

Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

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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
- _____
- _____
- _____
- _____



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Into the Future

Medicare continues to take an active approach to education and coverage of new services for beneficiaries.

Recognizing the power of multimedia communication, Medicare has recently launched a new Web site, the National Medicare Education Program (NMEP), in collaboration with private organizations and senior alliances. The NMEP creates a coordinated Medicare educational network extending from a national level to a community level. This Web site is intended to educate and empower Medicare beneficiaries to make informed choices as wise consumers in a dynamic health care system.

Department of Health and Human Services (DHHS) Secretary, Donna Shalala, in her opening statement of the NMEP, acknowledged that informing present and future beneficiaries about the changing Medicare system is a large undertaking, but one that cannot be ignored. The challenge, according to Secretary Shalala, is to help beneficiaries understand that, although new plan options and services are available, traditional fee-for-service Medicare remains an acceptable choice. More details on the NMEP and ongoing information updates can be found on the Web site: www.nmep.org.



Medicare coverage processes are also being redesigned to be more open and accessible via the Internet, to inform the public of the progress and determination of issues under coverage review, and to provide email contact so interested parties may send comments and feedback. This Web site is www.hcfa.gov/quality.

Continuing with this active approach, Medicare has been evaluating new, innovative techniques and treatments not traditionally covered by Medicare. This has resulted in a number of new national coverage policies. Among these are cryosurgery of the prostate gland, which uses extremely cold temperatures to treat patients with prostate cancer. (It is important to note that cryosurgery of the prostate for *advanced cancer* remains a noncovered service under Medicare.) Another example is the new national policy for coverage of pancreas transplantation. An overview of this and other new policies are included in the Medical Policy section of the June/July 1999 *Medicare A Bulletin*. We expect Medicare to continue to be on the cutting edge by creating policies for coverage of new technology as we move into the next millennium.

Sincerely,

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

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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

Y2K Provider Readiness Survey Results Reveal Providers Have Some Work to Do...

In a recent survey conducted by First Coast Service Options, Inc. (FCSO), providers were asked about their "readiness" for Y2K. Here are some of the key results.

The good news is that 92 percent of the responding providers said they consider their practice (computer systems, telephone systems, etc.) Y2K compliant. Unfortunately, only 51 percent of the responding providers have a contingency plan in place, in the event one or more failures occur. In other words, only half the providers who responded to the survey have taken time to think through and develop a backup plan for potential Y2K related failures. Even if providers have a contingency plan, they should discuss the issue with whom they do business (e.g., computer vendor, billing service) to ensure those organizations have a backup plan, too. For example, what action will the billing service take if claims cannot be transmitted electronically?

More than 87 percent of the responding providers said they have *no* special plan to reduce claim filing or review inventory before **January 1, 2000**. However, most providers reported that when filing claims they stay fairly current by filing within 1-3 days from the date of the service. Medicare is urging providers to keep claim and review filing inventories current. That means claims should be filed within 5 days from the date of service.

Providers should file review requests as soon as determinations they disagree with are received. Medicare is requesting that **all** inventories be depleted by no later than **October 1, 1999**.

This document is a Year 2000 disclosure made pursuant to the Year 2000 Information and Readiness Disclosure Act (S.2392). Your legal rights regarding the use of the statements made herein may be substantially limited as provided in the Act. ❖

Y2K Future Date Testing Available

The Health Care Financing Administration (HCFA) has instructed contractors to make available to providers the ability to test electronic claim submissions in a future date environment. First Coast Service Options, Inc. (FCSO) is offering this Y2K testing utility to the healthcare community from September 1, 1999, through October 29, 1999. To participate in Y2K future date testing with FCSO, please call Mary Anne Zingaro of the Medicare EDI Department at (904) 791-8769 or submit a written request to the address below:

**Medicare EDI Department - 7 Center
P. O. Box 44071
Jacksonville, FL 32231**

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GENERAL INFORMATION

Assisted Suicide Funding Restriction Act of 1997

The Assisted Suicide Funding Restriction Act of 1997 (Public Law 105-12) prohibits the use of federal funds to provide or pay for any health care item or service, or health benefit coverage for the purpose of causing, or assisting to cause, the death of any individual. The prohibition does not pertain to the withholding or withdrawing of medical treatment or care, nutrition or hydration. In addition, the prohibition does not pertain to the provision of an item or service for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so

long as the item or service is not furnished for the specific purpose of causing death.

Medicare payment for such services is already excluded by section 1862 (a) (1) (A) of the Act, which states that no payment may be made under Part A or Part B for any expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. ❖

Sanctioned Provider Information Available on the Internet

The Office of the Inspector General (OIG) keeps public records of individuals/entities that are excluded from reimbursement under Medicare (Title XVIII of the Social Security Act). This information is available on the Internet.

Providers may access www.arnet.gov/epls for the list of debarred, excluded, and suspended providers and entities. This Web site is updated daily. ❖

Health Care-Related Web Sites

The following list of Web sites is published solely as a helpful tool for finding information related to the Medicare program, health care and health care quality issues.

Medicare Program

- Medicare Computer Based Training (CBT)
www.medicaretraining.com
- Health Care Financing Administration (HCFA) Home Page, National Provider System
www.hcfa.gov
- Medicare Coverage Issues
www.medicare.gov
www.hcfa.gov
- HCFA National Education Program
www.nmed.org
- HCFA Transmittals
www.hcfa.gov/pubforms/transmit
- HCFA 1500, UB-92 (1450) Claim Forms, Electronic Data Interchange (EDI) Formats
www.hcfa.gov/medicare/edi/edi.htm
- Electronic Claim Format, Year 2000 (Y2K) Claim Specifications
www.hcfa.gov/medicare/edi3.htm
- Paper Claims, 1491-1490 Ambulance Claim Forms, Year 2000 (Y2K) Claim Specifications
www.hcfa.gov/medicare/edi5.htm
- Evaluation & Management (E&M) Documentation Information
www.hcfa.gov/medicare/mcarpti.htm
- Clinical Laboratory Fee Schedules
www.hcfa.gov/stats/pufiles.htm
- SNF/PPS Consolidated Billing
www.hcfa.gov/medicare/cbqa.htm and
www.hcfa.gov/medicare/ppsq.htm
- Correct Coding Initiative (CCI) Information & Ordering
www.ntis.gov/ccii
- Medicare Program Safeguards**
- DHHS, Office of the Inspector General (OIG) Fraud Alert
www.dhhs.gov/proorg/oig/frdalrt/index.htm
- Compliance Program/Workplan
www.dhhs.gov/proorg/oig
- Government Services Administration (GSA) Debarment, Exclusion, and Suspension List
www.arnet.gov/epls/
- Department of Health and Human Services Database for all Sanctioned Providers
www.hhs.gov

Government-Related

- American Compliance Institute, Alexandria, VA
www.compliance.com
- Consumer Information Health and Health Care Quality
www.consumer.gov
- Center for Healthcare Information Management
www.chim.org
- Coalition Against Insurance Fraud, Washington, DC
www.insurancefraud.org
- Code of Federal Regulations
www.access.gpo.gov/nara/cfr/index.html
- Congressional Record
www.access.gpo.gov/su-docs/aces/aces150.html
- False Claims Act Legal Center, Taxpayers Against Fraud
www.access.taf.org
- Federal Register
www.access.gpo.gov/su_docs/
- Department of Justice
www.usdoj.gov
- National Health Care Anti-Fraud Association
www.nhcaa.org
- Supreme Court Decisions
www.law.cornell.edu
- U.S. House of Representatives
www.house.gov
- U.S. Senate
www.senate.gov
- U.S. Sentencing Commission
www.ussc.gov
- Agency for Health Care Administration (AHCA)
www.fdhc.state.fl.us/medicaid/index.html

Medical Associations

- Florida Medical Association
www.fmaonline.org
- Florida Hospital Association
www.fha.org

For Year 2000 (Y2K) issues refer to *Medicare A Bulletin* G-361, page 13, issued January 25, 1999. ❖

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Promoting Influenza and Pneumococcal Vaccinations

The flu season is here! Please remember to promote influenza and pneumococcal vaccinations, both Medicare Part B covered preventive health care benefits. These vaccines greatly reduce hospital admissions for pneumonia and deaths due to complications from influenza. Research shows that a provider's recommendation is a strong motivator for a patient to get vaccinated.

Standing orders are one example of an effective strategy that a hospital, public health clinic, or nursing home can use to increase immunization rates. For example, a physician could write a standing order in the hospital inpatient setting requiring the assessment and vaccination of all Medicare patients. A missed opportunity in the inpatient hospital setting occurs when a beneficiary is discharged without being offered and receiving an influenza and/or pneumococcal vaccination. Missed opportunities can often result in a beneficiary being readmitted to a hospital for influenza and related illnesses, like pneumonia. Unfortunately, missed vaccination opportunities occur in all settings. Strategies aimed at modifying systems for delivering care, such as standing orders, are one way of reducing missed

opportunities. Please note that a standing order is not required for Medicare coverage of influenza immunizations, but it is required for coverage of pneumococcal vaccinations.

Other strategies are also effective in reducing missed vaccination opportunities. Health care providers and their office personnel can promote influenza and pneumococcal vaccinations by hanging posters on the facility walls to function as reminders for both the provider and his/her patients, and by using wall charts to track immunizations. Most importantly, physicians can make influenza and pneumococcal vaccinations available in their office or refer patients to other health care providers for these vaccinations. Postcards and phone calls to patients to remind them to get vaccinated are also powerful incentives.

The most effective strategies for increasing influenza and pneumococcal immunizations involve the health care provider. Simply put, Medicare beneficiaries are most likely to get immunized when their health care provider *specifically recommends vaccination*. We ask that providers realize their significant roles and discuss and promote influenza and pneumococcal vaccinations with their patients.

Please remember that while influenza immunizations are seasonal and should be given every year in the fall, pneumococcal vaccinations can be given at any time of the year. Generally, one pneumococcal vaccination after the age of 65 is all a person needs to be protected for a lifetime. However, persons who are considered at highest risk, such as persons with chronic illnesses, like diabetes, and cardiovascular or pulmonary disease, and people with compromised immune systems, like chronic renal failure, should discuss the necessity of a booster pneumococcal vaccination with their doctor. If any person 65 and over is unsure of his/her pneumococcal vaccination status, revaccination is recommended and will be covered by Medicare Part B.

Your Medicare contractor can provide you with free brochures and posters to display in general areas, to promote both influenza and pneumococcal vaccinations. To request these materials or for instructions on how to bill Medicare for influenza and pneumococcal vaccinations, please call Medicare Part A Customer Service at (904) 355-8899. ❖

New Form to Report Unsolicited/Voluntary Refund Checks

Medicare fiscal intermediaries generally receive voluntary refunds from providers in the form of an adjustment bill. Occasionally, a provider may send a check or report the voluntary refund as a credit balance. When the fiscal intermediary receives these checks with insufficient or missing information, the outcome causes delays and incorrect posting of the funds.

Medicare has developed the "Overpayment Refund" form (see sample on the following page) to assist providers with the return of voluntary refunds. If this form is properly filled out and submitted with a voluntary refund check, the payment will be credited timely and accurately.

The Office of the Inspector General (OIG), working with the Department of Justice and the Health Care Financing Administration (HCFA), has developed two initiatives to combat health care fraud and abuse by encouraging health care providers to comply with the federal health care rules and regulations.

- *Compliance Program Guidance* — a **voluntary** initiative providing guidance, recommendations, and suggestions to health care providers, to establish an internal self-monitoring process that will aid them in detecting potentially fraudulent and/or abusive practices resulting in overpayments due the Medicare program.
- *Corporate Integrity Agreements (CIA)* — a **mandatory** initiative entered into between a health care provider and OIG. In a CIA, the provider is required to undertake specific compliance obligations, such as designating a compliance officer, undergoing training, and being audited. The provider must report compliance activities on an annual basis to OIG.

Both initiatives are designed to assist providers to properly refund inappropriately received Medicare trust funds.

Providers should indicate on the Overpayment Refund form if they are subject to a CIA initiative when sending a refund, in order to credit the global settlement being reported to OIG. ❖

OVERPAYMENT REFUND

TO BE COMPLETED BY MEDICARE CONTRACTOR

Date: _____
Contractor Deposit Control # _____ Date of Deposit: _____
Contractor Contact Name: _____ Phone # _____
Contractor Address: _____
Contractor Fax: _____

TO BE COMPLETED BY PROVIDER/PHYSICIAN/SUPPLIER

Please complete and forward to:

Medicare Part A
P. O. Box 2711
Jacksonville, FL 32231-0048

This form, or a similar document containing the following information, should accompany every voluntary refund so that receipt of check is properly recorded and applied.

PROVIDER/PHYSICIAN/SUPPLIER NAME _____
ADDRESS _____
PROVIDER/PHYSICIAN/SUPPLIER # _____ CHECK NUMBER _____
CONTACT PERSON: _____ PHONE (____) _____
AMOUNT OF CHECK \$ _____ CHECK DATE _____

REFUND INFORMATION

For each claim, provide the following:

Patient Name _____ HIC # _____
Medicare Claim Number _____ Claim Amount Refunded \$ _____
Reason Code for Claim Adjustment: _____ (Select reason code from list below. Use one reason per claim)

(Please list all claim numbers involved. Attach separate sheet, if necessary)

Note: If Specific Patient/HIC/Claim #/Claim Amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine amount and reason for overpayment: _____

For Institutional Facilities Only:

Cost Report Year(s) _____
(If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)

For OIG Reporting Requirements:

Do you have a Corporate Integrity Agreement with OIG? _____ Yes _____ No

Reason Codes:

Billing/Clerical Error	MSP/Other Payer Involvement	Miscellaneous
01 - Corrected Date of Service	08 - MSP Group Health Plan Insurance	13 - Insufficient Documentation
02 - Duplicate	09 - MSP No Fault Insurance	14 - Patient Enrolled in an HMO
03 - Corrected CPT Code	10 - MSP Liability Insurance	15 - Services Not Rendered
04 - Not Our Patient(s)	11 - MSP, Workers Comp.(Including	16 - Medical Necessity
05 - Modifier Added/Removed	Black Lung	17 - Other (Please Specify)
06 - Billed in Error	12 - Veterans Administration	_____
07 - Corrected CPT Code		

GENERAL COVERAGE

Coverage Expansion of Certain Oral Anti-Cancer Drugs to Include FDA Approved Oral Anti-Cancer Prodrugs

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) provided for coverage of certain oral drugs used to treat patients with cancer. Under the original interpretation of the law, Medicare paid for certain oral anti-cancer drugs only if that drug has the same active ingredients as a non-self-administered drug. In addition, both the injectable and the oral drug must have the same chemical and generic name and be approved for the same indications.

Based on recent advances in drug technology, Medicare has reexamined its initial interpretation and now allows for coverage of certain oral anti-cancer drugs called "prodrugs" (e.g., prodrugs specifically used as anti-cancer drugs) when these drugs are approved by the Food and Drug Administration (FDA). Prodrugs have the same active ingredients in the body as injectable anti-cancer drugs. An oral drug may have a different chemical composition as an injectable drug at the outset, but will have the same chemical composition as the injectable drug when the body metabolizes the oral drug. Hence, this broader interpretation permits coverage of alternative forms of administration of the drug.

Coverage Expansion Effective Date

Coverage for FDA-approved oral anti-cancer prodrugs is effective for claims with dates of service **on or after January 1, 1999**.

Billing Requirements

FDA-approved oral anti-cancer prodrugs must be billed using the UB-92 HCFA-1450 claim form or its electronic equivalent, by following the general filing instructions.

Reporting and Coding Requirements

FDA-approved oral anti-cancer prodrugs must be reported under revenue code 636 and HCPCS level II code J8999 (prescription drug oral, chemotherapeutic, not otherwise specified). Additional reporting requirements are:

- Name of the FDA-approved oral anti-cancer prodrug(s)
- Number of units (one tablet or capsule equals one unit)
- Diagnosis of cancer

The following chart is a guide for reporting FDA-approved oral anti-cancer prodrugs.

Reporting Requirements	UB-92 HCFA-1450 Form Locator (FL)
Revenue Code 636	42
Name of the Prodrug	43
HCPCS-II J8999	44
Number of Units	46
Total Charges	47
Diagnosis of Cancer	67-75
Patient Control Number	3

Reimbursement Guidelines

Payment for FDA-approved oral anti-cancer prodrugs for hospitals is made based on Medicare Part B methodology, which allows 95 percent of the median average wholesale price (AWP) for these drugs when furnished by a provider. Deductible and coinsurance apply.

Payment for oral anti-cancer drugs or FDA-approved oral anti-cancer prodrugs is denied if a diagnosis of cancer is not indicated in form locator 67-75 of the UB-92 HCFA-1450 claim form or its electronic equivalent. ❖

Q0163-Q0181: Coverage Modification for Oral Antiemetic Drugs

The coverage of oral antiemetic drugs, as full therapeutic replacements for intravenous dosage forms as part of cancer chemotherapeutic regimen, has been modified to reflect that two or more oral antiemetics used concurrently may be covered when used as a full therapeutic replacement for the intravenous form of the antiemetic therapy that would otherwise have been given during the chemotherapy treatment.

The Balanced Budget Act of 1997 extended the coverage of oral antiemetic drugs under the following conditions:

- Coverage is provided only for oral drugs approved by the FDA for use as antiemetic drugs.
- The oral antiemetic drugs must either be administered by the treating physician or in accordance with a written order from

the physician as part of a cancer chemotherapy regimen.

- Oral antiemetic drugs administered with a particular chemotherapy treatment must be initiated within 2 hours of the administration of the chemotherapeutic agent and may be continued for a period not to exceed 48 hours from that time.
- The oral antiemetic drugs provided must be used as a full therapeutic replacement for the intravenous antiemetic drugs that would have otherwise been administered at the time of the chemotherapy treatment.

Only drugs pursuant to a physician's order at the time of the chemotherapy treatment qualify for this benefit. The dispensed number of dosage units may not exceed a loading dose administered within two hours of that treatment, plus a supply of additional dosage units not to exceed 48

hours of therapy. However, more than one oral antiemetic drug may be prescribed and will be covered for concurrent usage within these parameters if more than one oral antiemetic is needed to fully replace the intravenous drugs that would otherwise have been given.

Oral drugs that are not approved by the FDA for use as antiemetics and which are used by treating physicians adjunctively in a manner incidental to cancer chemotherapy are not covered by this benefit and are not reimbursable within the scope of this benefit.

Medicare recognizes that a limited number of patients will fail on oral antiemetic drugs. Intravenous antiemetics may be covered (subject to the rules of medical necessity) when furnished to patients who fail on oral antiemetic therapy.

Note: Existing coverage policies authorizing the administration of suppositories to prevent vomiting when oral cancer drugs are used are unchanged by this new coverage.

Coverage Effective Date

Medicare provides coverage for claims with dates of service **on or after January 1, 1998**, for oral antiemetic drugs as full therapeutic replacements for intravenous dosage forms as part of a chemotherapeutic regimen provided that the drugs are administered or prescribed by a physician for use immediately before, at, or within 48 hours after the time of administration of the chemotherapeutic agent.

Allowable Period Definition

For purposes of this provision, the allowable period of covered therapy is defined to include day one, the date of service of the chemotherapy drug (beginning with the time of treatment), plus a period not to exceed two additional calendar days, or a maximum period up to 48 hours. Oral antiemetic drugs must be prescribed on a per chemotherapy treatment basis. For example, only enough of the oral antiemetic drugs for one 24- or 48-hour dosage regimen (depending upon the drug) must be prescribed/supplied for each incidence of chemotherapy treatment at a time. The beneficiary's medical record must be documented to reflect that the beneficiary is receiving the oral antiemetic drugs as full therapeutic replacement for an intravenous antiemetic drug as part of a cancer chemotherapeutic regimen.

HCPCS Codes

- Q0163 DIPHENHYDRAMINE HYDROCHLORIDE, 50 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at time of chemotherapy treatment not to exceed a 48-hour dosage regimen.
- Q0164 PROCHLORPERAZINE MALEATE, 5 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.
- Q0165 PROCHLORPERAZINE MALEATE, 10 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.
- Q0166 GRANISETRON HYDROCHLORIDE, 1 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 24-hour dosage regimen.

- Q0167 DRONABINOL, 2.5 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.
- Q0168 DRONABINOL, 5 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.
- Q0169 PROMETHAZINE HYDROCHLORIDE, 12.5 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.
- Q0170 PROMETHAZINE HYDROCHLORIDE, 25 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.
- Q0171 CHLORPROMAZINE HYDROCHLORIDE, 10 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.
- Q0172 CHLORPROMAZINE HYDROCHLORIDE, 25 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.
- Q0173 TRIMETHOBENZAMIDE HYDROCHLORIDE, 250 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.
- Q0174 THIETHYLPERAZINE MALEATE, 10 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.
- Q0175 PERPHENAZINE, 4 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.
- Q0176 PERPHENAZINE, 8 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.
- Q0177 HYDROXYZINE PAMOATE, 25 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.
- Q0178 HYDROXYZINE PAMOATE, 50 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.

- Q0179 ONDANSETRON HYDROCHLORIDE, 8 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.
- Q0180 DOLASETRON MESYLATE, 100 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 24-hour dosage regimen.
- Q0181 UNSPECIFIED ORAL DOSAGE FORM, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for a IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.

Note: The 24-hour maximum drug supply limitation on dispensing, for HCPCS codes Q0166 and Q0180, has been established to bring the Medicare benefit as it applies to these two therapeutic entities in conformity with the "Indications and Usage" section of currently Food and Drug Administration approved product labeling for each affected drug product.

Billing Requirements

Oral antiemetic drugs as full therapeutic replacements for intravenous dosage forms as part of cancer chemotherapeutic regimen must be billed using the UB-92 HCFA-1450 claim form or its electronic equivalent

Reporting and Coding Requirements

Providers billing for the cost of oral antiemetic drugs must report the following:

Revenue Code — The cost for oral antiemetic drugs is reported as revenue code **636**, in form locator (FL) 42 "REV. CD".

HCPCS Codes — The appropriate HCPCS code (Q0163-181) for the oral antiemetic drug is reported in FL 44 "HCPCS/RATES" for claims with dates of service **on or after April 1, 1998**. For claims with

dates of service **on or after January 1, 1998** through **March 31, 1998**, the oral antiemetic drug is reported with HCPCS code J3490.

Line Item Dates of Service — Line item dates of service are reported in FL 45 "SERV. DATE" using eight-digit format: **MMDDYYYY**.

Service Unit — The number of units of the oral antiemetic drugs is reported in FL 46 "SERV. UNITS". Each HCPCS code descriptor is equal to one service unit.

In addition, when billing for chemotherapy drugs (which includes oral cancer and IV chemotherapy drugs), providers must report the HCPCS code of the chemotherapy drug in FL 44 under revenue code 636 in FL 42.

Description — When billing for an oral antiemetic drug(s) using the hard copy UB-92 HCFA-1450 form, the provider must report the **name** of the oral antiemetic drug(s) in FL 43 "DESCRIPTION" on the appropriate revenue lines.

Diagnosis Code — A diagnosis of cancer is required when the beneficiary is receiving the oral antiemetic drugs as part of a cancer chemotherapeutic regimen.

Providers must complete the remaining items in accordance with regular billing instructions.

Reimbursement Guidelines

Payment for FDA-approved oral anti-cancer prodrugs for hospitals is made based on Medicare Part B methodology, which allows 95 percent of the median average wholesale price (AWP) for these drugs when furnished by a provider. Deductible and coinsurance apply.

Payment for oral anti-cancer drugs or FDA-approved oral anti-cancer prodrugs is denied if a diagnosis of cancer is not indicated on record type 70 when using the UB-92 flat file or in form locator 67-75 when using paper UB-92 HCFA-1450 claim form. ❖

New Waived Tests

Listed below are the latest tests approved by the Centers for Disease Control as waived tests under the Clinical Laboratory Improvement Amendments (CLIA):

- Roche/Boehringer Mannheim CoaguChek System for Professional Use
- Applied Biotech SureStep Mono Test (whole blood)
- Becton Dickinson Link 2 *H. pylori* Rapid Test (for whole blood)
- Bion Diagnostic Sciences BTA Stat Test (for home use)
- Diatech Diagnostics Uriscreeen (for OTC use)
- Lifestream Technologies Cholesterol Monitor
- Abbott TestPack Plus *H. pylori* (for whole blood)
- Jant Accutest Infectious Mononucleosis Test (whole blood)

Two new waived procedure codes have been assigned:

- 83518QW for the Bion Diagnostics Sciences BTA Stat Test; and
- 81007QW for the Diatech Diagnostics Uriscreeen Test.

The procedure codes for these new tests must have the modifier QW, to be recognized as waived tests.

TEST NAME	MANUFACTURER	CPT CODE(S)
Bion Diagnostic Sciences BTA Stat Test (for home use)	Bion Diagnostic Sciences, Inc.	83518QW
Diatech Diagnostics Uriscreeen (for OTC use)	Savyon/USA	81007QW

Please see the June/July *Medicare A Bulletin* (page 110) for a complete list of waived tests prior to those published in this issue. ❖

Enhanced External Counterpulsation (EECP) - Revision to Coverage and Billing Guidelines

The Health Care Financing Administration has revised some of the coverage and billing guidelines for Enhanced External Counterpulsation (EECP). This additional information on the coverage and billing of EECP replaces the guidelines published in the June/July 1999 *Medicare A Bulletin*, pages 108-109.

- EECP must be performed under direct supervision of a physician. The physician must be present in the office and immediately available to provide assistance and direction throughout the time the personnel is performing the services.
- EECP must be billed on the UB-92 HCFA-1450 claim form or its electronic equivalent, using bill type **12X, 13X, 83X, or 85X**.
- EECP must be reported using CPT code 93799 (unlisted cardiovascular service or procedure) for services provided **on or after July 1, 1999**, until a specific code for EECP is developed. EECP services provided **prior to July 1, 1999** continue to be noncovered and must be billed using CPT code 92971.
- CPT codes for external cardiac assist (92971), ECG rhythm strip and report (93040 or 93041), pulse oximetry (94760 or 94761), and plethysmography (93922 or 939239) are not medically necessary with this service and are not paid on the same day, unless they occur in a clinical setting not connected with the delivery of the EECP.
- Payment made to hospitals for the facility cost is covered under Medicare Part B on a reasonable cost basis.
- Payment made to “prospective payment stays-exempt” hospitals for the facility cost is covered under Medicare Part B on a reasonable cost basis.
- Deductible and coinsurance apply for this service. ❖

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 **September 23, 1999**, and after, unless otherwise noted.

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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. ❖

Revisions to Previously Published Policies

64573 - Correction to Coverage of Vagus Nerve Stimulation

A revision to the local medical review policy 64573, Vagus Nerve Stimulation, published in the June/July *Medicare A Bulletin*, pages 33-36, included ICD-9 codes 345.01, 345.11, and 345.91. These ICD-9 codes must be deleted from the "ICD-9 Codes That Support Medical Necessity" section of the policy. The ICD-9 codes that support medical necessity for the coverage of a vagus nerve stimulation are:

- 345.41 Partial epilepsy, with impairment of consciousness, with intractable epilepsy, so stated
- 345.51 Partial epilepsy, without impairment of consciousness, with intractable epilepsy, so stated ❖

72192 - Computed Tomography of the Pelvis

Local medical review policy for Computed Tomography of the Pelvis was published on page 37 in the June/July 1999 *Medicare A Bulletin*. The coding guidelines section of the policy speaks to a billing problem uncovered by the Medicare Operations area. It is expected that, if the procedure is performed initially without contrast and, later in the same day the patient returns to have a contrast enhanced procedure, the CPT code 72194 must be billed. Claims billed with both CPT procedure codes 72192 and 72193 for the same patient on the same date of service will be returned ("Return to Provider") via the Artificial Intelligence Application to correct the billing. ❖

76075 - Addition to Coverage of Bone Mineral Density Studies

Medicare standardization of bone mineral density studies was published in the local medical review policy of the same name in the *Medicare A Bulletin* G-360, dated January 21, 1999. The following ICD-9 code has been added for coverage: 627.2, menopausal or female climacteric states. When billing this medical indication, the physician or a qualified non-physician practitioner must have documentation supporting the patient's estrogen deficiency and clinical risk for osteoporosis, based on her medical history and other findings. ❖

J9000: Correction to Coverage for Doxorubicin HCL

The policy for antineoplastic drugs was published in the June/July 1999 *Medicare A Bulletin*, pages 24-30. At the time of publication, the ICD-9 code range that supports the medical necessity for the antineoplastic drug, Doxorubicin (J9000), was shown on page 26 as 202.00 - 202.08. Since that time, it has been determined that the code range should, instead, be 202.00 - 202.98.

Again, the correct ICD-9 diagnosis range for **Doxorubicin** (J9000) is **202.00 - 202.98**. ❖

99183 - Delay in Implementation of Hyperbaric Oxygen Therapy

In the June/July 1999 *Medicare A Bulletin*, pages 101-106, the local medical review policy for hyperbaric oxygen therapy (HBO therapy) defined the covered conditions for HBO therapy under the Medicare program, and specified credentialing requirements for performance of HBO therapy.

Medicare has delayed implementation of the credentialing requirement to April 1, 2000. This delay is in response to concerns of professional organizations in the following areas: preparation of skin graft, physician attendance, credentialing requirements, and the ICD-9 diagnosis codes used to identify covered conditions.

Providers who have not submitted their credentials to Medicare need take no further action at this time. Final implementation instructions will be published accordingly.

Medicare continues to reimburse for HBO therapy based on the local medical review policy published in the June/July 1999 *Medicare A Bulletin*, pages 101-106. The covered diagnosis list published under the "ICD-9 Codes that Support Medical Necessity" section and the requirement indicating that the physician must be present during an HBO therapy session remain in effect.

Additional ICD-9 Codes That Support Medical Necessity

- 686.01 Pyoderma gangrenosum (Meleney's ulcer)
- 686.09 Other pyoderma (Meleney's ulcer)
- 733.41 - 733.49 Aseptic necrosis of bone
- 909.2 Late effect of radiation
- 993.9 Unspecified effect of air pressure

In addition, an incorrect code (441.81) for arterial embolism and thrombosis of iliac artery was printed on page 104 of the June/July 1999 *Bulletin*. The correct information is shown below:

- 444.81 Arterial embolism and thrombosis of iliac artery ❖

70450: Computerized Tomography Scans

Description

Tomography is the recording of internal body images at a pre-determined plane by X-ray. Computerized axial tomography, or CAT scans, involve the measurement of the emergent X-ray beam by a scintillation counter. The electronic pulses are recorded on a magnetic disk and then processed by a minicomputer for reconstruction display of the body in cross-section on a cathode ray tube.

Type of Bill

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

Revenue Code

350 CT Scan: General Classification
 351 CT Scan: Head Scan
 352 CT Scan: Body Scan
 359 CT Scan: Other CT Scans

Indications and Limitations of Coverage and/or Medical Necessity

Computerized Tomography Scans:

Medicare of Florida will only consider computerized tomography scans to be reasonable and necessary when performed for documented cases of illness or injury.

HCPCS Codes

- 70480 Computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material
- 70481 with contrast material(s)
- 70482 without contrast material, followed by contrast material(s) and further sections
- 70486 Computerized axial tomography, maxillofacial area; without contrast material
- 70487 with contrast material(s)
- 70488 without contrast material, followed by contrast material(s) and further sections
- 70490 Computerized axial tomography, soft tissue neck; without contrast material
- 70491 with contrast material(s)
- 70492 without contrast material, followed by contrast material(s) and further sections
- 71250 Computerized axial tomography, thorax; without contrast material
- 71260 with contrast material(s)
- 71270 without contrast material, followed by contrast material(s) and further sections
- 72125 Computerized axial tomography, cervical spine; without contrast material
- 72126 with contrast material(s)
- 72127 without contrast material, followed by contrast material(s) and further sections
- 72128 Computerized axial tomography, thoracic spine; without contrast material
- 72129 with contrast material(s)
- 72130 without contrast material, followed by contrast material(s) and further sections
- 72131 Computerized axial tomography, lumbar spine; without contrast material
- 72132 with contrast material(s)
- 72133 without contrast material, followed by contrast material(s) and further sections

- 73200 Computerized axial tomography, upper extremity; without contrast material
- 73201 with contrast material(s)
- 73202 without contrast material, followed by contrast material(s) and further sections
- 73700 Computerized axial tomography, lower extremity; without contrast material
- 73701 with contrast material(s)
- 73702 without contrast material, followed by contrast material(s) and further sections
- 74150 Computerized axial tomography, abdomen; without contrast material
- 74160 with contrast material(s)
- 74170 without contrast material, followed by contrast material(s) and further sections

ICD-9 Codes That Support Medical Necessity

N/A

Computerized Tomography Scans - Head:

Medicare of Florida will consider a computerized tomography scan of the head to be medically reasonable and necessary when performed to establish a diagnosis or to monitor treatment for the following conditions:

Intracranial neoplasms, cerebral infarctions, ventricular displacement or enlargement, cortical atrophy, cerebral aneurysms, intracranial hemorrhage and hematoma, infection, edema, degenerative processes, cyst formation, multiple sclerosis, seizure disorders, head trauma, congenital abnormalities, presence of a foreign body, and radiation treatment planning.

Coverage for headache should only be for the following situations:

1. Patient suffering from headaches after a head injury. Head CAT scan is performed to rule out the possibility of a bleed.
2. Patient suffering from headaches unusual in duration and not responding to medical therapy. Head CAT scan is performed to rule out the possibility of a tumor.
3. Patient suffering from headaches characterized by sudden onset and severity. Head CAT scan is performed to rule out possibility of aneurysm and/or arteriovenous malformation.

HCPCS Codes

- 70450 Computerized axial tomography, head or brain; without contrast material
- 70460 with contrast material(s)
- 70470 without contrast material, followed by contrast material(s) and further sections

ICD-9 Codes That Support Medical Necessity

- 006.5 Amebic brain abscess
- 013.00-013.36 Tuberculosis of meninges and central nervous system
- 013.60-013.96 Tuberculosis encephalitis or myelitis or other specified or unspecified tuberculosis of central nervous system
- 036.0-036.2 Meningococcal infection
- 042 Human immunodeficiency virus (HIV) disease

046.0-046.9	Slow virus infection of central nervous system	201.91	Hodgkin's disease, unspecified, involving lymph nodes of the head, face, and neck
047.0-047.9	Meningitis due to enterovirus	213.0	Benign neoplasm of bones of skull and face
049.0-049.9	Other non-arthropod-borne viral diseases of central nervous system	225.0-225.2	Benign neoplasm of brain and other parts of nervous system
052.0	Postvaricella encephalitis	225.8	Benign neoplasm of other specified sites of nervous system
053.0	Herpes zoster with meningitis		Benign neoplasm of pituitary gland and craniopharyngeal duct (pouch) or pineal gland
054.3	Herpetic meningoencephalitis	227.3-227.4	Neoplasm of uncertain behavior of pituitary gland and craniopharyngeal duct or pineal gland
054.72	Herpes simplex meningitis		Neoplasm of uncertain behavior of endocrine glands and nervous system
055.0	Postmeasles encephalitis		Neoplasm of unspecified nature of brain or endocrine glands and other parts of nervous system
056.01	Encephalomyelitis due to rubella	237.0-237.1	Diabetes with hyperosmolarity
062.0-062.9	Mosquito-borne viral encephalitis		Diabetes with other coma
063.0-063.9	Tick-borne viral encephalitis		Disorders of the pituitary gland and its hypothalamic control
064	Viral encephalitis transmitted by other and unspecified arthropods	237.5-237.9	Disorders of adrenal glands
072.1-072.2	Mumps; meningitis or encephalitis	239.6-239.7	Senile and presenile organic psychotic conditions
090.40-090.49	Juvenile neurosyphilis		Transient organic psychotic conditions
094.0-094.9	Neurosyphilis		Other organic psychotic conditions (chronic)
112.83	Candidal meningitis	250.20-250.23	Unspecified psychosis
114.2	Coccidioidal meningitis	250.30-250.33	Specific nonpsychotic mental disorders due to organic brain damage
115.01	Infection by <i>Histoplasma capsulatum</i> with meningitis	253.0-253.9	Inflammatory diseases of the central nervous system
115.11	Infection by <i>Histoplasma duboisii</i> with meningitis	255.0-255.9 290.0-290.9	Hereditary and degenerative diseases of the central nervous system
115.91	Histoplasmosis, unspecified, meningitis		Other demyelinating diseases of central nervous system
130.0	Meningoencephalitis due to toxoplasmosis	293.0-293.83	Hemiplegia and hemiparesis
162.0-162.9	Malignant neoplasm of trachea, bronchus, and lung	294.0-294.9	Infantile cerebral palsy
170.0	Malignant neoplasm of bones of skull and face, except mandible	298.9 310.0-310.9	Other paralytic syndromes
191.0-191.9	Malignant neoplasm of brain		Epilepsy
192.0-192.1	Malignant neoplasm of cranial nerves or cerebral meninges	320.0-326	Other conditions of brain
194.3-194.4	Malignant neoplasm of pituitary gland and craniopharyngeal duct or pineal gland	330.0-334.9	Other and unspecified disorders of the nervous system
195.0	Malignant neoplasm of head, face, and neck	341.0-341.9	Trigeminal nerve disorders
196.0	Secondary and unspecified malignant neoplasm of lymph nodes of head, face, and neck	342.00-342.92 343.0-343.9 344.00-344.9	Facial nerve disorders
198.3-198.5	Secondary malignant neoplasm of brain and spinal cord, or other parts of nervous system, or bone and bone marrow	345.00-345.91 348.0-348.9 349.1-349.9	Disorders of other cranial nerves
199.0-199.1	Malignant neoplasm without specification of site	350.1-350.9	Sudden visual loss
200.11	Lymphosarcoma involving lymph nodes of head, face, and neck	351.0-351.9 352.0-352.9	Transient visual loss
200.21	Burkitt's tumor or lymphoma involving lymph nodes of head, face, and neck	368.11	Diplopia
201.11	Hodgkin's granuloma involving lymph nodes of head, face, and neck	368.12 368.2 368.40	Visual field defect, unspecified
201.21	Hodgkin's sarcoma involving lymph nodes of head, face, and neck	368.8 368.9	Other specified visual disturbances
201.41	Hodgkin's disease, lymphocytic-histiocytic predominance, involving lymph nodes of head, face, and neck	374.31 377.00-377.01	Unspecified visual disturbance
201.51	Hodgkin's disease, nodular sclerosis, involving lymph nodes of head, face, and neck	377.51-377.52	Paralytic ptosis
201.61	Hodgkin's disease, mixed cellularity, involving lymph nodes of head, face, and neck	377.61	Papilledema, unspecified or associated with increased intracranial pressure
201.71	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of the head, face, and neck	377.71	Disorders of optic chiasm associated with pituitary neoplasms and disorders or associated with other neoplasms
			Disorders of other visual pathways associated with neoplasms
			Disorders of visual cortex associated with neoplasms

378.51-378.56 Paralytic strabismus
 386.2 Vertigo of central origin
 388.2 Sudden hearing loss, unspecified
 388.5 Disorders of acoustic nerve
 430-438.9 Cerebrovascular disease
 572.2 Hepatic coma
 674.00-674.04 Cerebrovascular disorders in the puerperium
 738.10-738.19 Other acquired deformity of head
 740.0-740.2 Anencephalus and similar anomalies
 742.0-742.4 Other congenital anomalies of nervous system
 742.8 Other specified anomalies of nervous system
 742.9 Unspecified anomaly of brain, spinal cord, and nervous system
 747.81 Anomalies of cerebrovascular system
 756.0 Anomalies of skull and face bones
 759.2-759.9 Other and unspecified congenital anomalies
 765.00-765.19 Disorders relating to short gestation and unspecified low birthweight
 767.0 Birth trauma, subdural and cerebral hemorrhage
 767.1 Birth trauma, injury to scalp
 767.3 Birth trauma, other injuries to skeleton (skull)
 768.5 Severe birth asphyxia
 768.6 Mild or moderate birth asphyxia
 768.9 Unspecified birth asphyxia in liveborn infant
 770.8 Other respiratory problems after birth
 772.1-772.2 Intraventricular or subarachnoid hemorrhage
 779.0-779.2 Other and ill-defined conditions originating in the perinatal period
 780.01-780.09 Alteration of consciousness
 780.1 Hallucinations
 780.2 Syncope and collapse
 780.31-780.39 Convulsions
 780.4 Dizziness and giddiness
 780.6 Fever
 780.9 Other general symptoms
 781.0-781.9 Symptoms involving nervous and musculoskeletal systems
 784.0 Headache
 784.2 Swelling, mass, or lump in head and neck
 784.3 Aphasia
 784.5 Other speech disturbance
 784.60-784.69 Other symbolic dysfunction
 793.0 Nonspecific abnormal findings on radiological and other examination of skull and head
 794.00-794.09 Nonspecific abnormal results of function studies of brain and central nervous system
 800.00-804.99 Fracture of skull
 850.0-854.19 Intracranial injury, excluding those with skull fracture
 873.0-873.1 Other open wound of scalp with or without mention of complication
 873.9 Other and unspecified open wound of head, complicated
 950.0-950.9 Injury to optic nerve and pathways
 951.0-951.9 Injury to other cranial nerve(s)
 959.01 Head injury, unspecified
 996.2 Mechanical complication of nervous system device, implant, and graft

997.00-997.09 Nervous system complications
 V10.85 Personal history of malignant neoplasm of brain
 V10.86 Personal history of malignant neoplasm of other parts of nervous system
 V10.88 Personal history of malignant neoplasm of other endocrine glands and related structures
 V45.2 Presence of cerebrospinal fluid drainage device
 V67.1 Follow-up examination, following radiotherapy
 V67.2 Follow-up examination, following chemotherapy

HCPCS Section and Benefit Category

Radiology

HCFA National Coverage Policy

Coverage Issues Manual, Section 50-12 A-E

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 Code(s)

Any diagnosis codes not listed under the "ICD-9 Codes That Support Medical Necessity" section of this policy for HCPCS Codes 70450-70470.

Sources of Information

Adams, R.D., Victor, M. (1993). *Principles of Neurology*. (5th ed.). New York: McGraw-Hill.
 Golish, J.A. (1994). *Diagnostic Procedure Handbook*. (pp 273-274). Cleveland, Ohio: Williams and Wilkins.
 Rowland, L.P. (1995). *Merritt's Textbook of Neurology* (9th ed.). Baltimore: Williams and Wilkins.

Coding Guidelines

N/A

Documentation Requirements

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.

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the test and the test results. This information is usually found in the history and physical, office/progress notes, or test results.

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 Diagnostic Radiology Society and the Florida Neurology Society. ❖

70541: Magnetic Resonance Angiography (MRA)

Description

Magnetic Resonance Angiography (MRA) is an application of magnetic resonance (MR) imaging that provides visualization of blood flow, as well as images of normal and diseased blood vessels. MRA techniques are typically noninvasive because they do not require the use of contrast media. While contrast media may sometimes be used to enhance the images obtained in MRA, the use of these agents is not necessary. As a result, MRA is an imaging alternative for patients who cannot tolerate contrast media.

Type of Bill

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

Revenue Code

320 Radiology Diagnostic, General Classification

Indications and Limitations of Coverage and/or Medical Necessity

Although MRA appears to be a rapidly developing technology, the clinical safety and effectiveness of this procedure for all anatomical regions have not been proven. As a result, Medicare will provide coverage on a limited basis. Below are the indications for which Medicare coverage is allowed for MRA. All other uses of MRA will not be covered.

Head and Neck (for services performed before 7/1/99)

Medicare will provide coverage for the evaluation of the carotid vessels in the head and neck when *all* of the following conditions are met:

- For a patient who has a positive ultrasonography; and
- When performed on patients with symptoms associated with carotid stenosis for which surgery may be found to be appropriate based on the results of these tests.

It should be noted that physicians may choose either contrast angiography (CA) or MRA as diagnostic tests *after* a positive ultrasound for their patients. MRA is not performed routinely as an adjunct to CA. CA furnished in addition to MRA might be appropriate *only* when the results from the MRA and the ultrasound are incongruent or inconclusive.

Head and Neck (for services performed on or after 7/1/99)

Medicare will provide coverage for the evaluation of the vessels in the head and neck when *all* of the following conditions are met:

- To evaluate the carotid arteries, the circle of Willis, the anterior, middle or posterior cerebral arteries, the vertebral or basilar arteries, or the venous sinuses; and
- Be performed on patients with conditions of the head and neck for which surgery is anticipated and may be found to be appropriate based on the MRA. These conditions include, but are not limited to, tumor, aneurysms, vascular malformations, vascular occlusion or thrombosis.

MRA and contrast angiography (CA) are not expected to be performed on the same patient for diagnostic purposes prior to the application of anticipated therapy. Only one of these tests will be covered routinely unless the physician can demonstrate the medical need to perform both tests.

HCPCS Codes

70541 Magnetic resonance angiography, head and/ or neck, with or without contrast material(s)

ICD-9 Codes That Support Medical Necessity

094.89	Other specified neurosyphilis
191.0-191.9	Malignant neoplasm of brain
192.1	Malignant neoplasm of cerebral meninges
194.5	Malignant neoplasm of carotid body
227.5	Benign neoplasm of carotid body
228.02	Hemangioma, any site, of intracranial structures
239.6	Neoplasms of unspecified nature of brain
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
432.1	Subdural hemorrhage
432.9	Unspecified intracranial hemorrhage
433.00-433.91	Occlusion and stenosis of precerebral arteries
434.00-434.91	Occlusion of cerebral arteries
435.0-435.9	Transient cerebral ischemia
436	Acute, but ill-defined, cerebrovascular disease
437.3	Cerebral aneurysm, nonruptured
442.81	Other aneurysm of artery of neck
446.5	Giant cell arteritis
747.81	Anomalies of cerebrovascular system
900.00-900.9	Injury to blood vessels of head and neck

Peripheral Arteries of Lower Extremities

Studies have proven that MRA of peripheral arteries is useful in determining the presence and extent of peripheral vascular disease in lower extremities.

Effective May 1, 1997, Medicare will consider MRA of the arteries of the lower extremities to be a covered service only when the following criteria have been met:

- Either MRA or CA can be performed to evaluate peripheral arteries of the lower extremities. However, both MRA and CA may be useful in some cases, such as:
 - A patient has had CA and this test was unable to identify a viable run-off for bypass. When exploratory surgery is not believed to be a reasonable medical course of action for this patient, MRA may be performed to identify the viable runoff vessel.
 - A patient has had MRA, but the results are inconclusive.

HCPCS Codes

73725 Magnetic resonance angiography, lower extremity, with or without contrast material(s)

ICD-9 Codes That Support Medical Necessity

N/A

Abdomen

Studies have proven that MRA is considered a reliable diagnostic tool for the preoperative evaluation of patients who will undergo elective abdominal aortic aneurysm (AAA) repair. In addition, scientific data has revealed that MRA is considered comparable to CA in determining the extent of AAA, as well as evaluation of aortoiliac occlusion disease and renal artery pathology that may be neces-

sary in the surgical planning for AAA repair. These studies also reveal that MRA could provide a net benefit to the patient. If preoperative angiography is not necessary then patients are not exposed to the risks associated with invasive procedures, contrast media, end-organ damage or arterial injury. As with coverage of MRA for other anatomical sites, Medicare will provide coverage for either MRA or CA and not both tests on a routine basis.

The physician may choose between CA or MRA for preoperative imaging, after other tests such as computed tomography (CT) or ultrasound have been used to diagnose AAA and evaluate aneurysm size over time. However, both MRA and CA may be used when the physician can demonstrate the medical need for both tests to be performed, such as when a followup CA is necessary to clarify renal artery pathology, which might not be diagnosed definitively by an initial MRA.

HCPCS Codes

74185 Magnetic resonance angiography, abdomen, with or without contrast material(s)

ICD-9 Codes That Support Medical Necessity

N/A

Chest

Medicare will cover MRA of the chest for the following indications:

For the Diagnosis of Pulmonary Embolism

Medicare will consider MRA of the chest for diagnosing a suspected pulmonary embolism to be a covered service when the following criteria have been met:

- A patient is suspected of having a pulmonary embolism and it is contraindicated for the patient to receive intravascular iodinated contrast material.
- A patient is allergic to iodinated contrast material and would face a high risk of developing complications if undergoing pulmonary angiography or computed tomography angiography.

For Pre-operative or Post-operative Evaluation of Thoracic Aortic Dissection and Aneurysm

Medicare will consider MRA of the chest for the evaluation of thoracic aortic dissection and aneurysm to be a covered service when the following criteria are met:

- Depending on the clinical presentation, MRA may be used as an alternative to other non-invasive imaging technologies, such as transesophageal echocardiography and CT.
- Either MRA or CA may be used as a diagnostic test for thoracic aortic dissection and aneurysm, but not both tests on a routine basis.
- If both MRA and CA of the chest are used to diagnose thoracic aortic dissection and aneurysm, the physician must demonstrate the medical need for performing both tests.

HCPCS Codes

71555 Magnetic resonance angiography, chest, (excluding myocardium), with or without contrast material(s)

ICD-9 Codes That Support Medical Necessity

N/A

HCPCS Section and Benefit Category

Radiology

HCFA National Coverage Policy

Coverage Issues Manual 50-14

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.

HCFA considers the following codes to be noncovered by Medicare:

- 72159 Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)
- 72198 Magnetic resonance angiography, pelvis, with or without contrast material(s)
- 73225 Magnetic resonance angiography, upper extremity, with or without contrast material(s)

Noncovered ICD-9 Code(s)

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

Sources of Information

Edelman, R. *MR Angiography: Present and Future*, AJR, 161:1-11, 1993

Handelsman, H. *Magnetic Resonance Angiography (MRA) for the Determination of Blood Flow and Blood Vessel Morphology*.

Tierney, L.M., Jr., McPhee, S.J., & Papadakis, M.A. (1998). *Current: Medical Diagnosis & Treatment (37th ed.)*. CT: Appleton & Lange.

Wentz, K. et. al., *Intracranial Vertebrobasilar System: MR Angiography*, Radiology, 1190: 105-110, 1994.

Coding Guidelines

N/A

Documentation Requirements

Documentation maintained in the patient's file must indicate the medical necessity of this procedure. All coverage criteria listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section must be documented in the patient's medical record, as well as a hard copy of the procedure results, made available to Medicare upon request. This information is generally found in the office/progress notes, history and physical, and/or operative notes.

If the provider of the magnetic resonance angiography study is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies. The physician must state the reason for the MRA 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 the Florida Radiological Society, Inc. ❖

85044: Reticulocyte Count

Description

Reticulocytes are nonnucleated, immature red blood cells (RBCs) that remain in the peripheral blood for 24 to 48 hours while maturing. In this test, reticulocytes in a whole blood sample are counted and expressed as a percentage of the total red cell count. When bone marrow activity and hemoglobin levels are normal, the reticulocyte count is between 0.5% to 1.5%.

The reticulocyte count is part of the initial evaluation of anemia and is an index of effective erythropoiesis and bone marrow response to anemia. It is useful, along with the complete blood count (CBC), serum iron, total iron-binding capacity, and serum ferritin, in classifying the anemia according to the functional defect in erythropoiesis—whether there is a failure in red blood cell production, an abnormality in precursor maturation, or an increase in red blood cell destruction.

Type of Bill

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

Revenue Code

305 Hematology

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider a reticulocyte count medically reasonable and necessary in the following circumstances:

- To initially evaluate a patient with unexplained anemia, and/or
- To evaluate the response to the therapeutic intervention(s) for the diagnosed anemia. Generally, it is expected that a follow up reticulocyte count will be performed when the test results will be used in the management of the patient’s anemia. Usually other laboratory tests, such as a hemoglobin, better reflect the effects of treatment on the patient’s laboratory values.

HCPCS Codes

- 85044 Blood count; reticulocyte count, manual
- 85045 Blood count; reticulocyte count, flow cytometry

ICD-9 Codes That Support Medical Necessity

280.0-285.9 Anemias

HCPCS Section and Benefit Category

Pathology and Laboratory/Hematology and Coagulation

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.

A reticulocyte count performed routinely with a complete blood count (CBC) without evidence of an anemic condition is considered screening and, therefore, is not covered by Medicare.

Noncovered ICD-9 Code(s)

Any diagnosis codes not listed in the “ICD-9 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, D., & Longo, D. (Eds.). (1998). *Harrison’s Principles of Internal Medicine*. (14th ed.). New York: McGraw-Hill.

Illustrated Guide to Diagnostic Tests. (1994). Springhouse: Springhouse Corporation.

Tilkian, S., Conover, M. & Tilkian, A. (1987). *Clinical Implications of Laboratory Tests*. St. Louis: The C. V. Mosby Co.

Coding Guidelines

N/A

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

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. ❖

86781: Fluorescent Treponemal Antibody Absorption (FTA-abs)

Description

The fluorescent treponemal antibody absorption (FTA-abs) test is the most widely employed treponemal test. It is a specific test for the diagnosis of syphilis. The FTA-abs test includes a serum specimen which is absorbed and then tested with immunofluorescence for the antibody to *Treponema pallidum*, the causative agent of syphilis.

FTA-abs is the most sensitive test in all stages of syphilis. The FTA-abs test is of value principally in determining whether a positive nontreponemal antigen test (e.g., Rapid Plasma Reagin [RPR] or Venereal Disease Research Laboratory [VDRL]) is “false positive” or is indicative of syphilis. Because of its great sensitivity, particularly in the late stages of the disease, the FTA-abs test is also of value when there is clinical evidence of syphilis but the nontreponemal serologic test for syphilis is negative. The test is positive in most patients with primary syphilis and in virtually all with secondary syphilis.

Type of Bill

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

Revenue Code

302 Immunology

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider FTA-abs (CPT code 86781) to be medically reasonable and necessary for the following indications:

- Confirmation of a positive RPR or VDRL test.
- A patient with suspected primary syphilis who has a negative RPR or VDRL.
- A patient with suspected latent syphilis or neurosyphilis who has a negative RPR or VDRL.

HCPCS Codes

86781 Treponema Pallidum, confirmatory test (e.g., FTA-abs)

ICD-9 Codes That Support Medical Necessity

090.0-090.9	Congenital syphilis
091.0-091.9	Early syphilis, symptomatic
092.0	Early syphilis, latent, serological relapse after treatment
092.9	Early syphilis, latent, unspecified
093.0-093.9	Cardiovascular syphilis
094.0-094.9	Neurosyphilis
095.0-095.9	Other forms of late syphilis with symptoms
096	Late syphilis, latent
097.0-097.9	Other and unspecified syphilis
386.10-386.19	Other and unspecified peripheral vertigo
386.2	Vertigo of central origin
386.9	Unspecified vertiginous syndromes and labyrinthine disorders

HCPCS Section and Benefit Category

Pathology and Laboratory

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.

Routine screening services are not covered by Medicare of Florida.

Noncovered ICD-9 Code(s)

Any diagnosis code not listed in the “ICD-9 Codes That Support Medical Necessity” section of this policy.

Sources of Information

Jacobs, D.S., Demott, W. R., Finley, P.R., et. Al. (1994). *Laboratory Test Handbook*. Hudson: Lexi Comp Inc.

Pagana, K. D., and Pagana, T. J. (1995). *Mosby’s Diagnostic and Laboratory Test Reference*. St. Louis: Mosby - Year Book, Inc.

Tierney, L. M., McPhee, S. J., and Papadakis, M. A. (1997). *Current Medical Diagnosis and Treatment 1997*. Stanford: Appleton and 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. This information is usually found in the history and physical, office/progress notes, or lab reports.

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

N/A

CAC Notes

This policy does not reflect 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 numerous societies. ❖

93000: Electrocardiography

Description

Electrocardiography (ECG, EKG) is the graphic tracing of the variations in electrical potential caused by the excitation of the heart muscle as detected at the body surface by electrodes placed on the patient's limbs and chest. The monitoring electrodes detect the electrical activity of the heart from a variety of spatial perspectives. The EKG lead system is composed of several electrodes that are placed on each of the four extremities and at varying sites on the chest. It provides information regarding rate, rhythm, myocardial injury, and conduction system.

The normal EKG pattern is composed of waves arbitrarily designated by the letters P, Q, R, S, and T. Through the analysis of these wave forms and time intervals, valuable information about the heart may be obtained. The EKG is used primarily to identify abnormal heart rhythms (arrhythmias or dysrhythmias) and to diagnose acute myocardial defects, ventricular hypertrophy, and/or strain.

Type of Bill

- Outpatient Hospital - 12x, 13x, 14x
- Skilled Nursing Facility - 21x, 22x, 23x
- Rural Health Clinic - 71x
- End Stage Renal Disease Facility - 72x
- Comprehensive Outpatient Rehabilitation Facility - 75x

Revenue Type

730 Electrocardiogram General Classification

Indications and Limitations of Coverage and/or Medical Necessity

Electrocardiograms are indicated for diagnosis and patient management purposes involving symptoms of the heart, pericardium, thoracic cavity, and systemic diseases that produce cardiac abnormalities.

Medicare of Florida will consider an EKG medically necessary in any of the following circumstances:

1. Initial diagnostic workup for a patient that presents with complaints of symptoms such as chest pain, palpitations, dyspnea, dizziness, syncope, etc., which may suggest a cardiac origin.
2. Evaluation of a patient on a cardiac medication for a cardiac arrhythmia or other cardiac condition that affects the electrical conduction system of the heart (e.g., inotropics such as digoxin; antiarrhythmics such as Tambacor, Procainamide, or Quinidine; and antianginals such as Cardizem, Isordil, Corgard, Procardia, Inderal, and Verapamil). The EKG is necessary to evaluate the effect of the cardiac medication on the patient's cardiac rhythm and/or conduction system.
3. Evaluation of a patient with a pacemaker with or without clinical findings (history or physical examination) that suggest possible pacemaker malfunction.
4. Evaluation of a patient who has a significant cardiac arrhythmia or conduction disorder in which an EKG is necessary as part of the evaluation and management of the patient. These disorders may include, but are not limited to, the following: Complete Heart Block, Second Degree AV block, Left Bundle Branch Block, Right Bundle Branch Block, Paroxysmal VT, Atrial Fib/flutter, Ventricular Fib/Flutter, Cardiac Arrest, Frequent

- PACs, Frequent PVCs, Wandering Atrial Pacemaker, and any other unspecified cardiac arrhythmia.
- 5. Evaluation of a patient with known Coronary Artery Disease (CAD) and/or heart muscle disease who presents with symptoms such as increasing shortness of breath (SOB), palpitations, angina, etc.
- 6. Evaluation of a patient's response to a newly established therapy for angina, palpitations, arrhythmias, SOB, or other cardiopulmonary disease process.
- 7. Evaluation of patients after coronary artery revascularization by Coronary Artery Bypass Grafting (CABGs), Percutaneous Transluminal Coronary Angiography (PTCA), thrombolytic therapy (e.g., TPA, Streptokinase, Urokinase), and/or stent placement.
- 8. Evaluation of the patient presenting with symptoms of a Myocardial Infarction (MI).
- 9. Evaluation of other symptomatology that may indicate a cardiac origin especially in those patients who have a history of an MI, CABG surgery, or PTCA, or patients who are being treated medically after a positive stress test or cardiac catheterization.
- 10. Pre-operative evaluation of the patient:
 - undergoing cardiac surgery such as CABGs, automatic implantable cardiac defibrillator, or pacemaker, or
 - the patient has a medical condition associated with a significant risk of serious cardiac arrhythmia and/or myocardial ischemia such as Dressler's Syndrome, history of MI, angina pectoris, aneurysm of heart wall, chronic ischemic heart disease, pericarditis, Valvular Disease, or cardiomyopathy to name a few.

HCPCS Codes

- 93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
- 93005 tracing only, without interpretation and report
- 93010 interpretation and report only

ICD-9 Codes That Support Medical Necessity

- 079.0-079.99 Viral and chlamydial infection in conditions classified elsewhere and of unspecified site
- 240.0-246.9 Disorders of thyroid gland
- 250.10-250.13 Diabetes with ketoacidosis
- 250.20-250.23 Diabetes with hyperosmolarity
- 250.30-250.33 Diabetes with other coma
- 250.70-250.73 Diabetes with peripheral circulatory disorders
- 276.0-276.9 Disorders of fluid, electrolyte, and acid-base balance
- 277.3 Amyloidosis
- 337.0 Idiopathic peripheral autonomic neuropathy
- 337.9 Unspecified disorder of autonomic nervous system
- 390-429.9 Diseases of the circulatory system
- 435.9 Unspecified transient cerebral ischemia (Transient ischemic attack TIA)
- 436 Acute, but ill-defined, cerebrovascular disease

440.0-448.9	Diseases of arteries, arterioles, and capillaries
668.10-668.14	Cardiac complications
710.0-710.9	Diffuse diseases of connective tissue
714.0-714.9	Rheumatoid arthritis and other inflammatory polyarthropathies
745.0-745.9	Bulbus cordis anomalies and anomalies of cardiac septal closure
746.00-747.9	Other congenital anomalies of heart and circulatory system
780.02	Transient alteration of awareness
780.2	Syncope and collapse
780.31-780.39	Convulsions
780.4	Dizziness and giddiness
780.79	Other malaise and fatigue
782.0	Disturbance of skin sensation
782.61-782.62	Pallor and flushing
785.0	Tachycardia, unspecified
785.1	Palpitations
785.2	Undiagnosed cardiac murmurs
785.3	Other abnormal heart sounds
785.50-785.59	Shock, without mention of trauma
786.00	Respiratory abnormality, unspecified
786.01	Hyperventilation
786.02	Orthopnea
786.03-786.09	Dyspnea and respiratory abnormalities
786.50-786.59	Chest pain
786.6	Swelling, mass, or lump in chest
789.01	Abdominal pain, right upper quadrant
789.02	Abdominal pain, left upper quadrant
789.06	Abdominal pain, epigastric
794.30-794.39	Nonspecific abnormal results of cardiovascular function study
799.0	Asphyxia
799.1	Respiratory arrest
860.0-860.5	Traumatic pneumothorax and hemothorax
861.00-861.32	Injury to heart and lung
959.1	Injury of trunk
972.0-972.9	Poisoning by agents primarily affecting the cardiovascular system
980.0-989.9	Toxic effects of substances chiefly nonmedicinal as to source
995.0-995.89	Certain adverse effects not elsewhere classified
996.00-996.09	Mechanical complication of cardiac device, implant and graft
996.80-996.89	Complications of transplanted organ
997.1	Cardiac complications
997.2	Peripheral vascular complications
997.3	Respiratory complications
V45.01-V45.09	Other postsurgical states, Cardiac pacemaker, automatic implantable cardiac defibrillator, and other specified cardiac device
V45.81-V45.82	Other postsurgical status, Aortocoronary bypass status and percutaneous transluminal coronary angioplasty status
V72.81	Pre-operative cardiovascular examination

HCPCS Section and Benefit Category

Cardiovascular/Medicine

HCFA National Coverage Policy

Intermediary Manual 3112.3, 3642E., 3627.9
 Coverage Issues Manual 50-15
 Hospital Manual §462, E204.3, E211.2, 442.7, 442.8,443
 Ren 207.3, 240.3D

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 Code(s)

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

Sources of Information

Jacobs, D., Demott, W., Finley, P., Horvat, R., Kasten, B. and Tilzer, L. (1994). *Laboratory Text Handbook* (3rd ed.) Hudson: Lexi-Comp, Inc.

Pagana, K., and Pagana, J. (1995). *Mosby’s Diagnostic and Laboratory Test Reference*. (2nd ed.). St. Louis: Mosby.

Coding Guidelines

Outpatient hospitals, hospital-based rural health clinics and CORFS may use *only* code 93005 when billing for this service.

The claim must indicate the signs and symptoms or other clinical reason necessitating the service.

The following Type of Bill must also include the applicable HCPCS code:

- Outpatient Hospital - 13x, 14x;
- Skilled Nursing Facility - 23x;
- Rural Health Clinic - 71x;
- End Stage Renal Disease Facility - 72x;
- Comprehensive Outpatient Rehabilitation Facility - 75x.

Documentation Requirements

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

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

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 Chapter of the American College of Cardiology. ❖

G0104: Colorectal Cancer Screening

Description

Cancer screening is a means of detecting disease early, in asymptomatic individuals, with the goal of decreasing morbidity and mortality. Generally, screening examinations, tests, or procedures are not diagnostic of cancer but instead indicate that a cancer may be present. The diagnosis is then made following a workup that generally includes a biopsy and pathologic confirmation. Colorectal cancer screening involves the use of fecal occult blood testing, rigid and flexible sigmoidoscopy, radiographic barium contrast studies, and colonoscopy.

The Balanced Budget Act (BBA) of 1997 provides coverage for various colorectal screening examinations subject to certain coverage, frequency, and payment limitations. This policy documents the provisions listed in the BBA.

Type of Bill

Outpatient Hospital - 13x

Revenue Codes

- 301 Laboratory; Chemistry
- 320 Radiology-Diagnostic; General Classification
- 750 Gastro-intestinal Services; General Classification

Indications and Limitations of Coverage and/or Medical Necessity

Effective for services furnished on or after January 1, 1998, Medicare covers colorectal cancer screening tests/procedures for the early detection of colorectal cancer. The following are the coverage criteria for these new screening services:

- Screening fecal-occult blood tests (code G0107) are covered at a frequency of once every 12 months for beneficiaries who have attained age 50. Screening fecal-occult blood test means a guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools. This screening requires a written order from the beneficiary's attending physician.
- Screening flexible sigmoidoscopies (code G0104) are covered at a frequency of once every 48 months for beneficiaries who have attained age 50. If during the course of a screening flexible sigmoidoscopy a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal (procedure codes 45330-45339) should be billed rather than code G0104.
- Screening colonoscopies (code G0105) are covered at a frequency of once every 24 months for beneficiaries at high risk for colorectal cancer. High risk for colorectal cancer means an individual with one or more of the following:
 1. A close relative (sibling, parent, or child) who has had colorectal cancer;
 2. A family history of familial adenomatous polyposis;
 3. A family history of hereditary nonpolyposis colorectal cancer;
 4. A personal history of adenomatous polyps;
 5. A personal history of colorectal cancer; or
 6. A personal history of inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis.

If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal (procedure codes 45378-45385) should be billed rather than code G0105. This screening must be performed by a doctor of medicine or osteopathy.

- Screening barium enema examinations (codes G0106 and G0120) are covered as an alternative to either a screening sigmoidoscopy (code G0104) or a screening colonoscopy (code G0105) examination. The same frequency parameters specified in the law for screening sigmoidoscopy and screening colonoscopy apply.

The screening barium enema must be ordered in writing after a determination that the test is the appropriate screening test. This means that in the case of a particular individual, the attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the screening potential that has been estimated for a screening flexible sigmoidoscopy, or for a screening colonoscopy, as appropriate, for the same individual. This screening single contrast barium enema also requires a written order from the beneficiary's attending physician in the same manner as described above for the screening double contrast barium enema examination.

It is not expected that these screening services are performed on patients that present with active gastrointestinal symptomatology.

HCPCS Codes

- G0104 Colorectal cancer screening; flexible sigmoidoscopy
- G0105 Colorectal cancer screening; colonoscopy on individual at high risk
- G0106 Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema
- G0107 Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations
- G0120 Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema
- G0121 Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk (non-covered)
- G0122 Colorectal cancer screening; barium enema (non-covered)

ICD-9 Codes That Support Medical Necessity

The following diagnosis list applies only to procedure codes G0105 (Screening colonoscopy) and G0120 (Barium enema).

- 555.0 - 555.9 Regional enteritis
- 556.0 - 556.9 Ulcerative colitis
- 558.1 - 558.9 Other noninfectious gastroenteritis and colitis
- V10.05 Personal history of malignant neoplasm; large intestine
- V10.06 Personal history of malignant neoplasm; rectum, rectosigmoid junction, and anus

- V12.72 Personal history of colonic polyps
- V16.0 Family history of malignant neoplasm: gastrointestinal tract
- V18.5 Family history of certain other specific conditions; digestive disorders

HCPCS Section and Benefit Category

Digestive System

HCFA National Coverage Policy

Hospital Manual, Section 456

Intermediary Manual, Section 3660.16

Reasons for Denial

Procedure code G0121 should be used when this procedure is performed on a beneficiary who does not meet the criteria for high risk. This service will be denied as non-covered because it fails to meet the requirements of the benefit.

Procedure code G0122 should be used when a screening barium enema is performed not as an alternative to either a screening colonoscopy (code G0105) or a screening flexible sigmoidoscopy (code G0104). This service will be denied as non-covered because it fails to meet the requirements of the benefit.

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 Code(s)

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

Sources of Information

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

Coding Guidelines

When billing for any of the covered services, the following guidelines apply to Type Of Bill 13x:

- Procedure code G0107 must be submitted with revenue code 301. Payment will be made under the clinical diagnostic laboratory fee schedule.
- Procedure code G0106 and G0120 must be submitted with revenue code 320. Payment will be subject to the radiology blended payment method.
- Procedure code G0104 must be submitted with revenue code 750. Payment will be based on cost reimbursement.
- Procedure code G0105 must be submitted with revenue code 750. Payment will be subject to the ambulatory surgical center blended payment.

When these tests/procedures are provided to inpatients of a hospital, they are covered under this benefit. However, the provider must bill under TOB 13x using the discharge date of the hospital stay to avoid editing in the Common Working File (CWF) as a result of the hospital bundling rules.

When billing procedure code G0105 (Screening colonoscopy) or G0120 (Barium enema), submit the applicable ICD-9 diagnosis for high risk:

- For patients with a close relative who has had colorectal cancer or a family history of hereditary nonpolyposis colorectal cancer, use diagnosis V16.0;
- For patients with a family history of familial adenomatous polyposis, use diagnosis V18.5;
- For patients with a personal history of adenomatous polyps, use diagnosis V12.72;
- For patients with a personal history of colorectal cancer, use diagnosis V10.05 or V10.06;
- For patients with an inflammatory bowel disease, use diagnosis 555.0-555.9, 556.0-556.9, or 558.1-558.9.

Any time the scheduled colorectal screening service turns into a diagnostic/therapeutic service, the applicable diagnostic/therapeutic procedure code should be billed.

Documentation Requirements

Medical record documentation must indicate that the service provided was screening in nature. In addition, if procedure code G0105 (Screening colonoscopy) or G0120 (Barium enema) is billed, the documentation should support that the patient is at high risk. This information is usually found in the office/progress notes, history/physical, and/or procedure note.

Other Comments

N/A

CAC Notes

This policy does not reflect 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 Gastroenterology Society. ❖

J0850: Cytomegalovirus Immune Globulin (Human), Intravenous (CMV-IGIV)

Description

CMV-IGIV (CytoGam®) is an intravenous immunoglobulin (Ig) that provides passive immunity by supplying a relatively high concentration of Ig-G antibodies against CMV.

CMV infection continues to be the most important disease encountered in organ transplantation. Patients who are at the greatest risk for morbidity are those who experience primary disease, (i.e., those individuals who have never been exposed to the virus [CMV seronegative] and receive an organ transplant from a CMV seropositive donor).

Type of Bill

- Hospital - 13x
- Skilled Nursing Facility - 21x
- Rural Health Clinic - 71x
- End Stage Renal Disease - 72x

Revenue Type

636 - Drugs Requiring Detailed Coding

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider the use of CMV-IGIV (CytoGam®) medically reasonable and necessary for the following indications:

- Prophylaxis against CMV disease associated with transplantation of lung, liver, pancreas, and heart. In transplants of these organs, prophylactic CMV-IGIV should be considered in combination with ganciclovir.
- To attenuate primary CMV disease in seronegative kidney transplant recipients who receive a kidney from a CMV seropositive donor.

CMV seropositive recipients who receive organs (lung, liver, pancreas, heart, or kidney) from seropositive donors may experience reactivation or reinfection, but the clinical manifestations are often milder than primary disease. Therefore, CytoGam® is not considered medically reasonable and necessary when the recipient and the donor are CMV seropositive.

CytoGam® is supplied as an injectable drug (2.5g/50ml vial). Its I.V. administration is prescribed in accordance with the post-transplant period.

The maximum recommended total dosage per infusion is 150 mg/kg, administered according to the following schedule:

	Type of Transplant	
	Kidney	Lung, Liver, Pancreas, Heart
Within 72 hours:	150 mg/kg	150 mg/kg
2 weeks after:	100 mg/kg	150 mg/kg
4 weeks after:	100 mg/kg	150 mg/kg
6 weeks after:	100 mg/kg	150 mg/kg
8 weeks after:	100 mg/kg	150 mg/kg
12 weeks after:	50 mg/kg	100 mg/kg
16 weeks after:	50 mg/kg	100 mg/kg

CytoGam® is not considered to be reasonable and necessary when given in excess of this administration/dosage schedule.

CytoGam® may not be used as a substitute for intravenous immunoglobulin (IVIg).

HCPCS Codes

J0850 Injection, cytomegalovirus immune globulin intravenous (human), per vial

ICD-9 Codes That Support Medical Necessity

- V07.2 Prophylactic immunotherapy
- V42.0 Organ or tissue replaced by transplant, kidney
- V42.1 Organ or tissue replaced by transplant, heart

- V42.6 Organ or tissue replaced by transplant, lung
- V42.7 Organ or tissue replaced by transplant, liver
- V42.83 Organ or tissue replaced by transplant, pancreas

Note: The billing of CytoGam® requires dual diagnoses. To ensure reimbursement for this service, dual diagnoses must be submitted. Providers must use ICD-9 codes V07.2 and the appropriate V diagnosis (V42.0, V42.1, V42.6, V42.7, or V42.83) to report the approved indication for J0850. (V07.2 represents prophylactic immunotherapy against CMV for coverage purposes in this policy.)

HCPCS Section and Benefit Category

Drugs and Biologicals

HCFA National Coverage Policy

MIM 3101.3, 3112.4B

Reasons for Denial

Administration of CytoGam® for any indication other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Administration of CytoGam® in excess of the administration/dosage schedule in this policy.

Noncovered ICD-9 Code(s)

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

Sources of Information

Norman, D.J., Suki, W.N., et. al. (Eds.). (1998). *Primer on Transplantation*. Thorofare: American Society of Transplant Physicians.

Coding Guidelines

The billing of CytoGam® requires dual diagnoses. To ensure reimbursement for this service, dual diagnoses must be submitted.

Providers must use ICD-9 codes V07.2 and the appropriate "V" diagnosis (V42.0, V42.1, V42.6, V42.7, or V42.83) to report the approved indication for J0850. (V07.2 represents prophylactic immunotherapy against CMV for coverage purposes in this policy.)

J0850 must be reported in form locator 44 for revenue code 636.

ESRD facilities must administer CytoGam® at the facility, and it must be administered by an ESRD staff member.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate:

The patient was CMV seronegative prior to the lung, liver, pancreas, heart, or kidney transplant and has received an organ from a CMV seropositive donor;

- The date of the organ transplantation;
- The patient's weight; and
- The administration and dosage of the CytoGam®.

This information is normally found in the history and physical, office notes, or progress notes.

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 the Florida Society of Nephrology. ❖

Q9920: Chronic Renal Failure Erythropoietin (Epogen)

Description

Erythropoietin (Epogen) is a glycoprotein that stimulates red blood cell production. It is produced in the kidney and stimulates the division and differentiation of committed erythroid progenitors in the bone marrow.

Endogenous production of erythropoietin is normally regulated by the level of tissue oxygenation. Hypoxia and anemia generally increase the production of erythropoietin, which in turn stimulates erythropoiesis. In normal subjects, plasma erythropoietin levels range from 0.01 to 0.03 units/ml, and increase up to 100 to 1,000-fold during hypoxia or anemia. In contrast, in patients with chronic renal failure (CRF), production of erythropoietin is impaired, and this erythropoietin deficiency is the primary cause of their anemia.

This policy addresses Epogen given to Chronic Renal Failure patients who are predialysis and patients who are on dialysis.

Type of Bill

Hospital - 13x
 Skilled Nursing Facility - 21x
 Rural Health Clinic - 71x
 End Stage Renal Disease - 72x

Revenue Code

634 Erythropoietin (EPO) less than 10,000 units
 635 Erythropoietin (EPO) 10,000 or more units

Indications and Limitations of Coverage and/or Medical Necessity

Epogen is considered medically reasonable and necessary for the treatment of anemia associated with chronic renal failure, including patients on dialysis and patients not on dialysis. Epogen is indicated to elevate or maintain the red blood cell level (as manifested by the hematocrit or hemoglobin determinations) and to decrease the need for transfusions in these patients. It is not intended for patients who require immediate correction of severe anemia.

Prior to and during Epogen therapy, the patient's iron stores, including transferrin saturation and serum ferritin, must be evaluated. Transferrin saturation should be at least 20% and ferritin at least 100ng/mL. Virtually all patients will eventually require supplemental iron, to increase or maintain transferrin saturation to levels that will adequately support erythropoiesis stimulated by Epogen. In addition, blood pressure should be adequately controlled prior to initiation of Epogen therapy, and must be closely monitored and controlled during therapy.

To initiate Epogen therapy, the patient must have a documented anemia as evidenced by symptoms and a hematocrit (HCT) of less than 30% or a hemoglobin (HGB) < 10g/dl and a creatinine level of 3 mg/dl or higher, unless there is medical documentation showing the need for EPO despite a HCT >29.9% or a HGB >9g/dl or a creatinine level < 3 mg/dl.

It may be medically necessary for a patient to initiate Epogen therapy when the hematocrit or hemoglobin is greater than 29.9% or 9.9g/dl and the patient exhibits severe signs and symptoms such as: extreme weakness and fatigue, cold intolerance, tachycardia, severe pulmonary distress, severe hypotension, angina, or con-

gestive heart failure which is caused by the anemic condition. In addition, it may be medically necessary to initiate Epogen therapy when the creatinine level is < 3mg/dl if one of the following indications is present: evidence of any type clearance test demonstrating a result of less than 30cc/min (e.g., creatinine clearance) or the patient's physical examination revealed muscle wasting or low muscle mass.

The initial dose of Epogen, whether given intravenously or subcutaneously, is between 50 and 100 units per kilogram (kg) of body weight. Subsequent injections are usually given at a frequency of three times per week. The dosage may be increased if, after eight weeks of therapy, the hematocrit has not increased by five to six points and is still below the suggested hematocrit target range of 30 to 36%. Adjustments in dosages are generally made in increments of 25 units/kg of body weight. The dose of Epogen should be reduced as the hematocrit approaches 36% or increases by more than 4 points in any 2-week period. Epogen should be temporarily withheld if the reduced dose does not stop the rise in the hematocrit, and the hematocrit exceeds 36%. When the hematocrit has returned to the desired range, therapy may be resumed using a dose that is 25 units/kg of body weight lower than the previous dose.

Note: The time required to elicit a clinically significant change in hematocrit (increase or decrease) following any dose adjustment may be 2 to 6 weeks. Dose adjustment should not be made more frequently than once a month, unless clinically indicated. After any dose adjustment, the hematocrit should be determined twice weekly (BIW) for at least 2 to 6 weeks.

Epogen is covered when it is furnished incident to a physician's service except when administered in a renal dialysis facility. In addition, Epogen is covered for patients with CRF who are on dialysis when:

- It is administered in the renal dialysis facility; or
- It is self-administered in the home by any dialysis patient (or patient caregiver) who is determined competent to use the drug and meets the other conditions listed below.

Requirements for Self Administration of Epogen

Self-administration of Epogen and items related to its administration are covered for dialysis patients who use Epogen in the home when the following conditions are met:

1. Patient Care Plan—a dialysis patient who uses EPO in the home must have a care plan for monitoring home use of EPO which includes the following:
 - a. Review of diet and fluid intake for aberrations as indicated by hyperkalemia and elevated blood pressure secondary to volume overload;
 - b. Review of medications to ensure adequate provision of supplemental iron;
 - c. Ongoing evaluations of hematocrit and iron stores;
 - d. Re-evaluation of the dialysis prescription taking into account the patient's increased appetite and red blood cell volume;

- e. Method for physician follow-up on blood tests and a mechanism (such as a patient log) for keeping the physician informed of the results;
 - f. Training of the patient to identify the signs and symptoms of hypotension and hypertension; and
 - g. The decrease or discontinuance of EPO if hypertension is uncontrollable.
2. Patient selection—the dialysis facility, or the physician responsible for all dialysis-related services furnished to the patient, must make a comprehensive assessment that includes the following:
- a. Pre-selection monitoring—the patient’s hematocrit (or hemoglobin), serum iron, transferrin saturation, serum ferritin, and blood pressure must be measured.
 - b. Conditions the patient must meet—the assessment must find that the patient meets the following conditions:
 - 1. Is a dialysis patient;
 - 2. Has a hematocrit (or comparable hemoglobin level) that is as follows:
 - a. For a patient who is initiating EPO treatment, no higher than 30 percent unless there is medical documentation showing the need for EPO despite a hematocrit (or comparable hemoglobin level) higher than 30 percent. Patients with severe angina, severe pulmonary distress, or severe hypotension may require EPO to prevent adverse symptoms even if they have higher hematocrit or hemoglobin levels.
 - b. For a patient who has been receiving EPO from the facility or the physician, between 30 and 36 percent; and
 - 3. Is under the care of:
 - a. A physician who is responsible for all dialysis-related services and who prescribes the EPO and follows the drug labeling instructions when monitoring the EPO home therapy; and
 - b. A renal dialysis facility that establishes the plan of care and monitors the progress of the home EPO therapy.
 - c. The assessment must find that the patient or a caregiver meets the following conditions:
 - 1. Is trained by the facility to inject EPO and is capable of carrying out the procedure;
 - 2. Is capable of reading and understanding the drug labeling; and
 - 3. Is trained in, and capable of observing, aseptic techniques.
 - d. Care and storage of the drug—the assessment must find that EPO can be stored in the patient’s residence under refrigeration, and that the patient is aware of the potential hazard of a child’s having access to the drug and syringes.

3. Responsibilities of physician or dialysis facility—the patient’s physician or dialysis facility must:
- a. Develop a protocol that follows the drug label instructions;
 - b. Make the protocol available to the patient to ensure safe and effective home use of EPO;
 - c. Through the amounts prescribed, ensure that the drug on hand at any time does not exceed a 2-month supply;
 - d. Maintain adequate records to allow quality assurance for review by the network and state survey agencies. For Method II patients, current records must be provided to and maintained by the designated backup facility.

HCPCS Codes

Listed below are the codes associated with the hematocrit levels that are reported using value code 49. HCPCS codes are not required on the UB-92 form.

Q9920	Injection of EPO, per 1,000 units, at patient HCT of 20 or less
Q9921	Injection of EPO, per 1,000 units, at patient HCT of 21
Q9922	Injection of EPO, per 1,000 units, at patient HCT of 22
Q9923	Injection of EPO, per 1,000 units, at patient HCT of 23
Q9924	Injection of EPO, per 1,000 units, at patient HCT of 24
Q9925	Injection of EPO, per 1,000 units, at patient HCT of 25
Q9926	Injection of EPO, per 1,000 units, at patient HCT of 26
Q9927	Injection of EPO, per 1,000 units, at patient HCT of 27
Q9928	Injection of EPO, per 1,000 units, at patient HCT of 28
Q9929	Injection of EPO, per 1,000 units, at patient HCT of 29
Q9930	Injection of EPO, per 1,000 units, at patient HCT of 30
Q9931	Injection of EPO, per 1,000 units, at patient HCT of 31
Q9932	Injection of EPO, per 1,000 units, at patient HCT of 32
Q9933	Injection of EPO, per 1,000 units, at patient HCT of 33
Q9934	Injection of EPO, per 1,000 units, at patient HCT of 34
Q9935	Injection of EPO, per 1,000 units, at patient HCT of 35
Q9936	Injection of EPO, per 1,000 units, at patient HCT of 36
Q9937	Injection of EPO, per 1,000 units, at patient HCT of 37
Q9938	Injection of EPO, per 1,000 units, at patient HCT of 38
Q9939	Injection of EPO, per 1,000 units, at patient HCT of 39
Q9940	Injection of EPO, per 1,000 units, at patient HCT of 40 or above

ICD-9 Codes That Support Medical Necessity

285.8*	Other specified anemias
285.9*	Anemia, unspecified
403.01	Malignant hypertensive renal disease with renal failure
403.11	Benign hypertensive renal disease with renal failure
403.91	Unspecified hypertensive renal disease with renal failure
404.02	Malignant hypertensive heart and renal disease with renal failure
404.03	Malignant hypertensive heart and renal disease with congestive heart failure and renal failure
404.12	Benign hypertensive heart and renal disease with renal failure
404.13	Benign hypertensive heart and renal disease with congestive heart failure and renal failure
404.92	Unspecified hypertensive heart and renal disease with renal failure
404.93	Unspecified hypertensive heart and renal disease with congestive heart failure and renal failure
585	Chronic renal failure
586	Renal failure, unspecified

* These diagnoses must be submitted with the appropriate condition causing the anemia.

HCPCS Section and Benefit Category

Drugs and Biologicals

HCFA National Coverage Policy

Hospital Manual, Section 230.4B4, E205C
 Intermediary Manual, Section 3168D, 3644D, 3907.2
 Renal Dialysis Facility Manual, Section 207.5, 319

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 Code(s)

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

Sources of Information

United States Pharmacopoeia Drug Information
1998 Physician's Desk Reference

Beusterien, K., Nissenson, A., Port, F., Kelly, M., Steinwald, B., & Ware, J. (1996). The effects of recombinant human erythropoietin on functional health and well-being in chronic dialysis patients. *Journal of the American Society of Nephrology*, 7(5). 763-773.

Erslev, A. (1997). Erythropoietin in the pathogenesis and treatment of the anemia of chronic renal failure. *Kidney International*, 51, 622-630.

Valderrabano, F. (1996). Erythropoietin in chronic renal failure. *Kidney International*, 50, 1373-1391.

Coding Guidelines

On initial claims for Epogen, the provider must report the most recent hematocrit and/or hemoglobin prior to the initiation of EPO therapy. On subsequent claims, the provider must report the latest hematocrit or hemoglobin performed in the billing period. The hemoglobin (value code 48) or hematocrit (value code 49) and the total units of EPO administered during the billing period (value code 68) must be reported in form locators 39-41.

Payment for Epogen is made in addition to the composite rate. The following information must be included on the UB-92 claim form:

- In form locator field 42, enter revenue code 634 (Erythropoietin [EPO] less than 10,000 units) or 635 (Erythropoietin [EPO] 10,000 or more units).
- In form locator field 39-41 enter value code 48 for reporting the hemoglobin reading or value code 49 for reporting the hematocrit reading.
- In form locator field 39-41, enter value code 68 and the total EPO units administered during the billing period.

In addition to the above information, Epogen billed for beneficiaries who are self-administering the drug, must submit condition code 70 in form locator field 24-30 to indicate that facilities are requesting payment for a supply of EPO furnished to a beneficiary. In cases where the facility is billing for both a supply and for administrations, field locator 46 must be completed to indicate the number of administrations given.

Note: Initially, a facility may bill for up to a two-month supply of Epogen for beneficiaries who meet the criteria for selection for self-administration. After the initial two months' supply, bill for one month's supply at a time.

Documentation Requirements

On the initial claim, the documentation (as indicated by the value codes 48 or 49 in form locator fields 39-41) must indicate the patient has a hematocrit of < 30% or a hemoglobin < 10 g/dl prior to initiation of EPO therapy. If the patient's hematocrit level is greater than or equal to 30 or a hemoglobin level greater than or equal to 10, then the documentation supporting the medical necessity for initiation of Epogen therapy despite the increased hematocrit or hemoglobin level must be maintained in the patient's medical record.

In addition, it is expected that a patient has a creatinine level > 3 mg/dl prior to initiation of Epogen therapy. This information must be maintained in the patient's medical record.

Other documentation that the provider is to maintain in the patient's medical record is:

- The patient's weight in kilograms;
- The Epogen units administered per kilogram of body weight; and
- Medical justification for administration of Epogen exceeding standards of normal clinical practice.

For patients self-administering Epogen, the following information must be available in the medical records:

- Patient care plan;
- Comprehensive assessment of patient; and
- Protocol identifying drug label instructions and home use of EPO.

Documentation maintained in the patient's file must support the medical necessity for continuation of Epogen therapy despite a hematocrit level greater than 36%. The medical record should describe the ongoing assessment of therapy (e.g., symptoms, dosage changes, lab work) over time.

Other Comments

N/A

CAC Notes

This policy does not reflect 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 Nephrology. ❖

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 2711

Jacksonville, FL 32231-0048

Facility Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Attention: _____ Area Code/Telephone Number: _____

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, Medpard 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”, “Hypertrm”, “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
(904) 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. ❖

FREE Medicare Training Courses

The Health Care Financing Administration (HCFA), through its Medicare contractor, First Coast Service Options, Inc. (FCSO) now offers a free Medicare Online Training Web Site (www.medicaretraining.com), designed to capitalize on the emerging Internet-based training market. Users can access the site to download free Medicare computer based training (CBT) courses that help them develop their Medicare billing skills and knowledge.

Each course is national in scope. CBT users can apply what they learn, no matter what state they are in. There are seven courses currently available, and three more courses are planned for 1999.

- ICD-9-CM Coding
- Front Office Management
- HCFA-1500 Claims Filing
- UB-92 HCFA-1450 Claims Filing
- Medicare Fraud & Abuse
- Medicare Home Health Benefit
- Introduction to the World of Medicare

Here's how it works:

Users visit the Medicare Online 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.

Computer Based Training 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 repeat the courses 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. ❖

MEDIFEST

Medicare Part A and B Symposiums for Physicians, Hospitals, Facilities, Suppliers, Office Manager, Non-Physician Practitioners, and Billing Staff

Medifest is a symposium of seminars that offer the latest and most accurate information regarding Medicare guidelines.

1999 Medifest Dates and Locations

LOCATION	ADDRESS
<p>ORLANDO <i>Medifest</i> <i>August 17-18</i></p> <p><i>Specialty Seminars</i> <i>August 19</i></p>	<p>Orlando Airport Marriott 7499 Augusta National Drive Orlando, FL 32822 (407) 851-9000</p> <p>Hotel: Orlando Airport Marriott ask for the Medifest Seminar hotel rate of \$85.00</p>
<p>MIAMI <i>Medifest</i> <i>Sept 21-22</i></p> <p><i>Specialty Seminars</i> <i>Sept 23</i></p>	<p>Radisson Mart Center 711 NW 72nd Ave Miami, FL 33126 (305) 261-3800</p> <p>Hotel: Radisson Mart Plaza Hotel ask for the Medicare/Medifest hotel rate of \$109.00</p>

Continuing Education Units Available

You can obtain continuing Education Units (CEUs) for most Medifest courses. Details regarding CEUs may be obtained from your Medifest Course Instructor or the Medifest Training Coordinator when you register.

5 Good Reasons

why you can't afford to miss these symposiums!

1. *You'll gain strategies for implementing processes to improve reimbursement efficiency.*
2. *You'll find out proven ways to resolve Medicare denials.*
3. *You'll discover new Medicare technologies and different avenues of education.*
4. *Your questions will be answered directly by Medicare experts.*
5. *You'll get the rare opportunity to make contacts and network with other providers who face the same challenges you do.*

IMPORTANT REGISTRATION INFORMATION

- ◆ *Pre-registration and pre-payment are required. See registration form inside for more information. Note: Bring your confirmation number to the seminar.*
- ◆ *Since seating is limited please register as soon as possible. All registrations may be faxed to Medicare Seminar Registration at (904)791-6035.*
- ◆ *Some courses require additional materials (e.g., ICD-9-CM book, CPT book, etc.). Please see course description on the Medicare bulletin board system (BBS) for more information.*
- ◆ *Only register for one course per time slot.*

Medifest/Specialty Seminar Registration Form

August - September 1999

Anyone interested in learning about Medicare billing may attend. Photocopies of these forms are acceptable. Be sure to make a copy of all forms for your records. Please print your name on all pages before you fax your registration to us.

Complete the Registration Form (one form per person)

<p>Registration</p> <ul style="list-style-type: none"> • Pre-registration is required. Registration will not be accepted at the door. <p>Payment</p> <ul style="list-style-type: none"> • Prepayment is required. Your method of payment may be in the form of checks or money orders (only). <p>Cancellations and Refunds</p> <ul style="list-style-type: none"> • All cancellation requests must be received 7 days prior to the seminar to receive a refund. • All refunds are subject to a \$20 per person cancellation fee. NO refunds or rainchecks will be issued for cancellations received less than 7 days prior to the event. (Also see substitution policy) <p>Substitution</p> <ul style="list-style-type: none"> • If you cannot attend, your company may send one substitute to take your place for the entire seminar. (Registration must be informed of any changes) • Once you have signed in at the seminar, substitutions will not be permitted for the remainder of the seminar. <p>Confirmation Number</p> <ul style="list-style-type: none"> • Your confirmation number will be issued by fax from Seminar Registration. • It is very important that you have a confirmation number. YOU MUST BRING THIS NUMBER WITH YOU. • If you do not receive a confirmation number, please call (904) 791-8299. 	<p style="text-align: center;">Please Print</p> <p>Registrant's Name _____</p> <p>Provider's Name _____</p> <p>Medicare billing provider # _____ (leave blank if you do not have one)</p> <p>Address _____</p> <p>City, State, ZIP code _____</p> <p>Phone () _____ Fax () _____</p> <p>Does your office bill electronically? Yes _____ No _____</p> <p>How did you learn about Medifest? Medicare B Update! _____ Part A Bulletin _____</p> <p>BBS _____ Co-worker _____ Other _____ Attended Previously _____ - _____ times</p> <div style="border: 1px solid black; padding: 5px; text-align: center;"> <p><i>Medifest/Specialty Seminar Package Deals are only valid for the same location/week</i></p> </div> <p>Medifest Only <i>(please fill out one form per person)</i></p> <p><input type="checkbox"/> One day Medifest \$149 - per person</p> <p><input type="checkbox"/> Two day Medifest \$199 - per person</p> <p>Specialty Seminar Only</p> <p><input type="checkbox"/> One Specialty Seminar \$99 - per person</p> <p>Medifest/Specialty Seminar Package Deals</p> <p><input type="checkbox"/> One day at Medifest and one Specialty Seminar \$199 - per person</p> <p><input type="checkbox"/> Two days at Medifest and one Specialty Seminar \$249 - per person</p> <div style="border: 1px solid black; padding: 5px; text-align: center;"> <p><i>Please ✓ check the location and Medifest/Specialty Seminars you will be attending</i></p> </div> <p>Orlando Medifest - August 17 & 18</p> <p>_____ Medifest - August 17 & 18, 1999 (payment and registration must be received by August 9, 1999)</p> <p>_____ Specialty Seminars - August 19, 1999 (payment and registration must be received by August 9, 1999)</p> <p>Miami Medifest - September 21 & 22</p> <p>_____ Medifest - September 21 & 22, 1999 (payment and registration must be received by September 13, 1999)</p> <p>_____ Specialty Seminars - September 23, 1999 (payment and registration must be received by September 13, 1999)</p>
<p>FOUR IMPORTANT STEPS</p>	
<p>Please follow all four</p> <p>STEP 1 FAX both registration form and class schedule to (904)791-6035.</p> <p>STEP 2 Make checks payable to First Coast Service Options(FCSO) Account #756240.</p> <p>STEP 3 (After you have faxed your form) Mail the form and payment to:</p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>Medifest Registration PO Box 45157 Jacksonville, FL 32231</p> </div> <p>STEP 4 YOU MUST BRING YOUR CONFIRMATION NUMBER WITH YOU.</p>	

Medifest Class Schedule

August - September 1999

Registrant's Name: _____

Please register for only one class per time slot.

Day 1

**August 17
September 21**

Day 2

**August 18
September 22**

8:30 - 10:00

- 54 Program Changes (A/B)
- 08 Medicaid (A/B)
- 57 PC-ACE for UB92 Claims Filing (A)
- 25 Direct Data Entry (A)
- 09 Bulletin Board System (BBS) (A/B)

8:30 - 12:00*

**check this section only if you have not checked a class from 8:30-10:00 or 10:30 12:00*

- 55 E/M Documentation & Coding (B)
- 05 Partial Hospitalization Program (A)
- 56 Medicare Part B Claims Filing (B)

10:30 - 12:00

- 76 Reimbursement Efficiency for Part A (A)
- 13 Global Surgery (B)
- 15 Electronic Media Claims (B)
- 19 Primary Care (B)
- 58 PC-ACE for HCFA-1500 Claims Filing (B)

1:30 - 3:00

- 59 Medical Review (A/B)
- 24 Bulletin Board System(BBS) (A/B)
- 60 Reimbursement Efficiency for Part B (B)
- 61 Direct Data Entry (A)
- 23 Medicaid (A/B)
- 62 How to Help Your Patients Understand Medicare (A/B)

1:30 - 5:00*

**check this section only if you have not checked a class from 1:30-3:00 or 3:30 5:00*

- 63 E/M Documentation & Coding (B)
- 44 ICD-9-CM for Beginners (B)

3:30 - 5:00

- 14 Fraud & Abuse (A/B)
- 06 Inquiries and Appeals (B)
- 66 Advanced Registered Nurse Practitioner/Physician Assistant (B)
- 28 Electronic Media Claims (B)

8:30 - 10:00

- 67 How to Help Your Patients Understand Medicare (A/B)
- 36 Electronic Media Claims (B)
- 70 Advanced Registered Nurse Practitioner/Physician Assistant (B)
- 47 Inquiries and Appeals (B)

8:30 - 12:00*

**check this section only if you have not checked a class from 8:30-10:00 or 10:30 12:00*

- 03 ICD-9-CM for Beginners (B)
- 71 UB-92 Claims Filing (A)

10:30 - 12:00

- 48 Global Surgery (B)
- 42 Bulletin Board System(BBS) (A/B)
- 43 Medicaid (A/B)
- 81 Reimbursement Efficiency for Part B (B)

1:30 - 3:00

- 72 Program Change (A/B)
- 73 How to Help Your Patients Understand Medicare (A/B)
- 52 Primary Care (B)
- 41 Medicaid (A/B)
- 50 Electronic Media Claims (B)
- 69 Reimbursement Efficiency for Part A (A)

1:30 - 5:00*

**check this section only if you have not checked a class from 1:30-3:00 or 3:30 5:00*

- 74 Medicare Part B Claims Filing (B)
- 17 CPT for Beginners (B)
- 75 E/M Documentation & Coding (B)

3:30 - 5:00

- 77 Medical Review (A/B)
- 53 Bulletin Board System(BBS) A/B)
- 01 Skilled Nursing Facilities/Consolidated Billing (A/B)
- 27 Fraud & Abuse (A/B)

Your registration form must accompany your class schedules

Specialty Seminar Class Schedule (Only \$99)

(Package deals are only valid for same location and week)

Registrant's Name _____

Orlando - August 19, 1999

A.M. 8:30 - 12:00

- 302 Medicare Part A Symposium (A)
- 306 Radiology (B)
- 307 Cardiology (B)
- 309 Mental Health (B)
- 317 Anesthesia (B)
- 320 Ambulatory Surgical Center (ASC) (B)

Miami - September 23, 1999

A.M. 8:30 - 12:00

- 306 Radiology (B)
- 308 End Stage Renal Disease - (ESRD) Facility (A)
- 309 Mental Health (B)
- 316 Orthopaedics (B)
- 319 Dermatology (B)

Your registration form must accompany your class schedule

FRAUD AND ABUSE

DHHS Announces Expanded “Senior Patrol” Grants to Help Spot Waste, Fraud, and Abuse in Medicare and Medicaid

The following information was excerpted from a U.S. Department of Health and Human Services (DHHS) press release.

DHHS Secretary Donna E. Shalala, joined by U.S. Senator Tom Harkin (D-Iowa), announced 41 grants totaling \$7 million, to expand a program that recruits and trains retired professionals to identify waste, fraud, and abuse in the Medicare and Medicaid programs.

The Senior Medicare Patrol Project grants, including 29 new and 12 renewed grants, will be distributed among 38 states, including Washington, D.C. and Puerto Rico. They are administered by the DHHS Administration on Aging to teach volunteer retired professionals such as doctors, nurses, accountants, investigators, law enforcement personnel, attorneys, teachers, and others how to work with Medicare and Medicaid beneficiaries. Volunteers work in their own communities and in local senior centers to help identify deceptive health care practices, such as overbilling, overcharging, or providing unnecessary or inappropriate services.

“We are committed to a strong, long-term effort to protect the integrity of the Medicare Trust Fund and prevent waste, fraud, and abuse in federal health programs,” Secretary Shalala said. “We have undertaken a wide range of actions within (D)HHS. We are working with the millions of honest health care providers. And equally important, we want to help enable older Americans themselves to work closely with their family members, friends, and neighbors to recognize problems and to report them. That is why today we are expanding the Senior Patrol project nationwide.”

The Senior Medicare Patrol Project grants, originally named the Health Care Anti-Fraud Waste and Abuse Community Volunteers Demonstration Projects, were authored in 1997 by Senator Harkin. The current projects have tested different models and in the past 18 months have trained more than 6,000 retired volunteers to serve as resources and educators for older persons in their communities. The train-

ees, in turn, have trained more than 70,000 Medicare beneficiaries to spot problems. Projects announced today will result in training 15,000 more volunteers, who will in turn help educate 250,000 additional beneficiaries. The projects teach not only what fraud and abuse is, but also what it isn't. Senior volunteers undergo several days of training reviewing health care benefit statements and outlining the steps seniors can take to protect themselves.

“We know that by expanding this program, even more volunteers and honest health care providers will join together to prevent older persons from being victimized,” said DHHS Assistant Secretary for Aging, Jeanette C. Takamura, “The success of this program underscores the contributions our national aging network continues to make to our country as it works closely with older Americans, their family members and peers to prevent and halt this drain on our health care system.”

The Senior Patrol project is part of the administration's broad initiative to combat waste, fraud and abuse in Medicare and Medicaid, including extensive efforts by the Health Care Financing Administration, which administers the programs, the DHHS Office of Inspector General (OIG), and the Department of Justice. Savings for this effort, including program and payment integrity improvements, total more than \$38 billion since 1993. In addition, convictions and other successful legal actions stemming from anti-fraud and abuse efforts have increased more than 240 percent during this period.

To help beneficiaries and others report possible problems, the DHHS OIG maintains a toll-free hotline, 1-800-HHS-TIPS (1-800-447-8477). The hotline has received over 50,000 tips warranting followup. In addition, DHHS and the American Association of Retired Persons (AARP), have recently joined forces in an outreach effort to AARP members, to help identify possible waste, fraud, and abuse by examining Medicare statements. ❖

Fifteen-Minute Increment Reporting Update

Note: First Coast Service Options, Inc. (FCSO) does not process claims for Home Health Agencies (HHAs) in Florida. These services are processed by Palmetto Government Benefits Association (Palmetto GBA). The information below is furnished by Palmetto GBA, and is provided as a convenience to providers who refer patients to Home Health Agencies. Any questions regarding this article should be directed to Palmetto GBA's customer service line at (803) 736-4730.

The March 1999 Monthly Medicare Advisory (Volume 99 Issue 03), informed home health agencies of the requirement to report home health visits in 15-minute increments beginning with service dates on or after July 1, 1999. Since that time, we have been notified by many home health agencies that the demands of Y2K compliance were competing with their efforts to implement the new reporting requirement. In recognition of this and in an effort to minimize the impact of these changes on home health agencies, HCFA has instructed Palmetto GBA to implement 15-minute increment reporting in the following "phased in" manner.

Effective July 1, 1999, claims processing systems will be changed to accommodate the reporting of the new home health specific HCPCS codes and the use of Form Locator 46 (service units) to report a number of fifteen minute increments rather than a number of service visits. In order to accommodate these changes, FISS will be changing the way that total home health visits are counted. Rather than using the 'service units' in Form Locator 46 on the claim, FISS must count each line on the claim with a visit related revenue code as one single, separate visit. Since claims are still paid per visit, payment will reflect the number of revenue lines on the claim, rather than the number of 'service units' in Form Locator 46.

Home health agencies should make every effort to prepare their billing systems to conform to these changes by July 1, 1999. Agencies should bill each visit as a separate line item, with the appropriate HCPCS code and with the number of 15-minute increments reported in Form Locator 46. If these instructions are followed, a claim with 'statement covers' dates (Form Locator 6) beginning on or after July 1, 1999, will process and be paid correctly. The HCPCS codes reported on the claim will be validated by FISS and claims will return to provider (RTP) if an incorrect HCPCS code is found.

If an agency cannot prepare their systems to report these HCPCS codes by July 1, 1999, FISS will allow these claims to be processed without them for a grace period that will end September 30, 1999. However, these agencies should be aware that visits for all claims will be counted by our system based on the number of revenue line items. If an agency continues to report multiple visits (rather than 15-minute increments) in Form Locator 46 on any given revenue line, that line will be interpreted after July 1, 1999, to represent a single visit and that provider may be underpaid. The agency would then need to submit an adjustment claim showing the additional visits as separate line items in order to receive the correct payment.

By allowing this degree of flexibility for a temporary period, providers can be assured that their cash flow will not be stopped by rejected claims. Some adjustment billing

could be necessary, but this can be avoided by billing one visit per line. If adjustment billing is necessary, cash flow may be affected as adjustment claims take longer to process. On or after October 1, 1999, all agencies will be expected to be in compliance with the new reporting requirement and any bill type 32x or 33x claim (for dates of service July 1, 1999, or after) without HCPCS coding will RTP.

Agencies should be aware of one additional caution. These changes in FISS are linked to 'statement covers' dates on claims. Claims with statement dates prior to July 1, 1999 but received after that date will be processed according to the reporting requirements that were in effect as of the statement dates (i.e., for claims with dates prior to July 1, 1999 units will be interpreted by the system as visits). Therefore, FISS will be programmed to RTP claims received with HCPCS codes for statement dates prior to July 1, 1999, in order to prevent the increments reported on those claims from being read as visits, resulting in an overpayment. Also, to ensure that these two processes operate separately, claims received with 'statement covers' dates spanning June and July 1999 will RTP by FISS and providers will need to split these into two claims with statement dates exclusive to June and to July.

It is important that you bill your June and July 1999 services on separate bills in order to receive the correct reimbursement. The 15-minute increment reporting changes will change where FISS looks for the total number of visits billed when calculating the reimbursement amount. For claims with services on or before June 30, 1999, FISS will use the 'Service Units' associated with revenue lines for disciplines identified as visits. For claims with services on or after July 1, 1999, FISS will begin counting each detail line with revenue lines for disciplines identified (one visit per revenue line) to determine the number of visits for calculating reimbursement.

Examples:

A. Example of billing with HCPCS coding:

42 REV CD	43 DESCRIPTION	44 HCPCS/ RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
055x	SKILLED NURSING FOR 45 MIN.	G0154	070199	3		
042x	PT VISIT FOR 1 HOUR	G0151	070599	4		
056x	MSW VISIT FOR 30 MIN.	G0155	070399	2		
057x	HH AIDE VISIT FOR 1 HOUR	G0156	070199	4		

This bill would not be returned to the provider. This provider would be reimbursed for 4 visits.

B. Example of billing without HCPCS coding:

42 REV CD	43 DESCRIPTION	44 HCPCS/ RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
055x	SKILLED NURSING FOR 45 MIN.		070199	3		
042x	PT VISIT FOR 1 HOUR		070599	4		
056x	MSW VISIT FOR 30 MIN.		070399	2		
057x	HH AIDE VISIT FOR 1 HOUR		070199	4		

This bill would not be returned to the provider. This provider would be reimbursed for 4 visits. This is based on the number of revenue code lines, not the number of units reported.

C. Example of billing with invalid HCPCS:

42 REV CD	43 DESCRIPTION	44 HCPCS/ RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
055x	SKILLED NURSING FOR 45 MIN.	G0159	070199	3		
042x	PT VISIT FOR 1 HOUR	G0160	070599	4		
056x	MSW VISIT FOR 30 MIN.	G0161	070399	2		
057x	HH AIDE VISIT FOR 1 HOUR	G0152	070199	4		

This bill would be returned to the provider, as the HCPCS codes are not valid for the revenue codes billed. This provider otherwise would have been reimbursed for 4 visits.

D. Example of billing with multiple visits on one day:

42 REV CD	43 DESCRIPTION	44 HCPCS/ RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
055x	SKILLED NURSING FOR 45 MIN.	G0154	070199	3		
042x	PT VISIT FOR 1 HOUR	G0151	070599	4		
042x	PT VISIT FOR 15 MIN	G0151	070599	1		
056x	MSW VISIT FOR 30 MIN.	G0155	070399	2		
057x	HH AIDE VISIT FOR 1 HOUR	G0156	070199	4		

This bill would not be returned to the provider. This provider would be reimbursed for 5 visits.

E. Example of billing with June and July services:

42 REV CD	43 DESCRIPTION	44 HCPCS/ RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
055x	SKILLED NURSING FOR 45 MIN.	G0154	062899	1		
055x	SKILLED NURSING FOR 1 HOUR	G0154	070299	1		
042x	2 PT VISITS FOR 1 HOUR	G0151	063099	2		
042x	PT VISIT FOR 15 MIN	G0151	070599	1		
056x	MSW VISIT FOR 30 MIN.	G0155	070399	2		
057x	HH AIDE VISIT FOR 1 HOUR	G0156	070199	1		

This bill would be returned to the provider, as it contains services in June and July of 1999. The provider would need to split the claim in example E as follows:

42 REV CD	43 DESCRIPTION	44 HCPCS/ RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
055x	SKILLED NURSING VISIT		062899	1		
042x	2 PT VISITS		063099	2		

The provider would be reimbursed for 3 visits:

42 REV CD	43 DESCRIPTION	44 HCPCS/ RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
055x	SKILLED NURSING FOR 1 HOUR	G0154	070299	4		
042x	PT VISIT FOR 15 MIN	G0151	070599	1		
056x	MSW VISIT FOR 30 MIN	G0155	070399	2		
057x	HH AIDE VISIT FOR 1 HOUR	G0156	070199	4		

The provider would be reimbursed for 4 visits.

Regarding the counting of increments, the Medicare Advisory, Volume 99 Issue 03, stated "When counting the number of 15-minute intervals, do not report services lasting less than 8 minutes." Please disregard those instructions. We have a received clarification from HCFA on this issue.

HCFA stated that visits of any length are to be reported and rounded to the nearest fifteen-minute increment. The chart for assistance in rounding minutes into increments should be amended as follows:

- 1 unit 1 minutes to < 23 minutes
- 2 units > 23 minutes to <38 minutes
- 3 units > 38 minutes to <53 minutes
- 4 units > 53 minutes to <68 minutes
- 5 units > 68 minutes to <83 minutes
- 6 units > 83 minutes to <98 minutes
- 7 units > 98 minutes to <113 minutes
- 8 units > 113 minutes to <128 minutes

The pattern continues for longer periods of time.

If patient assessment activities for completion of the OASIS data set are a part of an otherwise covered and billable visit, time spent in patient assessment may be included in the total count of 15-minute increments. The completion of the assessment activities must be incorporated into a visit providing otherwise necessary home health care to the beneficiary. A separate visit made only to collect information for the OASIS assessment but not to provide other covered home health services would not be billable, but would be a coverable overhead expense to the agency.

Applicable Revenue Codes

In addition to the revenue codes 42x, 43x, 44x, 55x, 56x, and 57x reported on bill types 32x and 33x, visits billed under revenue codes 58x or 59x should also be reported in 15-minute increments. As with visits in the 6 disciplines, report each visit billed under revenue codes 58x or 59x as a separate line item. Report the elapsed time of the visit in 15-minute increments, indicating the number of 15-minute increments in the "Service Units" field of the claim form. Since services billed under these revenue codes are not linked to a specific discipline, HCPCS coding for these line items is not required.

Electronic Billing Information

When implementing the 15-minute requirement for electronic billing the following information will be used for the formatting.

The correct field locator for revenue codes on the UB-92 version 5.0 is FL 4.

The following are instructions for the electronic X12 institutional claim transaction 837 version 3051.

- X12 837, version 3051, implementation 3A.01:
- 2 395 SV201 - Revenue Center Code
- 2 395 SV202-01 - HC Qualifier
- 2 395 SV202-02 - HCPCS Procedure Code
- 2 395 SV205 - Units of service

- X12 837, version 3051, implementation 1A.C1:
- 2 375 SV201 - Revenue Center Code
- 2 375 SV202-01 - HC Qualifier
- 2 375 SV202-02 - HCPCS Procedure Code
- 2 375 SV205 - Units of service

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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