
Start Date of Notice Period:	02/23/1998
Original Effective Date:	03/23/1998

J1561: Intravenous Immune Globulin

Revision Overview—ICD-9-CM code 357.8, which represents chronic inflammatory demyelinating polyneuropathy, has been added to the policy. Type of Bill 28x has been removed from the policy.

Description

Intravenous Immune Globulin is a solution of human immunoglobulins specifically prepared for intravenous infusion. Immunoglobulin contains a broad range of antibodies that specifically act against bacterial and viral antigens.

Type of Bill

Hospital - 12x, 13x
 Skilled Nursing Facility - 21x, 22x, 23x
 Rural Health Clinic - 71x
 End Stage Renal Disease - 72x
 Comprehensive Outpatient Rehabilitation Facility - 75x

Revenue Code

Drug requiring detailed coding - 636
 Pharmacy general classification - 250 (CORF only)

Indications and Limitations of Coverage and/or Medical Necessity

The use of intravenous Immune Globulin should be reserved for patients with serious defects of antibody function. The goal is to provide IgG antibodies to those who lack them. Medicare of Florida will provide coverage for intravenous Immune Globulin when it is used in treatment of the following conditions:

- Primary Humoral Immunodeficiency
 - Congenital agammaglobulinemia
 - Common variable immunodeficiency
 - Wiskott-Aldrich syndrome
 - X-linked agammaglobulinemia
 - Severe combined immunodeficiency

A serum trough IgG level should be measured every 3 months before the infusion, and the dose of intravenous immune globulin adjusted accordingly. Infusions are usually given every 4 weeks, but the interval should be adjusted, depending on the serum trough IgG concentrations and the patient's clinical condition. Serum trough levels should be maintained at 400-600mg/dl, a value close to the lower limit of normal. In a rare circumstance where a patient would need his serum trough level greater than 600/mg, documentation should support the rationale.
- Recurrent Severe Infection and documented severe deficiency or absence of IgG subclass
 - For IgG subclass deficiency, a serum IgG subclass trough level should be monitored at least every three months prior to the dose of intravenous immune globulin, along with clinical progress of signs and symptoms for which intravenous immune globulin therapy is required.
- Clinically significant functional deficiency of humoral immunity as evidenced by documented failure to produce antibodies to specific antigens **and** a history of recurrent infections.
 - For Functional Deficiency, the deficient antibody(ies) should be monitored at least every

three months prior to the dose of intravenous immune globulin, along with clinical progress of signs and symptoms for which intravenous immune globulin therapy is required.

- Idiopathic Thrombocytopenic Purpura (ITP)
 - Doses should be based on the patient's clinical appearance and platelet count. Infusions are usually administered when there are signs and symptoms of bleeding and/or a platelet count less than 30,000/mm3.
- Chronic Lymphocytic Leukemia with associated hypogammaglobulinemia
 - To initiate intravenous immunoglobulins for this disease, the IgG level should be less than 600 mg/dl or there should be evidence of specific antibody deficiency and the presence of repeated bacterial infections.
- Symptomatic Human Immunodeficiency Virus (HIV)-less than 13 years of age **and** CD4+ lymphocyte count 200/mm3 or greater
 - Indications for intravenous immunoglobulin would include:
 - Children less than 13 years of age
 - Entry CD4+ lymphocyte counts greater than or equal to 200/mm3
 - Clinically symptomatic or asymptomatic but immunologically abnormal
- Low-birth weight infants weighing between 500 and 1750 grams at birth
 - Indications for intravenous immunoglobulin would include:
 - Weight at birth between 500-1750 grams
 - Expected to survive for more than 48 hours
 - Stable cardiovascular function
 - Intravenous access for medical therapy
- Bone marrow transplantation
 - Indications for intravenous immunoglobulin would include:
 - Patients 20 years of age or older
 - Seropositive for cytomegalovirus (CMV) before transplantation
 - Seronegative, had seronegative marrow donors, and undergoing allogeneic transplantation for hematologic neoplasms
- Kawasaki Disease (mucocutaneous Lymph Node Syndrome)

For diagnoses of Guillain Barre syndrome, chronic inflammatory demyelinating polyneuropathy, autoimmune hemolytic anemia, autoimmune neutropenia, acquired inhibitor of clotting factor VIII, immune thrombocytopenic purpura in pregnancy, myasthenia gravis, refractory polymyositis and refractory dermatomyositis. It is noted that not all patients with these diseases need treatment with intravenous immunoglobulin. Intravenous immunoglobulin may be recommended when **other therapy has failed or is contraindicated, and for potentially severe or life threatening manifestations of these diseases.**

- **Acute Inflammatory Demyelinating Polyradiculoneuropathy, Guillain-Barre Syndrome, and Myasthenia Gravis:**
It is noted that not all patients with these diseases need treatment with intravenous immunoglobulin. The following situations would constitute appropriate indications:
Other therapy has failed or is contraindicated
Difficulty with venous access for plasmapheresis
Recommended for rapidly progressive forms of these diseases
- **Autoimmune Hemolytic Anemia**
It is noted that not all patients with this disease need treatment with intravenous immunoglobulin. Intravenous immunoglobulin should be used for patients whose condition is resistant to conventional forms of therapy and/or demonstrates severe or life threatening manifestations of this disease.
- **Autoimmune Neutropenia**
This disease is usually benign and self-limiting, and does not require treatment. Not all patients with this disease need treatment with intravenous immunoglobulin. Occasionally, however, it is marked by repeated infection. Intravenous immunoglobulin may be recommended for the treatment of patients with an absolute neutrophil count less than 800/mm³ with recurrent bacterial infections.
- **Coagulopathy due to inhibitors or antihemophilic factor (Factor VIII)**
This is a relatively rare bleeding disorder caused by circulating autoantibodies against Factor VIII. Not all patients with this disease need treatment with intravenous immunoglobulin. Patients who develop serious hemorrhage may be administered intravenous immunoglobulin, in addition to other appropriate therapies.
- **Immune Thrombocytopenic Purpura in Pregnancy**
Pregnant women with this disease are at risk for delivering thrombocytopenic infants. Protection of the fetus becomes an important consideration in the management of a pregnant woman with immune thrombocytopenic purpura. Intravenous immunoglobulin can be recommended in the following:
Pregnant women who have previously delivered infants with autoimmune thrombocytopenia
Pregnant women who have platelet count less than 75,000/mm³ during the current pregnancy
Pregnant women with past history of splenectomy
- **Inflammatory Myopathies: Refractory Polymyositis and Refractory Dermatomyositis**
The criteria for the use of intravenous immunoglobulin in polymyositis or dermatomyositis is: patients who are **refractory** to standard therapy which includes patients who are refractory to corticosteroids; patients who have been unable to successfully taper corticosteroids below moderately high doses; patients developing **severe** side effects due to steroid therapy; **and** patients who have also failed at least one immunosuppressive agent (e.g., azathioprine, Methotrexate, cyclophosphamide, cyclosporine).

HCPCS Codes

- J1561 Injection, immune globulin, intravenous, 500 mg
J1562 Injection, immune globulin, intravenous, 5 gms

ICD-9-CM Codes That Support Medical Necessity

- 042 Human immunodeficiency virus (HIV) disease
204.10 Chronic lymphoid leukemia without mention of remission (with associated hypogammaglobulinemia)
204.11 Chronic lymphoid leukemia in remission (with associated hypogammaglobulinemia)
279.03 Other selective immunoglobulin deficiencies
279.04 Congenital hypogammaglobulinemia
279.06 Common variable immunodeficiency
279.09 Other deficiency of humoral immunity
279.12 Wiskott-Aldrich syndrome
279.2 Combined immunity deficiency
283.0 Autoimmune hemolytic anemias
286.0 Congenital factor VIII disorder
287.3 Primary thrombocytopenia
288.0 Agranulocytosis
357.0 Acute infective polyneuritis
357.8 Inflammatory and toxic neuropathy, other
358.0 Myasthenia gravis
446.1 Acute febrile mucocutaneous lymph node syndrome (MCLS)
710.3 Dermatomyositis (refractory)
710.4 Polymyositis (refractory)
765.02-765.07 Disorders relating to short gestation and unspecified low birth weight; extreme immaturity
996.85 Complications of transplanted organ; bone marrow

HCPCS Section and Benefit Category

Drugs and Biologicals

HCFA National Coverage Policy

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.

Sources of Information

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Pizzo, P. A., and Wilfert, C.M. (1994). Passive Immunization Strategies for HIV-Infected Children. Mofensen, L.M., and Specter, S.A. (Eds), *Pediatric AIDS: The Challenge of HIV Infection in Infants, Children, and Adolescents*. (2nd ed.) (pp 841-855). Baltimore: Williams and Wilkins.

Ratko, T.A., Burnett, D.H., Foulke, G.E., Matuszewski, K.A., Sacher, R.A., and the University Hospital Consortium Expert Panel for Off-Label Use of Polyvalent Intravenous Administered Immunoglobulin Preparations (1995). Consensus Statement: Recommendations of Off-Label use of Intravenous Administered Immunoglobulin Preparations. *The Journal of the American Medical Association*, 273, 1865-1870.

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Coding Guidelines

All hospital, skilled nursing facility, rural health clinic and ESRD facility providers of service must bill Intravenous Immune Globulin under Revenue Code 636 - Drugs requiring detailed coding. In addition, HCPC J1561 or J1562 must be included to identify which product was administered. ESRD facility providers must bill procedure code X0051 for gamimune N 5% - 500 mg. Comprehensive outpatient rehabilitation facility (CORF) providers may bill this service if it is directly related to the skilled rehabilitation services required by the beneficiary. CORF providers must identify the HCPC J1561 or J1562 in addition to Revenue Code 250- drugs and biologicals.

IV immune globulin maybe billed by an ESRD facility only if it is actually administered in the facility by the facility staff. Staff time used is covered under the composite rate and may not be billed separately. However, the supplies used to administer this drug may be billed in addition to the composite rate.

Documentation Requirements

Medical record documentation maintained by the treating physician/facility must clearly document the medical necessity to initiate intravenous Immune Globulin therapy and the continued need thereof. Required documentation of medical necessity should include:

- history and physical
- office/progress note(s), and
- test results with written interpretation
- an accurate weight in kilograms should be documented prior to the infusion since the dosage is based mg/kg/dosage

Other Comments**Terms Defined:**

Antibody—a protein substance developed in response to, and interacting specifically with, an antigen. This antigen-antibody reaction forms the basis of immunity.

Antigen—a substance that induces the formation of antibodies that interact specifically with it.

CAC Notes

This policy does not express the sole opinion of the carrier or the Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee, which includes representatives from numerous societies.

Start Date of Comment Period:	N/A
Start Date of Notice Period:	October/November 1999 <i>Bulletin</i>
Original Effective Date:	01/19/1995 (AI)
Revision Date/Number:	11/15/1999

To add a covered ICD-9-CM code for covered indication chronic inflammatory demyelinating polyneuropathy when other therapy has failed or is contraindicated and for a potentially severe or life threatening manifestation.

Revision History:

Start Date of Comment Period:	N/A
Start Date of Notice Period:	N/A
Original Effective Date:	01/19/1995 (AI)
Revision Date/Number:	N/A
Start Date of Comment Period:	N/A
Start Date of Notice Period:	1/23/1998
Original Effective Date:	01/19/1995 (AI)
Revision Date/Number:	01/01/1998 2
Start Date of Comment Period:	N/A
Start Date of Notice Period:	N/A
Original Effective Date:	01/19/1995 (AI)
Revision Date/Number:	07/02/1997 1

Original effective date is based on Artificial Intelligence (AI) application implementation date. Revised to ensure ICD-9-CM list consistency between the carrier and intermediary.

Original Effective Date:	01/19/1995 (AI)
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J1950: Leuprolide Acetate

Description

Leuprolide Acetate injection is a synthetic analog of the naturally occurring gonadotropin-releasing hormone (GnRH or LH-RH). The analog possesses greater potency than the natural hormone. Gonadotropin-releasing hormone is produced in the arcuate nucleus of the hypothalamus and controls release of the gonadotropins, follicle-stimulating hormone (FSH) and luteinizing hormone (LH).

The administration of leuprolide acetate results in an initial increase in circulating levels of LH and FSH, leading to a transient increase in levels of the gonadal steroids (testosterone and dihydrotestosterone in males, and estrone and estradiol in premenopausal females). However, continuous administration of leuprolide acetate results in decreased levels of LH and FSH. In males, testosterone is reduced to castrate levels. In premenopausal females, estrogens are reduced to postmenopausal levels. These decreases occur within two to four weeks after initiation of treatment.

Type of Bill

Hospital - 13x

Skilled Nursing Facility - 21x

Rural Health Clinic - 71x

Revenue Code

636 Drugs Requiring Detailed Coding

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider leuprolide acetate medically reasonable and necessary for the following FDA approved indications:

- Endometriosis (treatment): for management of endometriosis, including pain relief and reduction of endometriotic lesions.
- Leiomyomata: in conjunction with iron supplement therapy, is indicated for the preoperative hematologic improvement of patients with anemia caused by uterine leiomyomata (fibroids).
- Carcinoma, prostatic (treatment): for the palliative treatment of advanced prostatic cancer, especially as an alternative to orchiectomy or estrogen administration.

Dosage and Frequency

- Endometriosis: Intramuscular, 3.75 mg depot suspension, (J1950) is administered once a month, or 11.25 mg every three months for a maximum duration of six months.
- Uterine leiomyomata: Intramuscular, 3.75 mg depot suspension, (J1950) is administered once a month for a maximum duration of three months or one 11.25 mg injection.
- Prostatic carcinoma: Intramuscular, 7.5 mg, (J9217) is administered once a month, 22.5 mg once every three months, or 30 mg dose every four months.

- Prostatic carcinoma: Subcutaneous, 1.0 mg (J9218) is administered on a daily basis by the patient in the home setting.

Leuprolide Acetate (J9218), when administered subcutaneously is generally self-administered. Based on national coverage guidelines, drugs and biologicals which are self-administered by the patient are not a benefit of Medicare. However, certain drugs that are generally self-administered may be covered under the "incident to" provision when administered under one or more of the following circumstances:

- The initiation of the therapy requires dose titration under the supervision of a physician to test the patient's responsiveness and appropriate dosage; and/or
- Prior to self administration of a drug, the patient/caregiver must be instructed by a medical professional on the administration and proper technique for the drug that is determined to be medically necessary for the patient's condition.

Under these **limited** circumstances, Medicare of Florida will allow payment only one time for the self-administration of Leuprolide Acetate (J9218).

HCPCS Codes

J1950 Injection, leuprolide acetate (for depot suspension), per 3.75 mg

J9217 Leuprolide acetate (for depot suspension), 7.5 mg

J9218 Leuprolide acetate, per 1 mg

ICD-9-CM Codes That Support Medical Necessity

185	Malignant neoplasm of prostate
280.0	Iron deficiency anemias, secondary to blood loss (chronic)
285.1	Acute posthemorrhagic anemia
617.0-617.9	Endometriosis

HCPCS Section and Benefit Category

Drugs and Biologicals

HCFA National Coverage Policy

Medicare Intermediary Manual 3112.4(B)

Reasons for Denial

The use of Leuprolide Acetate for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Drugs and biologicals that can be self-administered are not covered by Medicare unless the statute includes a benefit that specifically provides for such coverage. The statute does not currently include a benefit for the self-administration of Leuprolide Acetate. Therefore, self/caregiver administration of Leuprolide Acetate (J9218) is non-covered.

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.

Sources of Information

Craig, C., & Stitzer, R., (1997). *Modern Pharmacology with Clinical Applications* (5th ed.). Boston: Little Brown & Company.

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Drug Information for the Health Care Professional (1998). (18th ed.). (Vol. 1). Rockville: United States Pharmacopeial Convention, Inc.

Katzung, B. G. (1998). *Lange: Basic and Clinical Pharmacology* (7th ed.). Stamford: Appleton & Lange.

Oncology Drug Information. (1997). (1st ed.). Rockville: United States Pharmacopeial Convention, Inc.

Package Insert Lupron Depot® (Leuprolide acetate for depot suspension)

Physicians' Desk Reference (1998). (52nd ed). Montvale: Medical Economics Company, Inc.

Coding Guidelines

When leuprolide acetate is self-administered, the patient/caregiver must be instructed by a medical professional on the administration and proper technique for the usage of this drug. Therefore, the physician will be reimbursed **one** time only (per beneficiary) for the subcutaneous administration of leuprolide acetate (J9218) to allow for patient teaching.

Documentation Requirements

Medical record documentation maintained by the physician must indicate the medical necessity for using this drug. Documentation of the symptoms, the administration and dosage of the leuprolide acetate would be expected to be found in the patient's medical record. This information is usually found in the history and physical and/or office/progress notes.

In addition, if Lupron Depot 3.75 mg is given for the indication of anemia, the provider must indicate in the medical record that the patient's anemia was caused by uterine leiomyomata.

Other Comments**Terms Defined:**

Antineoplastic—preventing the development, growth, or proliferation of malignant cells.

Depot—a body area in which a substance (e.g., a drug) can be accumulated, deposited, or stored and from which it can be distributed.

Follicle-stimulating hormone—hormone produced by the anterior pituitary. It stimulates growth of the follicle in the ovary and spermatogenesis in the testis.

Gonadotropin—hormones produced by the anterior lobe of the hypophysis which include the follicle-stimulating hormone (FSH) and luteinizing hormone (LH) in the female and interstitial cell stimulating hormone (ICSH) in the male.

Luteinizing hormone—hormone secreted by anterior lobe of the hypophysis that stimulates development of the corpus luteum.

CAC Notes

This policy does not express the sole opinion of the carrier or the Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee which includes representatives from the numerous societies.

Start Date of Comment Period: 12/07/1998

Start Date of Notice Period: October/November 1999 *Bulletin*

Original Effective Date: 11/15/1999

PAINREH: Pain Rehabilitation

Description

Chronic pain is difficult and frustrating to manage, and patients who experience it are often viewed as being undesirable to treat. Patients with chronic pain are often characterized by low levels of activities of daily living (ADLs), a high demand for medication accompanied by physical and psychological dependency, high verbalization of pain, and the inability to work. In many cases, patients with chronic pain are so entrenched in pain behavior that a behavior modification approach is essential.

Pain rehabilitation programs are an innovative approach to the treatment of intractable pain. The goal of such programs is to give patient's the tools to manage and control their pain, and thereby, improve their ability to function independently.

Type of Bill

Outpatient - 13x

Comprehensive Outpatient Rehabilitation Facility (CORF); (**Outpatient hospital based only**) - 75x

Revenue Code

420	Physical Therapy: General Classification
430	Occupational Therapy: General Classification
910	Psychiatric/Psychological Services: General Classification
914	Psychiatric/Psychological Services: Individual Therapy
915	Psychiatric/Psychological Services: Group Therapy

Indications and Limitations of Coverage and/or Medical Necessity

Patient Medical Necessity Criteria

Services furnished under outpatient hospital pain rehabilitation programs are considered medically necessary and appropriate if:

1. The patient's pain is attributable to a physical cause;
2. The usual methods of treatment have not been successful in alleviating pain; and
3. A significant loss of ability by the patient to function independently has resulted from pain.

In addition, the following criteria must also be met:

- The patient must be under the care of a physician;
- The patient must have an evaluation which must include an evaluation of the physiological, psychological, and social aspects of pain;
- The patient must have an individualized treatment plan which is specific to their needs and functional limitations;
- The patient must exhibit limited functional status in relation to performance of ADLs;
- The patient must have the cognitive ability to understand and carry out instructions and must be compliant and cooperative; and
- The patient must demonstrate a high level of motivation to participate in their plan of care. The level of patient participation is usually measured by the team members and documented in the progress notes.

Clinical Guidelines

To enter the program, the patient must undergo an extensive evaluation. A problem-solving group attempts to identify the medical, behavioral, vocational, financial, social, and other significant problems of the patient. Coverage of services furnished under outpatient hospital pain rehabilitation programs, including services furnished in group settings under individualized plans of treatment, is available if the patient meets the criteria listed in this policy.

A pain rehabilitation program is one that employs a coordinated multidisciplinary team to deliver, in a controlled environment, a concentrated program which is designed to modify pain behavior through the treatment of physiological, psychological, and social aspects of pain. Such programs generally include diagnostic testing, skilled nursing, psychotherapy, structured progressive withdrawal from pain medication, physical therapy and occupational therapy to restore physical fitness (mobility and endurance) to a maximal level within the constraints of a physical disability, and the use of mechanical devices and/or activities to relieve pain or modify a patient's reaction to it (e.g., nerve stimulator, hydrotherapy, massage, ice, systemic muscle relaxation training, and diversional activities). The activities of this program are under general supervision and, as needed, direct supervision of a physician.

The multidisciplinary pain approach begins with a complete clinical evaluation. Comprehensive medical and psychosocial evaluations with particular emphasis on functional capabilities and behavioral responses to pain are essential. Previous medical records should be obtained to avoid repeating appropriately performed studies and unsuccessful treatment approaches.

The multidisciplinary team functions at several levels within the treatment process. They attempt to identify and resolve documentable organic problems when present and to improve the patient's ability to cope with pain. In addition, considerable effort is devoted to improving the patient's functional outcome, as measured by increased activity time, improved activities of daily living, increased distance walked, and increased tolerance for specific homemaking or vocational activities.

Pain rehabilitation services must be rendered under a written plan of care/treatment. The plan must:

- Be consistent with the nature and severity of the individual's symptoms and diagnosis and tailored to meet their specific needs;
- Be reasonable in terms of the modality, amount, frequency, and duration of the treatment;
- Include services which are generally accepted by the professional community as safe and effective treatment for the purpose used;
- Be developed upon admission and establish specific individualized objectives, measurable, functional goals and how the goals will be met; and
- Be signed by a physician.

Each pain rehabilitation session should be documented and it should reflect the treatment provided and the patient's response toward their goals.

Diagnostic tests may be an appropriate part of pain rehabilitation programs. Such tests would be covered on an individual basis only when the diagnostic test can be reasonably related to the patient's illness, complaint, symptom, or injury, and when they do not represent an unnecessary duplication of tests previously performed.

The average program will usually last 4 weeks on an inpatient or outpatient basis or a combination thereof.

HCPCS Codes

This list is not an all inclusive list. Other rehabilitation modalities may be used in addition to those described in this policy.

- 90804 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;
- 90805 with medical evaluation and management services
- 90806 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;
- 90807 with medical evaluation and management services
- 90808 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;
- 90809 with medical evaluation and management services
- 90853 Group psychotherapy (other than of a multiple-family group)
- 97010 Application of a modality to one or more areas; hot or cold packs
- 97012 traction, mechanical
- 97018 paraffin bath
- 97022 whirlpool
- 97024 diathermy
- 97026 infrared
- 97032 Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
- 97033 iontophoresis, each 15 minutes
- 97034 contrast baths, each 15 minutes
- 97035 ultrasound, each 15 minutes
- 97036 Hubbard tank, each 15 minutes
- 97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
- 97112 neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception
- 97116 gait training (includes stair climbing)
- 97124 massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
- 97140 Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes

- 97530 Therapeutic activities, direct (one on one) patient contact by the provider (use dynamic activities to improve functional performance), each 15 minutes
- 97535 Self care/home management training (eg, activities of daily living [ADL] and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes

ICD-9-CM Codes That Support Medical Necessity

N/A

HCPCS Section and Benefit Category

Medicine/Physical Medicine and Rehabilitation

HCFA National Coverage Policy

Coverage Issues Manual 35-8
 Coverage Issues Manual 35-14
 Coverage Issues Manual 35-21
 Coverage Issues Manual 35-21.1
 Coverage Issues Manual 35-27
 Coverage Issues Manual 65-8

Reasons for Denial

A pain rehabilitation service will be denied for the following circumstances:

- When the services do not meet all the criteria listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.
- When a patient has a severe psychiatric disturbance which would not allow them to comprehend and retain new learning.
- When the documentation indicates that the patient is not demonstrating progress toward achieving stated goals within a reasonable period of time. The time frame is included on the plan of care.
- When the patient has attained his/her pain rehabilitation goals and does not require the skills of a qualified clinician.
- When the documentation indicates a duplication of services (e.g., an overlap of physical and occupational therapies).
- Some pain rehabilitation programs may utilize services and devices which are excluded from coverage, (e.g., acupuncture, vocational counseling). Some of the services that may be utilized have limited coverage criteria, (e.g., biofeedback, dorsal column stimulator, family counseling services). See Coverage Issues Manual (CIM) for coverage criteria.
- Pain rehabilitation will be considered noncovered when chronic pain has resulted from a mental condition, rather than from any physical cause.
- Chemical dependency should not be the primary diagnosis. The chemical dependency must be secondary to the pain syndrome.

Noncovered ICD-9-CM Code(s)

N/A

Sources of Information

- Braddom, R. (Ed.). (1996). Chronic pain syndromes: Evaluation and treatment. *Physical Medicine and Rehabilitation*. (pp. 876-891). W.B. Saunders.
- DeLisa, J.A., Gans, B.M., Currie, D.M., et. al. (1993). Treatment of the patient with chronic pain. *Rehabilitation Medicine: Principles and Practice*. (2nd ed.). Philadelphia: J.B. Lippincott.
- University of Miami. Comprehensive Pain and Rehabilitation Center. Miami FL.
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- Weiner, R.S. (Eds.). (1998). *Pain Management: A Practical Guide of Clinicians* (5th ed.). FL: St. Lucie Press.

Coding Guidelines

This policy does not provide the medical necessity requirements for each modality rendered in the program. Some of the HCPCS codes listed in this policy are included in individual Local Medical Review Policies (LMRPs) which have specific coverage guidelines that must be met in order for the service to be covered by Medicare of Florida. Please see individual LMRP for coverage criteria for each HCPCS code listed in this policy. Some examples of LMRPs which may effect coverage are A97003 Occupational Therapy Policy for Rehabilitation Services and A97010 Physical Medicine and Rehabilitation. These LMRPs contain multiple HCPCS codes. The provider of the service is responsible for ensuring the medical necessity of each service rendered.

Documentation Requirements

The following documentation must be maintained in the patient's medical record:

- A physician order or referral for the Pain Rehabilitation services written by the treating physician (who evaluated the patient and determined that a medical need and rehabilitation potential exists).
- A copy of the evaluation/assessment performed by the treating physician which establishes that the patient has a medical need for Pain Rehabilitation services and rehabilitation potential.
- An evaluation/assessment of the patient performed by a physician and/or qualified staff members upon admission to the Pain Rehabilitation program to ensure the patient meets medical necessity criteria for the program.
- An individual treatment plan which contains an individualized problem list, the specific procedure or activity to be done and the responsible discipline, the frequency and duration of the service(s), individual treatment goals (which are objective, measurable, and functional) and a discharge plan. The treatment plan(s) must be dated and signed by the physician.
- Daily documentation (progress notes) which reflect the individualized activity, instruction given, the patient's response to the skilled service, and the patient's progress toward stated goals. The daily note must be signed by the qualified team member who rendered the service.
- Regular team conference notes that reflect the individual patient's goals and progress.
- Discharge summary to indicate the changes since the start of care, goals accomplished, the reason why goals were not achieved (if applicable), and the discharge plan.

Each progress note must be legible, dated, signed, and the credentials of the qualified person rendering the service must be present. In addition, if the HCPCS code billed is based on time, then the time spent by the provider in a face to face encounter with the patient should be documented.

Other Comments**Terms defined:**

Chronic pain—pain which lasts six months or more.

CAC Notes

This policy does not express the sole opinion of the carrier or Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee, which includes representatives from the Florida Society of Physical Medicine & Rehabilitation.

Start Date of Comment Period: 12/07/1998

Start Date of Notice Period: October/November 1999 *Bulletin*

Original Effective Date: 11/15/1999

Revision and Clarification of Final Rule on Ambulance Services

The Health Care Financing Administration (HCFA) has revised the final rule concerning ground ambulance transportation services for Medicare beneficiaries, to clarify the circumstances under which these services are paid by Part A or Part B benefit. These provisions are effective for ambulance services furnished on or after October 1, 1999.

Classification of Ambulance Service as Part A or Part B

If a beneficiary *is admitted* to a hospital, critical access hospital (CAH), or skilled nursing facility (SNF), and it becomes necessary to transport him/her to another hospital or other site for specialized care, the patient transportation is paid under Part A as an inpatient hospital or CAH service or a covered SNF service.

Alternatively, this service is *not* classified and paid for as an *ambulance service* under Part B, because it *is* covered and payable as a *beneficiary transportation service* under Part A.

Under the final rule, the following situations may be covered by Part B ambulance service, assuming medical necessity and other coverage criteria are met, but they are not covered by Part A:

- The transport of a beneficiary from his/her home, an accident scene, or any other point of origin to the nearest hospital, CAH, or SNF capable of furnishing the required level and type of care for the beneficiary's illness or injury. *Reason: At the time the beneficiary is in transit, he/she is not an inpatient of any Part A provider.*
- The transfer of a beneficiary from one provider to another. *Reason: At the time the beneficiary is in transit, he/she is not an inpatient of either the first or the second provider.*

The final rule also allows for scheduled round-trip transportation of a beneficiary with end stage renal disease from home to the nearest appropriate dialysis facility (freestanding or hospital-based), as well as allowing direct Medicare Part B payment for rural paramedic intercept services. (Note: The paramedic intercept provision does not apply in Florida.)

National Definition of "Bed Confined"

The final rule also revised medical necessity requirements to include a national definition of the term "bed confined." A bed-confined beneficiary is "unable to get up from bed without assistance; unable to ambulate; and is unable to sit in a chair or wheelchair." Note that "bed confined," "bed rest," and "non-ambulatory" do not all have the same meaning. In addition, "bed confined" should be only one factor, not the sole basis, for the determination of medical necessity.

Minimum Vehicle and Staff Requirements to Qualify as an Ambulance

Any vehicle used as an ambulance must be designed and equipped to respond to medical emergencies and, in nonemergency situations, be capable of transporting beneficiaries with acute medical conditions. The vehicle must comply with state or local laws governing the

licensing and certification of an emergency medical transportation vehicle. At a minimum, the ambulance must contain a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment, and be equipped with emergency warning lights, sirens, and telecommunications equipment as required by state or local law. This should include, at a minimum, one two-way voice radio or wireless telephone.

Basic Life Support ambulances must be staffed by at least two people, one of whom must be certified as an emergency medical technician (EMT) by the state or local authority where the services are being furnished, and be legally authorized to operate all lifesaving and life-sustaining equipment on the vehicle. Advanced Life Support (ALS) vehicles must be staffed by two people, with one of the two staff members certified as a paramedic or an EMT, trained and certified by the state or local authority where the services are being furnished, to perform one or more ALS services.

Physician's Written Order Required

For scheduled and unscheduled nonemergency ambulance transports, the rule requires ambulance service suppliers to obtain a physician's written order certifying the need for an ambulance (certificate of medical necessity—CMN). In addition to the physician's signature, signed certification statements may be obtained when professional services are furnished by state licensed/certified physician assistants, nurse practitioners, or clinical nurse specialists.

The physician's certification must be dated no more than 60 days prior to the date the service is provided. When a beneficiary requires a nonemergency, unscheduled transport, the physician's certification may be obtained up to 48 hours after the ambulance transportation has been provided. *Exception:* A physician's certification is not required for nonemergency, unscheduled transportation of beneficiaries residing at home or in facilities where they are not under the direct care of a physician. These situations are expected to be rare, since most transports occur for beneficiaries receiving dialysis or diagnostic tests.

In addition to obtaining the certification, ambulance suppliers are required to retain and, upon request, present the certificate. This requirement applies to both repetitive and one-time ambulance transports.

Ambulance suppliers should note that the Health Care Financing Administration (HCFA) has not made revisions to the HCFA-1500 and HCFA-1491 claim forms to include the requirements of the physician certification provision. *Although the claim forms have not been modified, ambulance suppliers must still comply with the requirements.*

Delay of Standardized Form Provision

Pending further notification from HCFA, implementation of the provision requiring ambulance suppliers to use a standardized form to document compliance with state or local licensure and certification requirements is delayed. ❖

48554: Revision to Pancreas Transplantation Coverage

The Health Care Financing Administration has revised the coverage of pancreas transplantation by removing the requirement that Medicare cover the kidney transplant that must take place either simultaneous with or previous to a pancreas transplant. The following statement replaces the coverage requirement published in the June/July 1999 *Medicare A Bulletin*, page 108:

Effective July 1, 1999, Medicare covers whole organ pancreas transplantation (ICD-9-CM code 52.80, or 52.83, CPT code 48554) only when it is performed simultaneous with or after a kidney transplant (ICD-9-CM code 55.69, CPT code 50360 or 50365). If the pancreas transplant occurs after the kidney transplant, the 36-month period of entitlement to immunosuppressive therapy will begin with the date of discharge from the inpatient stay for the pancreas transplant. ❖

G0102-G0103: Coverage for Prostate Cancer Screening

Section 4103 of the Balanced Budget Act of 1997 provides for coverage of certain prostate cancer screening tests subject to certain coverage, frequency, and payment limitations. Effective for services furnished **on or after January 1, 2000**, Medicare will cover prostate cancer screening tests/procedures for the early detection of prostate cancer. Coverage of prostate cancer screening tests includes the following procedures furnished to an individual for the early detection of prostate cancer:

- Screening digital rectal examination. This test is a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate; and
- Screening prostate specific antigen (PSA) blood test. This test detects the marker for adenocarcinoma of the prostate.

Coverage Requirements

Screening digital rectal examinations are covered at a frequency of once every 12 months for men who have attained age 50 (i.e., at least 11 months have passed following the month of the last Medicare-covered screening digital rectal examination). This screening must be performed by a doctor of medicine or osteopathy; by a physician assistant, nurse practitioner, or clinical nurse specialist; or by a certified nurse midwife who is authorized under state law to perform the examinations and who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.

Screening prostate specific antigen tests are covered at a frequency of once every 12 months for men who have attained age 50 (i.e., at least 11 months have passed following the month of the last Medicare-covered screening prostate specific antigen test). Screening PSA is a test to detect the marker for adenocarcinoma of the prostate. This screening must be ordered from the beneficiary's attending physician or by the beneficiary's attending physician assistant, nurse practitioner, or clinical nurse specialist.

HCPCS Codes

- G0102 Prostate cancer screening; digital rectal examination.
- G0103 Prostate cancer screening; prostate specific antigen testing.

Billing Requirements

Prostate cancer screening must be billed using the UB-92 HCFA-1450 claim form or its electronic equivalent, by following the general bill review instructions in section 3604 of the Medicare Intermediary Manual, Part 3.

Reporting and Coding Requirements

Providers must report HCPCS codes for prostate screening under revenue code **32X**.

The appropriate bill types for these tests are **12X, 13X, 14X, 22X, 23X, 34X, 42X, 52X, 71X, 74X, 83X, and 85X**.

Reimbursement Guidelines

- G0102 digital rectal examination is paid on a reasonable cost basis (e.g., the lower of reasonable costs or customary).
- G0103 antigen test is paid under the clinical diagnostic lab fee schedule.

To determine the 11-month period, the counting begins with the month after the month in which a previous test/procedure is performed.

EXAMPLE: The beneficiary receives a screening prostate specific antigen test in January 2000. The counting starts at the beginning of February 2000. The beneficiary is eligible to receive another screening prostate specific antigen test in January 2001 (the month after 11 months have passed).

System Edits

Effective for dates of service January 1, 2000, and later, the Medicare processing system will edit prostate cancer screening tests and procedures claims for

- Age
- Frequency
- Sex
- Valid HCPCS code
- Valid revenue code

Denial Messages

If a claim for a screening prostate antigen test or screening digital rectal examination denies because the patient is under 50 years of age, the remittance advice notice will indicate claim adjustment reason code 6, "Athe procedure code is inconsistent with the patient's age," at the line level along with line level remark code M82 "AService is not covered when beneficiary is under age 50."

If a claim for a screening prostate specific antigen test or screening digital rectal examination denies because the time period between the test/procedure has not passed, the remittance advice notice will indicate claim adjustment reason code 119, "ABenefit maximum for this time period has been reached" at the line level. ❖

Adoption of Standard Electronic Health Care Transaction Formats

NOTE: This information is for the purpose of future planning. No action is required until after January 1, 2000, when Medicare will issue specific instructions.

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) include requirements to improve and simplify the administrative demands on health care providers.

Although electronic health care transactions have increased in number, especially for Medicare, providers object to the variety of format requirements different health plans use for transactions. Although the same format may be accepted by multiple plans, each plan frequently has its own electronic coding or other completion requirements. Providers must then respond to each plan's individual requirements for electronic billing, payment, eligibility, claim status query, and other transactions. This is inefficient and confusing, and it can be expensive.

Providers will begin to see the benefits of HIPAA on electronic health care transactions within a few years. Because the changes may have an impact on their billing management and planning, Medicare plans a series of educational projects to assist them in making informed choices. In addition, to publicize the impact of these changes, information will also be shared with professional associations, their publications, and the national media.

HIPAA Administrative Simplification Summary Background

HIPAA requires that the Secretary of the Department of Health and Human Services adopt standards for electronic transactions, data elements for those transactions, standard code sets for the transactions, unique health identifiers, and security standards and safeguards for electronic information systems involved in those transactions. This article provides only information on the HIPAA transaction standards. Information on unique health identifiers, standard code sets, and security issues will be addressed in the future.

The following health care transaction standards are specified:

- Health claims or equivalent encounter information
- Enrollment and disenrollment in a health plan
- Eligibility for a health plan
- Health care payment and remittance advice
- Health plan premium payments
- Health claim status
- Referral certification and authorization
- First report of injury
- Coordination of benefits
- Attachments.

A proposed rule was published in the **Federal Register** on May 7, 1998, to adopt certain version 4010 electronic formats developed by the American National Standards Institute (ANSI) accredited X12N subcommittee as the national standards for each of the specified electronic health care transactions (except attachments and first report of injury) and National Council for Prescription Drug Programs (NCPDP) electronic formats for retail pharmacy transactions. Those X12N standards are the 837 (claims, encounters, and coordination of benefits), 834 (enrollment and disenrollment), 270/271 (eligibility query and response), 835 (payment and

remittance advice), 820 (premium payments), 276/277 (claim status inquiry and response), and 278 (referral certification and authorization). Publication of the final rule for those transactions is expected later this year. The attachments transaction proposed rule is also expected to be published later this year, and a first report of injury transaction proposed rule should be published next year.

Although the NCPDP standards are for real time and batch transactions, Medicare contractors are not required to support real time health care transactions at this time. Some Medicare contractors are able to offer some real time and direct data entry (DDE) connections on a limited basis though. They may continue their limited support of real time and DDE after implementation of the Administrative Simplification transaction standards, as long as the real time transactions meet the format and content requirements of the Administrative Simplification standards. Since Medicare does not currently cover retail pharmacy services, however, Medicare does not expect to transfer data in NCPDP formats.

HIPAA requires that the adopted standards be implemented by virtually all health plans in the United States (including, but not limited to, Medicare and Medicaid) that perform any business function related to each standard transaction whether that function is performed electronically, in paper form, by telephone, or in another mode, and by providers of health care that transmit any of these transactions electronically.

Providers that electronically exchange any of these transactions with health plans must either transfer transactions complying with the implementation guides adopted in the final rule, or contract with a clearinghouse to translate their transactions into or from the standard formats. If a provider contracts with a clearinghouse for these translation services, the provider is responsible for the accuracy of the translations performed by that clearinghouse, as well as the clearinghouse charges.

Similarly, health plans that conduct these transactions electronically must be able to receive and send standard transactions that comply with the requirements in the published implementation guides. *Effective with implementation of these standard transaction formats, a health plan may not require a provider to exchange electronic transactions of these types in any other format.* Nor may a provider or a health plan use a trading partner agreement to override, substitute, or otherwise change any requirement or condition of use of any part of a standard transaction's implementation guide.

A health plan that is unable to directly exchange electronic transactions in a standard format may contract with a clearinghouse to translate incoming and outgoing transactions to comply with the standard format requirements. If a health plan chooses this option, it may not charge those translation costs to providers or other clearinghouses who choose to use a standard format. Nor may a health plan delay or disadvantage processing of transactions that are submitted or issued in a standard format.

HIPAA does *not* require that providers submit claims or receive remittance advices electronically. Nor does HIPAA require that providers submit electronic queries and

receive electronic responses for claim status and eligibility. Providers may continue to make mail and telephone inquiries, if they prefer. HIPAA will, however, make it easier and more cost-effective to use electronic transactions, hopefully resulting in more frequent use of electronic data interchange (EDI). For a nominal handling fee, Medicare contractors will continue to issue free billing software that may be used by providers to electronically bill Medicare; contractors will also continue to issue free PC-Print software for use with Medicare's remittance advice transactions.

HIPAA requires that the transaction standards be implemented by most health plans and "electronic" providers within two years of the effective date of publication of the final rule in the *Federal Register*. Certain "small" health plans will be allowed three years for implementation. Due to the number of providers involved and the need for system testing with those providers, Medicare expects to allow a 12-15 month transition period for electronic providers to convert to the HIPAA version of the transaction standards.

What This Means for Providers

Once the transaction standards are implemented nationally, a provider will be able to submit the same transaction in the same format to any health plan equipped for the receipt of electronic transactions of these types. Similarly, an "electronic" provider will be able to receive transactions of these types from any plan in the same format. HIPAA will reduce the need for manual handling in day-to-day processing of patient account information. Therefore, costs should decrease for most health care providers who use software to automatically produce standard transactions that they send to health plans, as well as to automatically post data directly to accounts receivable.

However, to benefit fully from HIPAA, many providers and plans will need to make significant changes. Once the HIPAA transaction standards are fully implemented, Medicare will no longer accept flat-file electronic UB-92 or National Standard Format (NSF) transactions for claims. Nor will Medicare issue any electronic remittance advices in the NSF, or exchange any electronic transactions of the type specified by HIPAA, such as eligibility queries/responses, in any version not adopted as a national standard in the final rules for Administrative Simplification transaction standards.

If providers currently use a clearinghouse to translate outgoing or incoming electronic transactions, they may continue to use a clearinghouse for those services, *if that clearinghouse is capable of translation in the HIPAA standard format*. Providers who do not use a clearinghouse must either install software able to send and receive in the HIPAA transaction standard or contract with a clearinghouse for this service.

Providers not currently electronically transmitting HIPAA transactions, as well as providers who electronically submit only certain transactions, should reexamine their situations with regard to possible cost savings by using or expanding their use of EDI. Medicare EDI staff at local offices have information about the impact of the HIPAA transaction standards, EDI advantages and requirements, and vendors to assist providers in becoming EDI-capable.

Medicare contractors, other than Durable Medical Equipment Regional Carriers (DMERCs) and intermedi-

aries, are already able to receive claims in the X12N 837 format and issue remittance advices in the X12N 835 format. However, this format is an earlier version than the version expected to be adopted for national use, under the HIPAA final transactions rules. *The X12N 835 is the only electronic remittance advice intermediaries may send*. Medicare contractors are also able to accept eligibility inquiries electronically and respond electronically, but not in an X12 format. They will need to convert to use of the X12N 270/271 formats for these transmissions. Medicare has not previously required that contractors use any of the other electronic transactions mentioned in HIPAA, but Medicare will implement those that apply to Medicare operations, when the Administrative Simplification transactions become effective. DMERCs will also convert to sole use of the HIPAA X12N standards at that time.

What Medicare Providers Can Do Now

Providers and clearinghouses desiring to "jump-start" their understanding of X12N transactions, or those who are considering a switch from the electronic UB-92 or NSF formats, may wish to consider upgrading *after January 2000*, to the latest X12 claim and/or remittance advice version available at that time from their Medicare carrier or intermediary. While not absolutely identical to the HIPAA transaction version likely to be implemented, the version 3051 claim and 3051.4 remittance advice currently available are similar enough to make the subsequent transition to the HIPAA version much easier. As an additional benefit, providers will become familiar with the X12N format rules and syntax, facilitating use of other HIPAA transactions as they are implemented by Medicare and other payers, thus potentially allowing providers the earliest possible opportunity for transition to the HIPAA transaction standards, and giving them a head start on realizing the benefits of the Administrative Simplification program.

How to Get More Information

As the final rules for HIPAA transaction standards are published, Medicare will issue additional information to providers. Providers desiring more information about EDI under Medicare and HIPAA may also wish to consult the following Web sites:

- EDI standards currently used by Medicare: **www.hcfa.gov/medicare/edi/edi.htm**
- X12N version 4010 transaction implementation guides: **www.wpc-edi.com/hipaa**
- Text of Administrative Simplification law and regulations: **www.aspe.os.dhhs.gov/admsimp**
- X12N meeting and workgroup meeting information and minutes: **www.disa.org** (select "Insurance," "X12N," "Subcommittee")

Providers desiring to increase their use of EDI, including use of X12N transactions already implemented by Medicare, may contact Provider Electronic Services Marketing at (904) 791-8767. ❖

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.

Clarification of Dialysis Coverage for Skilled Nursing Facility Residents

The Health Care Financing Administration (HCFA) has issued clarification of Medicare's dialysis coverage for skilled nursing facility (SNF) residents. The following article addresses specific concerns about Medicare dialysis policy.

Section 1861(h) of the Social Security Act (the Act) describes coverage of extended care (i.e., Part A SNF) services. For a specific type of service to be covered under this benefit, it must fall within one of the seven individual service categories set out in this section of the Act. Dialysis can potentially fit into this benefit under either of two categories in section 1861(h).

The **first** category is in section 1861(h)(6), which provides for coverage under the SNF benefit of transfer agreement hospital services. Section 1819(a)(2) of the Act specifies that, in order to participate in Medicare as an SNF, a nursing home must have a transfer agreement with a hospital to facilitate the ready exchange of patients and information between the two institutions. Under section 1861(h)(6), services such as dialysis may be covered under the SNF benefit when furnished to the SNF's residents under arrangements between the SNF and its transfer agreement hospital. However, to be covered under this provision, the dialysis must be furnished directly by the SNF's transfer agreement hospital itself, rather than under arrangements between the hospital and a third party.

The **second** category is in section 1861(h)(7). In addition to the specific service categories set out in paragraphs (1) through (6) of section 1861(h), paragraph (7) provides for coverage of other services generally provided by SNFs. Under a longstanding administrative policy reflected in section 3133.9.A. of the Medicare Intermediary Manual, Part 3, most of the Part B medical and other health services described in section 1861(s) of the Act (including dialysis, at section 1861(s)(2)(F)) are considered to be generally provided by SNFs for purposes of this provision.

However, prior to the Balanced Budget Act of 1997 (BBA, P.L. 105-33), the statutory language regarding services generally provided by SNFs required a particular service to be generally provided (i.e., the provision of that type of service to be the prevailing practice among SNFs nationwide), and provided directly by the SNF itself. However, effective for services furnished to SNF residents on or after July 1, 1998, section 4432(b)(5)(D) of the BBA expanded section 1861(h)(7) of the Act to include coverage of services generally provided by SNFs or by others under arrangements with them made by the SNF.

As a result, the extended care benefit now covers the full range of services that SNFs generally provide, either directly or under arrangements with outside sources. For example, dialysis services (which have until now been specifically coverable as extended care services only

when directly provided by either the SNF itself or its transfer agreement hospital) also become coverable when provided under an arrangement between the SNF and a freestanding dialysis facility.

Also, dialysis is one of the service categories the BBA specifically excludes from the SNF Consolidated Billing provision (which makes the SNF itself responsible for billing Medicare for virtually all of the services that its residents receive). This means that while the BBA change in section 1861(h)(7) of the Act makes dialysis coverable as a Part A SNF service if an SNF elects to provide it either directly or under arrangements with a qualified outside source, the SNF also has the option to unbundle the dialysis altogether. If the SNF elects this latter option, dialysis services that meet the Part B dialysis benefits coverage requirements could be furnished and billed directly by an outside dialysis supplier, without having to make an arrangement with the SNF in which the SNF does the Medicare billing.

There are only two situations under which dialysis services are considered a Part B service and billable by an ESRD facility or supplier when provided to a SNF patient. The first is for institutional dialysis services received at a Medicare-certified ESRD facility. Institutional dialysis services must be provided by entities that meet the ESRD conditions of coverage specified in code 42 of Federal Regulations, Part 405, Subpart U. These regulations limit outpatient maintenance dialysis services to those services provided on the premises of the facility. Thus, it is not possible for Part B institutional dialysis services to be provided at the site of a nursing facility or SNF that does not itself meet the ESRD conditions of coverage.

The second situation involves Part B coverage of home dialysis services for patients in nursing facilities or SNFs as such facilities may qualify as the patient's home for purposes of this benefit. For Medicare payment of home dialysis to be made, the patient must elect to become a home dialysis patient and have completed a training program provided by an approved ESRD facility. Once a patient has completed the training, he/she must elect either Method I, where an ESRD approved facility furnishes the dialysis equipment and supplies, or Method II, where the patient elects a single supplier other than the ESRD facility to furnish all of his/her dialysis equipment and supplies other than laboratory services and support services, which are provided by a certified ESRD facility. Each home patient must have his/her own supplies and equipment. These may not be shared with other SNF patients. Also, home dialysis is intended to be self-dialysis performed by the patient and/or his/her family. Therefore, Medicare does not cover the services of staff to assist with home dialysis services.

Questions and Answers

Q When may an outside dialysis provider bill for services for a SNF patient? What are the criteria?

A An outside dialysis provider may bill for dialysis services for a SNF patient only if the services meet the Part B dialysis benefit's coverage requirements. That is, the services are:

- provided on the premises of a certified ESRD facility. In this case the SNF patient must be transported to the certified ESRD facility for dialysis services, or
- the SNF patient qualifies as a home patient in the SNF facility, and the patient has his/her own equipment and supplies. The patient must meet the criteria for a home patient.

Q May the outside dialysis provider actually provide the services *at* the SNF, in the patient's room, and bill?

A The ESRD facility may provide dialysis services at the SNF, under arrangement with the SNF. In this case, the SNF is required to bill for the services under Part A. The ESRD facility may only bill for services provided to SNF patients if the patient meets the criteria to a home dialysis patient as referenced above.

Q If the hospital has contracted with a dialysis provider to provide acute services and the SNF has been sending the patients to the acute setting for dialysis, may hospital bill Medicare Part B for SNF patients?

A No, the hospital may bill for the service only if it is a certified ESRD facility.

Q Must the outpatient provider be ESRD-licensed to provide services to SNF patients to provide and bill for the services?

A Yes, the outpatient provider must be a certified ESRD facility to provide and bill Medicare for ESRD services to SNF patients under Part B.

Q Is the provider or the location certified as an ESRD?

A The provider is certified/approved by the Health Care Financing Administration to furnish specific types of care or services furnished to ESRD patients.

Q Is the outpatient dialysis provider licensed by location or by service?

A The HCFA certifies the ESRD outpatient dialysis facility for the services that it will provide. However, the ESRD conditions for coverage under Medicare require that outpatient maintenance dialysis services be provided on the premises of the facility or, if a home patient, at the patient's residence.

Medicare Offers FREE National Education Programs

The Health Care Financing Administration (HCFA) has partnered with First Coast Service Options, Inc. (FCSO), the Florida contracted carrier and intermediary, to launch a series of FREE education and training programs designed to give healthcare providers the opportunity to study various topics about Medicare benefits, coverage and billing rules. Leveraging internet-based training and satellite technology to make Medicare education more readily available to healthcare providers throughout the nation saves on travel, challenging schedules and missed office hours. "This approach also helps Medicare providers and beneficiaries avoid potential problems before they occur further reducing waste, fraud and abuse," explains Diane Kelley, director of Medicare Program Relations at FCSO.



Computer Based Training Courses via the Internet

Healthcare providers can download FREE Medicare computer based training (CBT) courses that will help them strengthen their understanding of a variety of topics related to Medicare. The current Medicare library has several self-paced courses that are available 24 hours a day, seven days a week. These courses include:

- ICD-9-CM Coding
- Front Office Management
- HCFA-1500 Claims Filing
- HCFA-1450 (UB92) Claims Filing
- Medicare Fraud & Abuse
- Medicare Home Health Benefit
- Medicare Secondary Payer
- Introduction to the World of Medicare

Here's How it Works:

Users visit the Medicare On-line Training Web Site at www.medicaretraining.com and click on "Computer Based Training" to download the course(s) of their choice. Once a course is downloaded and set up on their PC, users are then able to take the courses at their leisure. The site provides complete step-by-step instructions on how to download and set up the courses.

CBT System Requirements:

- Windows 95, 98 or NT
- mouse
- VGA color monitor

CBT offers users the flexibility to have control over their learning environment. In every course, users are given the opportunity to practice what they've learned through quizzes and tests. After each test is taken, users are given full access to their results, instantly. Users can take as long as they want to complete each lesson and they can take them as often as they like.

The Medicare Online Training Web Site gives Medicare contractors yet another channel to reach new audiences, build new partnerships, and deliver up-to-date materials and services. To date, the site has recorded more than 20,000 course downloads. HCFA and FCSO welcome your participation in this overwhelmingly successful program. Please visit the Medicare Online Training Web Site at www.medicaretraining.com.

Courses via Satellite Broadcast



When everyone better understands Medicare guidelines, appropriate services are rendered, claims are filed correctly, providers are paid timely (and accurately) and beneficiaries obtain the care and good service they are entitled to receive. The use of satellite technology gives healthcare providers the opportunity to share a nationwide "virtual" classroom and participate in "live" presentations. Participants retain the interactivity offered in a live seminar, as most programs offer a toll-free hotline for participants to call or to fax questions during the broadcast. The following broadcasts are currently scheduled:

Steps to Promoting Wellness: Adult Immunizations

Available on Videotape from the June 1999 National Satellite Broadcast

Medicare Fraud and Abuse: Proactive Measures to Avoid Becoming a Victim

Available on Videotape from the July 1999 National Satellite Broadcast

Steps to Promoting Wellness: Women's Health

Available on Videotape from the August 1999 National Satellite Broadcast

The Medicare Resident Training Program

Available on Videotape from the September 1999 National Satellite Broadcast

"Time and distance have very little meaning in computer-based training and satellite broadcasting education," adds Joe Montano, manager of the national program at FCSO. Additional computer-based training courses and satellite broadcasts are currently being planned. To access the computer-based training courses, a complete list of satellite-based courses, host sites, dates, times, and video availability, please visit the Medicare Online Training Web Site at www.medicaretraining.com or the "Learning Resources" section of HCFA's web site at www.hcfa.gov.

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Medicare Online

Electronic Bulletin Board System(BBS)



Florida Electronic Bulletin Board System (BBS)

WHAT IS THE BBS?

The BBS is a bulletin board system maintained in a computer similar to your own. It is located at Medicare of Florida and enables you to access vast amounts of important Medicare (Part A and B) claims processing information. This system is available 24 hours a day, 7 days a week, to **anyone** (with no restrictions), from anywhere, even outside Florida). Access can be obtained by using your office **or** home computer, via a **TOLLFREE** telephone line.

WHAT'S AVAILABLE?

Once you've connected to the BBS you can view and search through information while online. You will also be able to copy the same information to your own computer by downloading for future access. You'll find information on the BBS like:

Medicare Part A - Medical Policies, Publications (*Bulletin*), Reason Codes, etc.

Medicare Part B - UPIN Directory, Medigap Listing, Publications (*Update!*), Fee Schedules, Local Medical Policies, EDI Format Specifications Manuals, Medipart Directories, and more..

Computer Based Training (CBT) - Free interactive electronic educational software programs for Part A and B are available to download for use in your office. These programs can be used as training and/or hiring tools. Available modules include Fraud and Abuse, ICD-9-CM, Front Office, World of Medicare, Claims Completion Require-

ments for Part B - HCFA-1500 and Part A - HCFA-1450.

(CBT is also available online www.medicaretraining.com)

WHAT YOU WILL NEED:

To access the BBS, you will need:

A Personal Computer

A telephone line with long-distance access—a dedicated line is suggested but not required

A modem—internal or external

The communication software - There are dozens of programs available such as HyperTerminal, PCAnywhere, Procomm, etc.

Most computers purchased within the last five years that have modems, include communication software. Follow your communication software instructions to set up access to the BBS using the Medicare Online BBS phone numbers.

The following two items are examples of some of the communication software options available:

Windows95/98/NT - comes with a built-in program called HyperTerminal and can be accessed by: selecting Start, then Programs, then Accessories, and then HyperTerminal. Follow the setup instructions onscreen to access the BBS.

Free Windows-based communication software is available for your use. If you are unable to use your existing software, Medicare has a Windows-based communication program available. To obtain it, send a fax request on your office letterhead (with your office name, address and contact name) to (904)791-6035.

TOLL FREE ACCESS:

Users - outside Jacksonville FL area:
(800) 838-8859

Users - within Jacksonville FL area:
(904) 791-6991

USER ID AND PASSWORD:

Upon initial access to the BBS, you will be taken through an online registration process that will **enable you to assign your own User ID and password**. It's very important that you write this information down exactly as you entered it (including any special characters). You will need your User ID and password for future access to the BBS!

BBS HELP LINE:

Questions, comments and concerns:
(904) 791-8384

*Welcome To
Medicare Online !!*

Using Windows 95/NT/98 To Access “Medicare Online BBS”

What is Medicare Online BBS?

Medicare Online BBS is an electronic Bulletin Board System (BBS) maintained at Medicare of Florida. It enables you to access vast amounts of important Medicare A and B claims processing information. This BBS is available to anyone (with no restrictions), from anywhere even outside Florida, and is available 24 hours a day, 7 days a week. Access can be obtained by using your office and/or home computer, via a TOLL FREE telephone number. All you need is a computer, telephone line, modem and communications software. The following are instructions for using a communications program included within Windows 95/NT/98 operating systems.

Using HyperTerminal

Windows 95/NT/98 includes a communications program called HyperTerminal that will allow you to connect to the Medicare Online BBS. The program includes a simple setup “wizard” used to establish your connection.

Step 1: Accessing HyperTerminal

To access the HyperTerminal program: from the Start menu, click Programs, then Accessories, then HyperTerminal.

Step 2: Setup Wizard

Look for the icon labeled “HyperTerminal”, “Hypertm”, “HyperTrm.exe” or “HYPER.TRM”. Double-click this icon to start the setup wizard.

Step 3: Connection Description

The setup wizard will ask you to name the connection and select an icon. Name the connection Medicare Online BBS (or any name you like), select the icon you want to use by clicking on it, and click OK. It doesn’t matter which icon you use; you can change it later if you like.

Step 4: Phone Number

The setup wizard will ask you for the phone number to dial. Enter the appropriate phone number and then click OK.

All users outside Jacksonville, FL
(800) 838-8859

Users within Jacksonville, FL area
791-6991

Step 5: Dialing Properties

The setup wizard allows you to revise dialing properties to make your connection. Click on Dialing Properties. Revise settings appropriately under “How I dial from this location”: how your location accesses an outside line (e.g., “9” for an outside line), long distance access (e.g., “1” for long distance), and disabling call waiting (click on selections available and choose appropriately: e.g., “*70”). When complete, click OK.

Step 6: Connect

The setup wizard will ask you to make the connection (call). At this time choose Dial to call the Medicare Online BBS.

Step 7: Signing On To Medicare Online BBS

If you are a new user to the Medicare Online BBS, type *NEW* when the system asks for your User ID. You will then complete a brief questionnaire (registration) about your practice/office, along with allowing you to assign your own User ID and password. It’s very important that you write your User ID and password down exactly as you entered it (including any special characters), as you will need it for future access to the BBS.

That’s it! - When you sign off the Medicare Online BBS and then exit HyperTerminal, be sure to save this new connection when prompted. The next time you open HyperTerminal, you will have an icon in this group titled “Medicare Online BBS.” Simply double-click on this icon to connect in the future.

Need Help? - If you have any questions or need assistance with the Medicare Online BBS, contact our BBS Help Line at (904)791-8384. When leaving your message, please speak slowly and clearly when leaving your company name, contact name, telephone number and detailed description of your inquiry. Existing users should also leave their User ID. Please do not leave your password.

FREE Windows-Based Communications Software

We suggest you try this program; it’s much more user friendly than the terminal access (which HyperTerminal uses) and makes downloading a lot easier. Once you access the BBS, you can download this program by selecting (M) at the Main Menu. If you are unable to use your existing communication software to access the BBS to download this program, it can be mailed to you. Fax your request to (904)791-6035, or contact the BBS Help Line at (904)791-8384. ❖

ORDER FORM - 1999 PART A MATERIALS

The following materials are available for purchase by Medicare providers. To order these items, please complete and **submit this form along with your check/money order (PAYABLE TO: First Coast Service Options, Inc. account number 756134)**

NUMBER ORDERED	ITEM	COST PER ITEM
	Medicare Part A UB-92 Manual - This document contains the allowable billing entries for all 86 form locators on the UB-92 HCFA-1450 billing form.	\$ 25.00
	Skilled Nursing Facility (SNF) Manual - This document contains specific Health Care Financing Administration (HCFA) guidelines as they pertain to SNF providers and services. Descriptions of some of the key UB-92 HCFA-1450 form locators and billing elements.	\$ 25.00
	Comprehensive Outpatient Rehabilitation Facility (CORF) and Outpatient Rehabilitation Facility (ORF) Manual - This document contains specific Health Care Financing Administration (HCFA) guidelines as they pertain to the CORF and ORF providers and services. Descriptions of some of the key UB-92 HCFA-1450 form locators and billing elements.	\$ 25.00
	Partial Hospitalization Program (PHP) Manual - This document contains specific Health Care Financing Administration (HCFA) guidelines as they pertain to the Medicare outpatient partial hospitalization benefit, eligibility, and scope of services. Descriptions of some of the key UB-92 HCFA-1450 form locators and billing elements.	\$ 25.00
	Medicare Part A Bulletin Subscription - For non-providers (e.g., billing agencies, consultants, software vendors, etc.) or providers who need additional copies at other office locations, an annual subscription is available. This subscription includes all Medicare bulletins published during calendar year 1998. Please check here if this will be a Subscription Renewal <input type="checkbox"/> or New <input type="checkbox"/>	\$ 125.00
	Reason Codes CD ROM -The Reason Codes list provides comprehensive definitions of the intermediary's locally assigned five-digit reason code messages identifying claims payment, Return to Provider (RTP), Rejects, and/or Denials.	\$15.00

Subtotal \$ _____

Tax (6.5%) \$ _____

Total \$ _____

Mail this form with payment to:

Medicare Part A

Program Relations Department

P.O. Box 45280

Jacksonville, FL 32231-0048

Facility Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Attention: _____ Area Code/Telephone Number: _____

“LET’S TALK” SESSION with the Management and Leaders of FIRST COAST SERVICE OPTIONS, INC. October 21, 1999

You are cordially invited to a powerful half-day session with your Intermediary’s Leadership Team.

This session will provide an opportunity to:

- meet key representatives from Medicare and discuss issues related to the Medicare Part A provider community
- establish a communications network with other providers
- launch your facility to peak performance by gaining strategies to implement efficiency-improving processes

Your feedback has been instrumental in key operational improvements for First Coast Service Options, Inc. (a subsidiary of Blue Cross Blue Shield of Florida, Inc.). You have proven that partnership works. Recent improvements to our new **Medicare A Bulletin**, enhancements to our customer service automated response unit (ARU), and the development of new Medicare Part A courses (e.g., Reimbursement Efficiency for Part A Providers) are direct results of your feedback.

Key performance goals for fiscal year 2000 (October 1, 1999 through September 2000) include working with the provider community to achieve the following:

- | | |
|---|--|
| • improve service delivery | • improve services to the beneficiary |
| • reduce administrative expenses | • protect Medicare benefit payouts |
| • increase awareness of key program policies and procedures | • improve overall program delivery and requirements by serving as a catalyst for program changes |

Your feedback is important to us. Take advantage of this opportunity to effect change! Seating is limited. Secure your reservation today!

“LET’S TALK” SESSION with the Management and Leaders of FIRST COAST SERVICE OPTIONS, INC. October 21, 1999

Registration Form for Medicare Part A Providers

Registrant's Name: _____

Registrant's Title/Position: _____

Provider's Name: _____

Medicare Billing Provider Number: _____

Address: _____

City, State, Zip Code: _____

Phone: () _____ Fax: () _____

Note: Please complete one form per person.

Mark your Calendar:

Date: Thursday, October 21, 1999

Time: 12:00 p.m. - 4:00 p.m.

Cost: **None - It's Free!!**

Location:

Adam's Mark Of Orlando

1500 Sand Lake Road

Orlando, Florida 32809

For directions, please contact the hotel at (407) 859-1500

Influenza Virus Vaccine Roster

Provider Payee Name _____

Provider Number _____ Date of Service _____

Number	Insured's I.D. number	Patient's Name (Last, First, Middle Initial)	Patient's Address (Number, street, city, ZIP code)	Patient's date of birth	Patient's sex	Patient's signature, or "signature on file"
00						
01						
02						
03						
04						
05						
06						
07						
08						
09						

Pneumococcal Pneumonia Virus Vaccine Roster

Provider Payee Name _____

Provider Number _____ Date of Service _____

Number	Insured's I.D. number	Patient's Name (Last, First, Middle Initial)	Patient's Address (Number, street, city, ZIP code)	Patient's date of birth	Patient's sex	Patient's signature, or "signature on file"
00						
01						
02						
03						
04						
05						
06						
07						
08						
09						

Warning! Ask beneficiaries if they have been vaccinated with PPV

- Rely on patient's memory to determine prior vaccination status
- If patients are uncertain whether they have been vaccinated within the past 5 years, administer the vaccine
- If patients are certain they have been vaccinated within the past 5 years, do not revaccinate

A

Abortion, Elective: 59840, 59841, 59850-59852, 59855-59857, 59866	Jun/Jul 1999	31
Ambulance Services, Revision and Clarification of Final Rule on	Oct/Nov 1999	44
Angina, Severe, Transmyocardial Revascularization (TMR) for Treatment of	Jun/Jul 1999	109
Anti-Cancer Prodrugs, FDA Approved, Oral, Coverage of	Aug/Sep 1999	9
Antiemetic Drugs, Oral, Modification for: Q0163-Q0181	Aug/Sep 1999	9
Antigen, Extractable Nuclear: 86235	Jun/Jul 1999	54
Antigen, Free Prostate Specific: 84154	Jun/Jul 1999	52
Antineoplastic Drugs: J9000, J9170, J9350, J9999	Jun/Jul 1999	24
Are You Ready for the Year 2000?	Jun/Jul 1999	5
Assisted Suicide Funding Restriction Act of 1997	Aug/Sep 1999	5

B

BBS (Medicare Online)	Oct/Nov 1999	51
BBS, Medicare Online, Using Windows 95/NT/98 to Access	Oct/Nov 1999	52
Beneficiary Right to Itemized Statement for Medicare Items and Services	Jun/Jul 1999	8
Billing Instructions for EECF	Aug/Sep 1999	12
Billing Guidelines for Influenza and Pneumococcal Pneumonia Vaccines	Oct/Nov 1999	6
Bills, Requirement to Submit in Sequence for a Continuous Inpatient Stay or Course of Treatment	Jun/Jul 1999	6
Bioimpedance, Electrical, Cardiac Output Monitoring by: M0302	Jun/Jul 1999	107
Blood Clotting Factor Administered to Hemophilia Inpatients, Payment for	Jun/Jul 1999	113
Blood Testing, Fecal Occult: 82270	Jun/Jul 1999	47
Bone Mineral Density Studies, Addition to Coverage of: 76075	Aug/Sep 1999	14

C

Cardiac Catheterization: 93501, 93510, 93511, 93514, 93524, 93527-93529, 93530-93533	Jun/Jul 1999	89
Cardiac Output Monitoring by Electrical Bioimpedance: M0302	Jun/Jul 1999	107
Ceredase/Cerezyme: J0205, J1785	Jun/Jul 1999	22
Claims, Inpatient or Hospice, Need to Reprocess Claims in Sequence When Liability Changes	Jun/Jul 1999	7
Computed Tomography of the Pelvis: 72192-72194	Jun/Jul 1999	37
Computed Tomography of the Pelvis: 72192	Aug/Sep 1999	14
Coverage and Billing Guidelines for Enhanced External Counter- pulsation (EECP): 97016	Jun/Jul 1999	108
Cryosurgery of Prostate: G0160, G0161	Jun/Jul 1999	107
Cryosurgical Ablation of the Prostate: G0160, G0161	Jun/Jul 1999	20
Computed Tomography of the Pelvis: 72192-72194	Jun/Jul 1999	37

D

Date of Service, Line Item	Jun/Jul 1999	7
Defibrillators, Automatic, Implantation of: 33246	Jun/Jul 1999	107
Dialysis Coverage, Clarification of, for Skilled Nursing Facility Residents	Oct/Nov 1999	48
Doxorubicin HCL, Correction to Coverage for: J9000	Aug/Sep 1999	14
Drug Screen, Qualitative: 80100-80102	Jun/Jul 1999	44
Due Date for Filing Provider Cost Reports, More Information About the Extension of	Jun/Jul 1999	9
Duplex Scanning: 93975-93979	Jun/Jul 1999	95

E

Edits, Removal of, Requiring Providers to Submit Home Health Claims in Sequence	Jun/Jul 1999	6
Electronic Health Care Transaction Formats, Adoption of Standard	Oct/Nov 1999	46
EECP, Billing Instructions for	Aug/Sep 1999	12
EECP, Enhanced External Counterpulsation, Coverage and Billing Guidelines for: 97016	Jun/Jul 1999	108
Extractable Nuclear Antigen: 86235	Jun/Jul 1999	54

F

Fecal Occult Blood Testing: 82270	Jun/Jul 1999	47
Fluorescein Angiography: 92235	Jun/Jul 1999	74
Flu and Pneumococcal Vaccination Campaign, the 1999/2000, is Under Way! Mobilize to Immunize!	Oct/Nov 1999	3
Flu: Promoting Influenza and Pneumococcal Vaccinations	Aug/Sep 1999	7
Fraud and Abuse, Floridians Can Help Fight Medicare	Oct/Nov 1999	17
Fraud: DHHS Announces Expanded "Senior Patrol" Grants to Help Spot Waste, Fraud, and Abuse in Medicare and Medicaid	Aug/Sep 1999	38
Free Medicare Training Courses	Aug/Sep 1999	33
Free Prostate Specific Antigen: 84154	Jun/Jul 1999	52

H

Hyperbaric Oxygen Therapy: 99183	Jun/Jul 1999	101
Hyperbaric Oxygen Therapy (99183), Delay in	Aug/Sep 1999	14
HCFA Y2K Outreach Toll-Free Line, Implementation of	Jun/Jul 1999	6
Hemophilia Inpatients, Payment for Blood Clotting Factor Administered to	Jun/Jul 1999	113
Hepatitis C Lookback, Qualified Candidates for	Jun/Jul 1999	110
Holter Monitoring: 93224-93227, 93231-93237	Jun/Jul 1999	80
Home Health Care: Fifteen- Minute Reporting Update	Aug/Sep 1999	39

I

Implantation of Automatic Defibrillators: 33246	Jun/Jul 1999	107
Indocyanine-Green Angiography: 92240	Jun/Jul 1999	78
Interest Rate for Overpayments and Underpayments, Notice of New	Oct/Nov 1999	16
Internet: Health Care Related Web Sites	Aug/Sep 1999	6

Internet, Sanctioned Provider Information Available on the	Aug/Sep 1999	6
Into the Future (From the Intermediary Medical Director)	Aug/Sep 1999	3
Itemized Statement, Beneficiary Right to, for Medicare Items and Services	Jun/Jul 1999	8

L

Laboratory Services	Jun/Jul 1999	114
Laboratory Services, Rural Health Clinic (RHC)	June/July 1999	114
Laboratory Tests and Venipunctures Performed in an RHC	Jun/Jul 1999	114
"LET'S TALK" Session (October 21)	Oct/Nov 1999	54
Liability Changes, Need to Reprocess Inpatient or Hospice Claims in Sequence When	Jun/Jul 1999	7
Line Item Date of Service	Jun/Jul 1999	7
Liver Transplant Centers, Addition to List of Approved	Oct/Nov 1999	16
Local Medical Review Policies	Aug/Sep 1999	13

M

Medicare Remarks Codes, Additions and Changes to the	Jun/Jul 1999	9
Medifest Information	Aug/Sep 1999	34
Medicare Online (BBS)	Oct/Nov 1999	51
Medicare Online, BBS, Using Windows 95/NT/98 to Access	Oct/Nov 1999	52

N

Need to Reprocess Inpatient or Hospice Claims in Sequence When Liability Changes	Jun/Jul 1999	7
New Waived Tests	Jun/Jul 1999	110
..... Aug/Sep 1999		11
Nuclear Antigen, Extractable: 86235	Jun/Jul 1999	54

O

Ophthalmoscopy: 92225, 92226	Jun/Jul 1999	70
Overpayments: New Form to Report Unsolicited/Voluntary Refund Checks	Aug/Sep 1999	7

P

Pancreas Transplantation: 48554	Jun/Jul 1999	108
Pap Smears: 88142-88155, 88164- 88167, G0123, G0143-G0145, G0147, G0148, P3000	Jun/Jul 1999	56
Part A Materials, 1999, Order Form	Oct/Nov 1999	53
Patient Demand Single or Multiple Event Recorder: 93012, 93268, 93270, 93271, G0004-G0006, G0015	Jun/Jul 1999	84
Payment for Blood Clotting Factor Administered to Hemophilia Inpatients	Jun/Jul 1999	113
PET Scan: G0030-G0047, G0125, G0126, G0163-G0165	Jun/Jul 1999	13
Phone Numbers	Back Cover	
Previously Published Policies, Revisions to 64573, 721792, 76075, J9000	Aug/Sep 1999	14
Prodrugs, FDA Approved, Oral Anti- Cancer, Coverage of	Aug/Sep 1999	9
Prostate, Cryosurgery of: G0160, G0161	Jun/Jul 1999	107
Prostate Specific Antigen, Free: 84154	Jun/Jul 1999	52
Psychotherapy, Family: 90846, 90847, 90849	Jun/Jul 1999	61

Q

Qualified Candidates for Hepatitis C Lookback	Jun/Jul 1999	110
Qualitative Drug Screen: 80100-80102	Jun/Jul 1999	44

R

Radiochemicals not Covered	Jun/Jul 1999	110
Recorder, Event, Patient Demand Single or Multiple: 93012, 93268, 93270, 93271, G0004-G0006, G0015	Jun/Jul 1999	84
Refund Checks, New Form to Report Unsolicited/Voluntary	Aug/Sep 1999	7
Remarks Codes, Medicare, Additions and Changes to the	Jun/Jul 1999	9
Removal of Edits Requiring Providers to Submit Home Health Claims in Sequence	Jun/Jul 1999	6
Reopenings for Sole Community and Medicare Dependent Hospital Open Cost Reports Affected by the Cost Report Change	June/July 1999	113
Requirement to Submit Bills in Sequence for a Continuous Inpatient Stay or Course of Treatment	June/July 1999	6
RHC, Venipunctures and Laboratory Tests Performed in an	Jun/Jul 1999	114
Rural Health Clinic (RHC) Laboratory Services	June/July 1999	114

S

Sanctioned Provider Information Available on the Internet	Aug/Sep 1999	6
Scanning, Duplex: 93975-93979	Jun/Jul 1999	95
Statement, Itemized, for Medicare Items and Services, Beneficiary Right to	Jun/Jul 1999	8
Suicide, Assisted, Funding Restriction Act of 1997	Aug/Sep 1999	5

T

Training Courses, FREE Medicare	Oct/Nov 1999	50
Transmyocardial Revascularization (TMR) for Treatment of Severe Angina	Jun/Jul 1999	109
Transplantation, Pancreas: 48554	Jun/Jul 1999	108

V

Vaccine Benefit, 1999 Medicare Influenza Questions & Answers	Oct/Nov 1999	7
Vaccine Benefit, 1999 Medicare Influenza Virus Oct/Nov 1999		7
Vaccine (PPV) Benefit, 1999 Medicare Pneumococcal Questions & Answers	Oct/Nov 1999	12
Vaccine (PPV) Benefit, 1999 Medicare Pneumococcal	Oct/Nov 1999	11
Vagus Nerve Stimulation: 61885, 64573, 64585, 64590, 64595, 95970, 95971, 95974, 95975	Jun/Jul 1999	33
Vagus Nerve Stimulation, Correction to Coverage of	Aug/Sep 1999	14
Venipunctures, Laboratory Tests and, Performed in an RHC	Jun/Jul 1999	114
Visual Field Examination: 92081-92083	Jun/Jul 1999	64

W

Waived Tests, New	Jun/Jul 1999	110
..... Aug/Sep 1999		11
Windows 95/NT/98, Using, to Access Medicare Online BBS	Jun/Jul 1999	116
Winds Of Change, The (From the Intermediary Medical Director)	Jun/Jul 1999	3

Y

Y2K Future Date Testing Available	Aug/Sep 1999	5
Y2K, HCFA Outreach Toll-Free Line, Implementation of	Jun/Jul 1999	6
Y2K Provider Readiness Survey Results Reveal Providers Have Some Work to Do	Aug/Sep 1999	5
Year 2000?, Are You Ready for the	Jun/Jul 1999	5
Year 2000 Medicare Claims, Submitting, Processing, and Paying in the	Oct/Nov 1999	5
Y2K Readiness for PC-ACE™ Software	Oct/Nov 1999	6

CPT C ODES

00100-69979, Anesthesia/Surgery

33223: Implantation of Automatic Defibrillators	Oct/Nov 1999	19
33246, Implantation of Automatic Defibrillators	Jun/Jul 1999	107
48554, Pancreas Transplantation	Jun/Jul 1999	108
Revision to Pancreas Transplantation Coverage	Oct/Nov 1999	45
53850: Prostate Treatments	Oct/Nov 1999	20
59840, 59841, 59850-59852, 59855-59857, 59866, Elective Abortion	Jun/Jul 1999	31
61885, 64573, 64585, 64590, 64595, Vagus Nerve Stimulation	Jun/Jul 1999	33

70010-89399, Diagnostic Tests

70450, Computerized Tomo- graphy Scans	Aug/Sep 1999	15
70541: Magnetic Resonance Angio- graphy (MRA)	Aug/Sep 1999	18
72192-72194, Computed Tomography of the Pelvis	Jun/Jul 1999	37
80100-80102, Qualitative Drug Screen ..	Jun/Jul 1999	44
82270, Fecal Occult Blood Testing	Jun/Jul 1999	47
84154, Free Prostate Specific Antigen ..	Jun/Jul 1999	52
85044: Reticulocyte Count	Aug/Sep 1999	20
86235, Extractable Nuclear Antigen ...	Jun/Jul 1999	54
86706: Hepatitis B Surface Antibody and Surface Antigen	Oct/Nov 1999	23
86781: Fluorescent Treponemal Antibody Absorption (FTA-abs)	Aug/Sep 1999	21
88142-88155, 88164-88167, Pap Smears	Jun/Jul 1999	56
88230: Cytogenetic Studies	Oct/Nov 1999	27

90281-99199, Medicine

90846, 90847, 90849, Family Psychotherapy	Jun/Jul 1999	61
92081-92083, Visual Field Examination	Jun/Jul 1999	64
92225, 92226, Ophthalmoscopy,	Jun/Jul 1999	70
92235, Fluorescein Angiography.....	Jun/Jul 1999	74
92240, Indocyanine-Green Angiography.....	Jun/Jul 1999	78
93012, Patient Demand Single or Multiple Event Recorder	Jun/Jul 1999	84
93000: Electrocardiography	Aug/Sep 1999	22
93224-93227, 93231-93237, Holter Monitoring	Jun/Jul 1999	80
93268, 93270, 93271, Patient Demand Single or Multiple Event Recorder	Jun/Jul 1999	84
93501, 93510, 93511, 93514, 93524, 93527-93529, 93530-93533, 93975-93979, Duplex Scanning	Jun/Jul 1999	95
93875: Noninvasive Extracranial Arterial Studies	Oct/Nov 1999	29
95970, 95971, 95974, 95975,		

Vagus Nerve Stimulation	Jun/Jul 1999	33
97016, Coverage and Billing Guidelines for Enhanced External Counterpulsation (EECP)	Jun/Jul 1999	108
99183, HBO Therapy	Jun/Jul 1999	101
99183, Delay in Implementation.....	Aug/Sep 1999	14

HCPCS CODES

G0004-G0006, G0015, Patient Demand Single or Multiple Event Recorder	Jun/Jul 1999	84
G0030-G0047, PET Scan	Jun/Jul 1999	13
G0102-G0103: Coverage for Prostate Cancer Screening	Oct/Nov 1999	45
G0104: Colorectal Cancer Screening	Aug/Sep 1999	24
G0123, Pap Smears	Jun/Jul 1999	56
G0125, G0126, PET Scan	Jun/Jul 1999	13
G0143-G0145, G0147, G0148, Pap Smears	Jun/Jul 1999	56
G0160, G0161, Cryosurgery of Prostate	Jun/Jul 1999	107
G0160, G0161, Cryosurgical Ablation of the Prostate	Jun/Jul 1999	20
G0163-G0165, PET Scan	Jun/Jul 1999	13
J0205, J1785, Ceredase/Cerezyme	Jun/Jul 1999	22
J0585: Botulinum Toxin Type A (Botox)	Oct/Nov 1999	32
J0850: Cytomegalovirus Immune Globulin (Human), Intravenous (CMV-IGIV)	Aug/Sep 1999	26
J1561: Intravenous Immune Globulin.....	Oct/Nov 1999	35
J1950: Leuprolide Acetate	Oct/Nov 1999	39
J9000, J9170, J9350, J9999, Antineoplastic Drugs	Jun/Jul 1999	24
J9000: Doxorubicin HCL, Correction to Coverage for:	Aug/Sep 1999	14
J9170, J9350, J9999, Antineoplastic Drugs	Jun/Jul 1999	24
M0302, Cardiac Output Monitoring by Electrical Bioimpedance	Jun/Jul 1999	107
P3000, Pap Smears	Jun/Jul 1999	56
Q9920, Chronic Renal Failure Erythropoietin	Aug/Sep 1999	27
PAINREH: Pain Rehabilitation	Oct/Nov 1999	41

PHONE NUMBERS

PROVIDERS

Automated Response Unit:
904-355-8899

Customer Service Reps:
904-355-8899

Medicare Online BBS

Access:
800-838-8859
904-791-6991

Technical Problems:
904-791-8384

BENEFICIARY

904-355-8899

EMC

EMC Start-Up:
904-791-8767

EMC Front-End Edits/Rejects:
904-791-8767

Electronic Remittance Advice:
904-791-6895

Electronic Claim Status:
904-791-6895

Electronic Eligibility:
904-791-6895

PC-ACE Support:
904-355-0313

Testing:
904-791-6865

Help Desk (Confirmation/Transmission):
904-791-9880