

# Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

## In This Issue...

Information About the Re-designed *Medicare A Bulletin*  
*Read about the changes made to the Bulletin, effective this issue!* .....4

Are You Ready for the Year 2000?  
*A checklist to assess your office's readiness for the "Year 2000 bug"* .....5

Beneficiary Right to Itemized Statement for Medicare Items and Services  
*Information about this important beneficiary right* .....8

Medical Policies  
*Final medical policies. These changes will affect your facility!* .....12

Cardiac Output Monitoring by Electrical Bioimpedance  
*Coverage now available for certain patients* .....107

Pancreas Transplantation  
*Coverage available, effective July 1, 1999* ..... 108

Enhanced External Counterpulsation (EECP)  
*Coverage now available for patients with stable angina pectoris* .....108

Transmyocardial Revascularization (TMR)  
*Coverage available for patients with severe angina* .....109

## Features

From the Medical Director	3
Administrative	5
Medical Policy	12
General Coverage	107
Hospital	113
Rural Health Clinic	114
Bulletin Board System	115
Medifest Seminars	117

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

### Routing Suggestions:

- Medicare Manager
- Reimbursement Director
- Chief Financial Officer
- Compliance Officer
- Other \_\_\_\_\_



**Medicare A  
Bulletin**

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Publications Staff:  
Alan Tolleson  
Bill Angel  
Cynthia Moore  
Millie C. Perez

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Medicare Part A Medicare Education and Outreach - Pubs.  
P.O. Box 2078  
Jacksonville, FL 32231-0048

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**TABLE OF CONTENTS**

In This Issue .....	1	92081-92083: Visual Field Examination .....	64
Features .....	1	92225, 92226: Ophthalmoscopy .....	70
Table of Contents .....	2	92235: Fluorescein Angiography .....	74
The Winds Of Change .....	3	92240: Indocyanine-Green Angiography .....	78
<b>Administrative</b>		93224-93227, 93231-93237: Holter Monitoring .....	80
Information About the Re-designed <i>Medicare A Bulletin</i> .....	4	93012, 93268, 93270, 93271, G0004-G0006, G0015: Patient Demand Single or Multiple Event Recorder.....	84
<b>Year 2000</b>		93501, 93510, 93511, 93514, 93524, 93527-93529, 93530-93533 : Cardiac Catheterization .....	89
Are You Ready for the Year 2000? .....	5	93975-93979: Duplex Scanning .....	95
Implementation of HCFA Y2K Outreach Toll-Free Line .....	6	99183: HBO Therapy .....	101
<b>Claim &amp; Bill Submission Information</b>		<b>General Coverage</b>	
Requirement to Submit Bills in Sequence for a Continuous Inpatient Stay or Course of Treatment .....	6	G0160, G0161: Cryosurgery of Prostate .....	107
Removal of Edits Requiring Providers to Submit Home Health Claims in Sequence .....	6	M0302: Cardiac Output Monitoring by Electrical Bioimpedance .....	107
Need to Reprocess Inpatient or Hospice Claims in Sequence When Liability Changes .....	7	33246: Implantation of Automatic Defibrillators .....	107
Notice of New Interest Rate for Overpayments and Underpayments .....	7	48554: Pancreas Transplantation .....	108
Line Item Date of Service .....	7	97016: Coverage and Billing Guidelines for Enhanced External Counterpulsation (EECP) .....	108
Beneficiary Right to Itemized Statement for Medicare Items and Services .....	8	Transmyocardial Revascularization (TMR) for Treatment of Severe Angina .....	109
More Information About the Extension of Due Date for Filing Provider Cost Reports .....	9	Qualified Candidates for Hepatitis C Lookback .....	110
Additions and Changes to the Medicare Remarks Codes .....	9	Radiochemicals not Covered .....	110
<b>Medical Policy</b>		New Waived Tests .....	110
G0030-G0047, G0125, G0126, G0163-G0165: PET Scan .....	13	<b>Hospital</b>	
G0160, G0161: Cryosurgical Ablation of the Prostate .....	20	Reopenings for Sole Community and Medicare Dependent Hospital Open Cost Reports Affected by the Cost Report Change .....	113
J0205, J1785: Ceredase/Cerezyme .....	22	Payment for Blood Clotting Factor Administered to Hemophilia Inpatients .....	113
J9000, J9170, J9350, J9999: Antineoplastic Drugs .....	24	<b>Rural Health Clinic</b>	
59840, 59841, 59850-59852, 59855-59857, 59866: Elective Abortion .....	31	Laboratory Services .....	114
61885, 64573, 64585, 64590, 64595, 95970, 95971, 95974, 95975: Vagus Nerve Stimulation .....	33	Laboratory Tests and Venipunctures Performed in an RHC .....	114
72192-72194: Computed Tomography of the Pelvis .....	37	<b>Bulletin Board System</b>	
80100-80102: Qualitative Drug Screen .....	44	Medicare Online BBS .....	115
82270: Fecal Occult Blood Testing .....	47	Using Windows 95/NT/98 to Access Medicare Online BBS .....	116
84154: Free Prostate Specific Antigen .....	52	<b>Medifest and Specialty Seminars</b>	
86235: Extractable Nuclear Antigen .....	54	Medifest and Specialty Seminar Information .....	117
88142-88155, 88164-88167, G0123, G0143-G0145, G0147, G0148, P3000: Pap Smears .....	56		
90846, 90847, 90849: Family Psychotherapy .....	61		

### The Winds Of Change

The winds of change are blowing strongly for Medicare. Nationally, several initiatives, including the Balanced Budget Act of 1997, have brought some of the most sweeping changes to the Medicare program since its inception in 1966. Here at home, Blue Cross and Blue Shield of Florida (BCBSF) has launched First Coast Service Options (FCSO), Inc. to assume BCBSF's current Medicare contracts and pursue new business. FCSO (sounds like fix-so) is a wholly-owned subsidiary of BCBSF and, as such, you will continue to receive the same high levels of service and satisfaction that BCBSF has provided to the Medicare program for more than three decades.



As depicted by our logo, FCSO is a vessel under full sail, serving as our symbol that we are committed to staying our course through the high seas and winds of change now sweeping the ocean of health care. By making this change, we are making a long-term commitment to the Medicare program, a commitment that will benefit all Medicare beneficiaries and providers in Florida.

The formation of FCSO reflects BCBSF's response to the Health Care Financing Administration's (HCFA) new contracting strategy which emphasizes enhanced customer service and Medicare program safeguard functions. This new approach also increases opportunities for partnerships that achieve economies of scale, and promotes innovations that will reduce costs and improve management of the Medicare program.

Like BCBSF, FCSO will serve as an intermediary for Medicare Part A claims and as the carrier for Medicare Part B claims. Additionally, we will process claims for several other Medicare intermediaries, maintain the national Part A claims processing system for HCFA and provide beneficiary eligibility verification for Medicare contractors in Florida and Georgia.

Our 1,200 highly-talented employees and managers are the same individuals who oversaw the Medicare program as part of BCBSF. This brings the added benefits of excellence, experience, commitment and stability- the same as Floridians have come to expect from Blue Cross and Blue Shield of Florida's Medicare administration over the past 33 years. Indeed, as one of the largest Medicare contractors in the country, in 1999 we expect to process almost 55 million claims, issue approximately \$9 billion in benefit payments and respond to almost 3 million customer inquiries from Florida's Medicare beneficiaries and providers.

We believe our mission is to help Medicare beneficiaries improve their health by assisting them in receiving efficient, quality health care, and to deliver excellent, cost-effective administrative services. We also strongly believe that our transformation to FCSO will enhance the Medicare experience of beneficiaries and providers, and that we are perfectly situated to grow and evolve with Medicare through changes in the years to come.

We look forward to continuing to serve you in our role as one of the nation's largest Medicare administrators. We are proud of our reputation for efficiency and our good standing amongst beneficiaries and providers, and anticipate that we will continue to excel at meeting your needs as stewards of the Medicare program.

Sincerely,

Sidney R. Sewell, M.D.  
Medical Director

## Information About the Re-designed Medicare A Bulletin

The Medicare Education and Outreach Department is pleased to announce several enhancements to the Medicare A Bulletin. Starting with this edition, June/July 1999, the Bulletin will be produced in a magazine-style format, and all Part A providers will receive the same edition.

The Bulletin will be published bimonthly (i.e., every two months) beginning with June/July 1999, which will be released the first week of June. Editions to be published through the remainder of calendar year 1999 are:

- August/September 1999
- October/November 1999
- December 1999/January 2000
- HCPCS 2000 Special Edition (scheduled to be released in late December 1999)

The Bulletin will be mailed during the first two weeks of the first month of an edition (e.g., the first week of August for the August/September issue).

### **How Will I Know What Articles to Read?**

The Bulletin is divided into general sections that all providers should read, and facility-specific sections, which only those providers who work in or with the facilities in question need to read.

The publication will begin with an article by the contractor's Medical Director. Following is the Administrative section, which contains general information for all facilities and Part A providers, including Year 2000 information, ARU upgrades, Medicare secondary payer, cost reports, and interest rates. The Medical Policy section follows, then the General Coverage section is included. General Coverage contains coverage guidelines applicable to all facilities and Part A providers. Next, sections containing information specific to facility types are included. These sections will appear in the Bulletin only when an article in that category is published. (For example, if there is no CORF/ORF information to be published, that section will be omitted.) Then, as needed, Electronic Data Interchange (EDI) information will appear. Finally, at the end of the Bulletin, other general information will be included, such as Medifest schedules, information pertaining to the Medicare Online BBS (the contractor's on-line bulletin board system), and reproducible forms. Important phone numbers are on the back cover.

### **Who Will Receive the Re-designed Bulletin?**

If you currently receive the Bulletin, you will continue to receive the re-designed Bulletin. Please remember that Medicare Part A (First Coast Service Options, Inc.) uses the same mailing address for all correspondence, and cannot designate that each issue of the Bulletin 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 with the Medicare Registration Department.

### **Bulletin Represents Formal Notice of Coverage Policies**

Remember that articles included in each Medicare A Bulletin represent formal notice that specific coverage policies either have or will take effect on the date given. Providers who receive each issue are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines. Medicare Part A (First Coast Service Options, Inc.) maintains copies of the mailing lists for each issue, and inclusion on these mailing lists implies that the issue was received by the provider in the event there is a dispute over whether a provider received advance notice regarding coverage of a specific service and the financial liability for it.

### **Do You Have Comments?**

We welcome your thoughts and feedback on the new publication. Please mail them to:

Medicare Education and Outreach  
Editor, Medicare A Bulletin  
P.O. Box 2078  
Jacksonville, FL 32231-0048

The publications staff hopes that you like the changes made to the *Medicare A Bulletin*.

The Medicare Education and Outreach Department wants to find out if your facility or business is ready for the challenges we may all face as a result of the Year 2000 "bug." Please complete the questionnaire below, and fax it to 904/791-8378. Tell us how you answer the question.....

# Are You Ready for the Year 2000?

## *The Non-Negotiable Deadline*

### What Can You Do To Prepare for Y2K?

Listed below are a few key tips:

1. Become aware of potential impacts
2. Assess your readiness
3. Test existing and newly purchased systems and software
4. Develop contingency plans for continuity of business

**Please take a moment to complete the sample readiness list. Additionally, please indicate any questions and/or comments you have regarding Y2K in the spaces provided below.**

Provider Type/Specialty (i.e., Skilled Nursing Facility): \_\_\_\_\_  
 Your Occupation: \_\_\_\_\_

Checklist Items	Y2K Ready	Percent of Compliance	Contingency Plan in Place? (yes/no)	Unable to determine if preparation has occurred
1. Medical Equipment				
2. Computer Hardware				
3. Computer Software				
4. Physician Referral Forms				
5. Claim Forms				
6. Billing Requirements				
7. Diagnostic Equipment				
8. Custom Applications				
9. Personnel Training Completed				
10. Telephone Systems				

**Questions?**

**Your thoughts regarding Y2K.....**

**Additional Information on Y2K may be obtained from the following Web sites.**

- 1) [www.y2k.gov](http://www.y2k.gov) 2) [www.fcc.gov/year2000](http://www.fcc.gov/year2000) 3) [www.itpolicy.gsa.gov](http://www.itpolicy.gsa.gov)

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

## Year 2000

### Implementation of HCFA Y2K Outreach Toll-Free Line

The Health Care Financing Administration (HCFA) has established a toll-free Year 2000 (Y2K) Outreach telephone site at **(800) 958-HCFA [4232]**.

Available Y2K information at this telephone site is limited to:

- \*Upcoming HCFA outreach conferences and other Y2K activities
- \*HCFA Y2K policies
- \*Y2K provider suppliers, facilities, and business issues

Provider calls to this site about contractor-specific issues may be referred to the intermediary.

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.

## Claim & Bill Submission Information

### Requirements to Submit Bills in Sequence for a Continuous Inpatient Stay or Course of Treatment

To permit accurate recording of periods of hospice election and home health benefits, hospice and home health providers must bill in the sequence in which services were furnished to each beneficiary. When a beneficiary is an inpatient of a non-preferred-provider-service hospital, distinct part unit, or swing bed for over 30 days, the provider is allowed to bill every 30 days.

If an out-of-sequence claim for a continuous stay or course of treatment is received, the intermediary searches its history for the prior bill. If the prior bill has not been processed, the bill is rejected back to the provider, with an error message and instructions for resubmitting the bill. A typical error message follows:

*Bills for a continuous stay or admission or for a hospice or home health course of treatment must be submitted in the same sequence in which services are furnished. If you have not already done so, please submit the prior bill. Then, resubmit this bill after you receive the remittance advice for the prior bill.*

If the prior bill has already been submitted, the provider should hold the rejected bill until remittance advice for the prior bill is received.

### Removal of Edits Requiring Providers to Submit Home Health Claims in Sequence

As of July 1, 1999, providers of home health services under a plan of care (bill types 32x and 33x) are no longer required to submit claims in sequence (*Medicare Intermediary Manual*, section 3603.1). This instruction does not affect current sequential billing requirements for other claim types, such as hospice claims.

### Notification to Home Providers

- Claims backlogs due to sequential billing requirements may be submitted after the effective date.
- Providers are urged to submit backlogged claims in sequence, in order to avoid later adjustments, and to submit current and future claims in sequence, when possible.
- Current payment floor requirements will be govern backlogged claims processing.

**Note:** Palmetto Government Benefits Administrator (GBA) is the regional Home Health Intermediary (HHI). The Florida Contractor, *First Coast Service Options, Inc.*, does not process HHI claims. this region's HHI claims should be filed with Palmetto GBA at:

Palmetto GBA  
P.O. Box 100141  
Columbia, SC 29202-3141

**Need to Reprocess Inpatient or Hospice Claims in Sequence When Liability Changes**

Intermediaries must process bills for multiple institutional stays or courses of treatment in the sequence in which the services were furnished. This situation occurs most often when long-term care hospitals are involved, for example, when a beneficiary experiences multiple admissions (to the same or different facilities) or is an inpatient for more than 30 days during a spell-of-illness or hospice election period.

<b>IF...</b>	<b>THE INTERMEDIARY WILL...</b>
A beneficiary, provider, or secondary insurer notifies an intermediary that out-of-sequence processing has raised the beneficiary's liability or that of a secondary insurer, or if inconsistencies are found in the hospice election record,	<p>Cancel previously processed bills for the affected spell(s) of illness or hospice election period(s).</p> <p>Reprocess them in sequence.</p> <p>Notify other involved intermediaries to cancel affected bills.</p>
An intermediary is contacted by another intermediary, a regional office (RO), or provider about improper payment resulting from out-of-sequence billing,	<p>Cancel all affected claims.</p> <p>Reprocess them according to instructions from the lead intermediary or RO.</p>
More than one intermediary is involved, the <i>lead intermediary</i> (i.e., the one alerted to improper payment resulting from out-of-sequence billing) will:	<p>Coordinate actions with other intermediaries to cancel and reprocess the bills as necessary.</p> <p>Reprocess the bills, based on the actual sequence of the beneficiary's stays at the various providers.</p>

**Note:** These instructions apply only if the liability changes. They do not apply if the liability stays the same, e.g., if the deductible is applied on the second stay instead of the first but there is no issue with regard to the effective date of supplementary coverage.

**Notice of New Interest Rate for Overpayments and Underpayments**

Medicare A assesses interest on overpaid amounts that are not refunded in a timely manner. Medicare Regulation 42 CFR 405.378 provides for the assessment of interest if the overpaid amount is not refunded within 30 days from the overpayment demand letter rate. The interest rate on overpayments is based on the higher of the private consumer rate (PCR) or the current value of funds (CVF) rate.

Effective May 5, 1999, the interest rate applied to Medicare overpayments is 13.375 percent based on the new revised PCR rate.

<b>Period</b>	<b>Interest Rate</b>
October 24 1996 - January 22 1997	13.375%
January 23 1997 - April 23,	13.625%
April 24 1997 - July 24 1997	13.50%
July 25 1997 - October 23 1997	13.75%
October 24 1997 - January 27 1998	13.875%
January 28 1998 - May 12 1998	14.50%
May 13 1998 - July 30. 1998	14.00 %
July 31 1998 - October 22 1998	13.75%
October 23 1998 - January 31 1999	13.50%
February 1 1999 - May 4 1999	13.75%
May 5 1999 - PRESENT	13.375%

**Line Item Date of Service**

This item clarifies bulletin G-342 (July 28, 1998), concerning line item date of service reporting: Health Care Financing Administration (HCFA) guidelines state that providers must bill the line item date of service per the revenue code line, whether single or multiple dates of service. If a provider fails to report line item date(s) of service, the claim will be returned to the provider.

**Beneficiary Rights to Itemized Statement for Medicare Items and Services****A. Requirements of the Law**

Effective January 1, 1999, the Balanced Budget Act of 1997 gives beneficiaries the right to submit a written request for an itemized statement from their provider/supplier for any Medicare item or service. The law requires that providers/suppliers furnish the itemized statement within 30 days of the request, or they may be subject to a civil monetary penalty of \$100 for each unfulfilled request. If an itemized statement is received, the beneficiary may request the Medicare contractor to review specific issues (e.g., services not provided, billing irregularities, and appropriate measures to recover any amount inappropriately paid).

Medicare contractors currently issue beneficiaries an Explanation of Medicare Benefits (EOMB) or a Medicare Summary (MSN). Information that may be listed include the following: date(s) of services, a description of services provided, number of services provided, benefit days used, noncovered charges, deductible and coinsurance, beneficiary liability, amount charged, claim number, name of provider/supplier submitting the claim, claim total paid by Medicare and referring physician (if applicable). Other information that may be included are deductibles, appeal rights or notices, and explanatory notes and general information regarding the specific claim. On April 1, 1999, at most Medicare contractors (including Florida Medicare), these notices began to include the following statement: "You have the right to make a request in writing for an itemized statement which details each Medicare item or service which you have received from your physician, hospital or any other health supplier or health professional. Please contact them directly, in writing, if you would like an itemized statement." The remaining Medicare contractors will print this message beginning July 1, 1999.

**B. Guidance Concerning the Format and Substance of the Itemized Statement**

Included below are suggestions regarding the types of information that the beneficiary might find helpful. We hope this information will enable the beneficiary to reconcile the itemized statement with the Medicare notice. These are recommendations only. Since most providers/suppliers have established an itemized billing system for internal accounting procedures and billing of other payers, the furnishing of an itemized statement should not pose a significant additional burden. However, some providers/suppliers may not regularly create or furnish hardcopy itemized statements and may wish to reexamine their internal billing and tracking process to ensure that it has the capability to comply with this new requirement.

**Note: Providers/suppliers should not charge beneficiaries for the itemized statement.**

**Itemized Statement Recommendations:**

- \* Name of beneficiary,
- \* Date(s) of services,
- \* Description of item or service furnished,
- \* Number of services furnished,
- \* Provider/supplier charges,
- \* An internal reference or tracking number.

If the claim has been adjudicated by Medicare, additional information that may be included on the itemized statement are:

- \* Amounts paid by Medicare,
- \* Beneficiary responsibility for co-insurance,
- \* Medicare claim number.

The statement should also include a name and a telephone number for the beneficiary to call if there are further questions.

**C. Reconciliation of the Itemized Statement with the MSN/EOMB**

After receiving an itemized statement, beneficiaries may attempt to reconcile it with the MSN. In situations where there are questions, especially involving some services and payment methods, providers/suppliers are requested to assist beneficiaries in understanding any differences between the two documents.

In addition, although Medicare contractor customer service representatives may not have a copy of the itemized statement, they will also answer any beneficiary inquiries regarding the EOMB/MSN and attempt to reconcile them with the itemized statement. Where appropriate, customer service representatives will attempt to resolve any questions by generally explaining applicable Medicare reimbursement rules, (prospective payment systems, revenue codes, bundling, interim rates, HCPCS/CPT codes, etc.).

**D. Beneficiary Right to Request Review of the Itemized Statement**

Beneficiaries may submit a written request to their Medicare contractor for a review of a claim based on information they provide from their itemized statement. The request should identify the specific items or services that the beneficiary believes were not provided as claimed, or any other billing irregularity (including duplicate billing). A review will be conducted into the matter by the Medicare contractor and providers/suppliers may be requested to assist in the review of the itemized statement/Medicare claim. Contractors will review and take appropriate actions to resolve the complaint.



**More Information About the Extension of Due Date for Filing Provider Cost Reports**

In *Medicare A Bulletin #G-369 (4/16/99)*, an article was published regarding the extension of due dates for filing several kinds of provider cost reports. Due to the complexities of the changes required by the Balanced Budget Act (BBA), a number of electronic cost reporting vendors, including the free software provided for SNFs and HHAs, were not approved in time for providers to file the cost report due by April 30, 1999. As a result, the providers utilizing the cost reporting forms identified below are granted an additional month for filing their respective cost reports. Therefore, effective for fiscal years ending September 30 and October 31, 1998:

- \* Cost reports with fiscal years ending September 30, 1998, October 31, 1998, or November 30, 1998 will be due June 1, 1999. ( May 31, 1999 is a federal holiday.)
- \* Cost reporting periods ending December 31, 1998 are also granted a 30 day extension. The cost report for this period for the providers identified below is due June 30, 1999.

The affected cost reports are:

- \* Hospital and Hospital Complex cost report (Form HCFA-2552-96);
- \* Skilled Nursing Facility (SNF) cost report (Form HCFA-2540-96);
- \* Home Health Agency (HHA) cost report (Form HCFA-1728); and
- \* Outpatient Rehabilitation Provider cost report (Form HCFA-2088).

For purposes of determining interest on overpayments to a provider, a cost report filed no later than the extended due date, as determined under this program memorandum, will be considered a timely filed cost report. With respect to a cost report not filed on or before the extended due date, interest and penalties will commence on the day following the date the cost report was due until the cost report is filed.

**Additions and Changes to the Medicare Remarks Codes**

**Medicare Line Level Remark Codes**

Remark codes are used to relay service-specific Medicare informational messages that cannot be expressed with a reason code. Medicare remark codes are maintained by the Health Care Financing Administration (HCFA).

**Line Level Remark Codes**

Code	Description
M33	Claim lacks the UPIN of the ordering/referring or performing physician, physician assistant, nurse practitioner or clinical nurse specialist, or the UPIN is invalid.
M51	Incomplete/invalid, procedure code(s) and/or rates, including "not otherwise classified" or unlisted procedure codes submitted without a narrative description. Refer to the HCFA Common Procedure Coding System directory. If an appropriate procedure code(s) does not exist, refer to Item 19 on the HCFA-1500 instructions.
M65	One interpreting physician can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each interpreting physician.
M86	Service denied because payment already made for similar procedure within set time frame.
M87	Claim/service(s) subjected to CFO-CAP prepayment review.
M88	We cannot pay for laboratory tests unless billed by the laboratory that did the work.
M89	Not covered more than once under age 40.
M90	Not covered more than once in a 12 month period.
M91	Lab procedures with different CLIA certification numbers must be billed on separate claims.
M92	Services subjected to review under the Home Health Medical Review Initiative.
M93	Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment.
M94	Information supplied does not support a break in therapy. A new capped rental period will not begin.
M95	Services subjected to Home Health Initiative medical review/cost report audit.

# ADMINISTRATIVE

Code	Description
M96	The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.
M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
M98	Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.
M99	Incomplete/invalid/missing Universal Product Number.
M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
M101	Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.
M102	Service not performed on equipment approved by the FDA for this purpose.
M103	Information supplied supports a break in therapy. However, the medical information we have for this beneficiary does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.
M104	Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the Medicare fee schedule for this item or service.
M105	Information supplied does not support a break in therapy. The medical information we have for this beneficiary does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.
M106	Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the Medicare fee schedule for this item or service.
M107	Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.
M108	Must report the PIN of the physician who interpreted the diagnostic test.
M109	We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation payment to the referring practitioner.
M110	Missing/invalid provider number for the provider from whom you purchased interpretation services.
M111	We do not pay for chiropractic manipulative treatment when the beneficiary refuses to have an X-ray taken.
M112	The approved amount is based on the maximum allowance for this item under the DMEPOS Competitive Bidding Demonstration.
M113	Our records indicate that this patient began using this service(s) prior to the current round of the DMEPOS Competitive Bidding Demonstration. Therefore, the approved amount is based on the allowance in effect prior to this round of bidding for this item.
M114	This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may phone 1-888-289-0710.
M115	This item is denied when provided to this patient by a nondemonstration supplier.
M116	Even though this service is being paid in accordance with the rules and guidelines under the Competitive Bidding Demonstration, future claims may be denied when this item is provided to this patient by a nondemonstration supplier. If you would like more information regarding this project, you may phone 1-888-289-0710.
M117	Not covered unless supplier files an electronic media claim (EMC).
M118	Letter to follow containing further information.
M119	National Drug Code (NDC) needed.
M120	Lacks UPIN of the substituting physician who furnished the services(s) under a reciprocal billing or loco tenens arrangement.
M121	and following. Reserved for future use.

“Additions and Changes to the Medicare Remarks Codes” is continued on the next page.

**Medicare Claim Level Remarks Codes**

Medicare Inpatient Adjudication (MIA) and Medicare Outpatient Adjudication (MOA) claim level remarks codes are used to convey appeal information and other claim-specific information that does not involve a financial adjustment. An appropriate appeal, limitation of liability or other message is used whenever applicable. A maximum of five MIA and five MOA claim level remarks codes may be used per claim.

<b>Code</b>	<b>Description</b>
MA47	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.
MA52	Did not enter full 8-digit date (MM/DD/CCYY for paper form or CCYY/MM/DD for electronic format).
MA53	Inconsistent demonstration project information. Correct and resubmit with information on no more than one demonstration project.
MA54	Physician certification or election consent for hospice care not received timely.
MA55	Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.
MA56	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.
MA57	Patient submitted written request to revoke his/her election for religious non-medical health care services.
MA85	Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the Payer ID when effective.
MA93	Non-PIP claim.
MA101	A SNF is responsible for payment of outside providers who furnish these services/supplies to residents.
MA102	Did not complete or enter accurately the referring/ordering/supervising physician's/physician assistant's, nurse practitioner's, or clinical nurse specialist's name and/or UPIN.
MA103	Hemophilia Add On
MA105	Missing/invalid provider number for this place of service. Place of service shown as 21, 22, or 23 (hospital).
MA106	PIP claim
MA107	Paper claim contains more than three separate data items in field 19.
MA108	Paper claim contains more than one data item in field 23.
MA109	Claim processed in accordance with ambulance surgical guidelines.
MA113	Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.
MA117	This claim has been assessed a \$1.00 user fee.
MA123	Your center was not selected to participate in this study, therefore, we cannot pay for these services.
MA124	Processed for IME only.
MA125	Per legislation governing this program, payment constitutes payment in full.
MA126	Pancreas transplant not covered unless kidney transplant performed.
MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

**TABLE OF CONTENTS**

G0030-G0047, G0125, G0126, G0163-G0165: PET Scan .....	13
G0160, G0161: Cryosurgical Ablation of the Prostate .....	20
J0205, J1785: Ceredase/Cerezyme .....	22
J9000, J9170, J9350, J9999: Antineoplastic Drugs .....	24
59840, 59841, 59850-59852, 59855-59857, 59866: Elective Abortion .....	31
61885, 64573, 64585, 64590, 64595, 95970, 95971, 95974, 95975: Vagus Nerve Stimulation .....	33
72192-72194: Computed Tomography of the Pelvis .....	37
80100-80102: Qualitative Drug Screen .....	44
82270: Fecal Occult Blood Testing .....	47
84154: Free Prostate Specific Antigen .....	52
86235: Extractable Nuclear Antigen .....	54
88142-88155, 88164-88167, G0123, G0143-G0145, G0147, G0148, P3000: Pap Smears .....	56
90846, 90847, 90849: Family Psychotherapy .....	61
92081-92083: Visual Field Examination .....	64
92225, 92226: Ophthalmoscopy .....	70
92235: Fluorescein Angiography .....	74
92240: Indocyanine-Green Angiography .....	78
93224-93227, 93231-93237: Holter Monitoring .....	80
93012, 93268, 93270, 93271, G0004-G0006, G0015: Patient Demand Single or Multiple Event Recorder .....	84
93501, 93510, 93511, 93514, 93524, 93527-93529, 93530-93533 : Cardiac Catheterization .....	89
93975-93979: Duplex Scanning .....	95
99183: HBO Therapy .....	101

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 (LMRP’s).” 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 Local Medical Review Policies (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, unless otherwise noted, the policies contained in this section are effective for claims processed July 8, 1999, and after, unless otherwise noted.

**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. All Medicare Part A Final Medical Policy Procedures are available to the provider customers via our Medicare Online Bulletin Board System (BBS) to view or download. Please refer to page 115 for information about accessing the BBS.

**Pages 13-106 (The Local Medical Review Policies) were intentionally left blank.**

**See Final LMRP section on website.**

**General Coverage****M0302: Cardiac Output Monitoring by Electrical Bioimpedance**

Effective for services furnished on or after July 1, 1999, cardiac monitoring using electrical bioimpedance, a form of plethysmography, is covered for the uses and conditions described below.

These devices utilize electrical bioimpedance to noninvasively produce hemodynamic measurements of cardiac output, specifically, stroke volume, contractility, systemic vascular resistance and thoracic fluid content. The devices are covered for the following uses:

- \* Noninvasive diagnosis or monitoring of hemodynamics in patients with suspected or known cardiovascular disease;
- \* Differentiation of cardiogenic from pulmonary causes of acute dyspnea;
- \* Optimization of atrioventricular interval for patient with A/V sequential cardiac pacemakers;
- \* Patients with need of determination for intravenous inotropic therapy;
- \* Post-heart transplant myocardial biopsy patients; and,
- \* Patients with a need for fluid management.

Not covered at this time is the use of such devices for any monitoring of patients with proven or suspected disease involving severe regurgitation of the aorta, or for patients with minute ventilation (MV) sensor function pacemakers, since the device may adversely affect the functioning of that type of pacemaker. Also, these devices do not render accurate measurements in cardiac bypapulmonary bypass machine, but do provide accurate measurements prior to and post-bypass pump.

This technology is in the process of being proven for additional uses. Therefore, the above uses represent the current situation. Local medical review policy (LMRP) may be developed that may cover additional uses when there is sufficient evidence of the medical effectiveness of such uses. If developed, the new LMRP will be published in a future issue of the Medicare A Bulletin.

**33246: Implantation of Automatic Defibrillators**

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

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

**G0160, G0161: Cryosurgery of Prostate**

Cryosurgery of the prostate gland, also known as cryosurgical ablation of the prostate (CSAP), destroys prostate tissue by applying extremely cold temperatures in order to reduce the size of the prostate gland. It is safe and effective, as well as medically necessary and appropriate, as primary treatment for patients with clinically localized prostate cancer, Stages T1-T3. Effective for services performed on or after July 1, 1999, it is covered only as primary treatment for clinically localized prostate cancer.

The evidence is not yet sufficient to demonstrate the effectiveness of this procedure as salvage therapy for local failures after radical prostatectomy, external beam irradiation, and brachytherapy. Therefore, cryosurgery of the prostate as salvage therapy is not covered under Medicare.

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

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

## 48554: Pancreas Transplantation

Pancreas transplantation is performed to induce an insulin independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness.

Medicare has had a policy of not covering pancreas transplantation for many years, as the safety and effectiveness of the procedure had not been demonstrated. The Office of Health Technology Assessment performed an assess-

ment on pancreas kidney transplantation in 1994. They found reasonable graft survival outcomes for patients receiving either simultaneous pancreas-kidney transplantation and pancreas after kidney transplantation.

Effective July 1, 1999, Medicare will cover whole organ pancreas transplantation (ICD-9-CM code 52.80, 52.83, or procedure code 48554) only when it is performed simultaneous with or after a Medicare covered kidney transplant (ICD-9-CM code 55.69, or procedure code 50360 or 50365). If the pancreas transplant occurs after the kidney transplant, the 36-month period of entitle-

ment to immunosuppressive therapy will begin with the date of discharge from the inpatient stay for the pancreas transplant.

Pancreas transplantation for diabetic patients who have not experienced end stage renal failure secondary to diabetes continues to be excluded from Medicare coverage. Medicare also excludes coverage of transplantation of partial pancreatic tissue or islet cells. There is not sufficient evidence at this time to support a determination that these procedures are reasonable and necessary.

## 97016: Coverage and Billing Guidelines for Enhanced External Counterpulsation (EECP)

Effective for services rendered on or after July 1, 1999, Enhanced External Counterpulsation (EECP) is a covered service on a limited basis.

EECP is a non-invasive outpatient treatment for coronary artery disease refractory to medical and/or surgical therapy. Although these and similar devices are cleared by the Food and Drug Administration (FDA) for use in treating a variety of conditions, including stable angina pectoris, acute myocardial infarction and cardiogenic shock, Medicare coverage is limited to EECP's use in patients with angina pectoris who meet the criteria identified below, since only that use has developed sufficient evidence to demonstrate its medical effectiveness. Other uses of this device and similar devices remain non-covered. In addition, the non-coverage of hydraulic versions of these types of devices remains in force.

Coverage is further limited to those enhanced external counterpulsation systems that have sufficiently demonstrated their medical effectiveness in treating patients with severe angina in well-designed clinical trials. Note that a 510(k) clearance by the Food and Drug Administration does not, by itself, satisfy this requirement.

Coverage is provided for the use of EECP for patients who have been diagnosed with disabling angina (Class III or Class IV, Canadian Cardiovascular Society Classification or equivalent classification) who, in the opinion of a cardiologist or cardiothoracic surgeon, are not readily amenable to surgical intervention, such as PTCA or cardiac bypass, because: (1) their condition is inoperable, or at high risk of operative complications or post-operative failure; (2) their coronary anatomy is not readily amenable to such procedures; or they are (3) they have co-morbid states which create excessive risk.

### How EECP Works

EECP works in the following manner: During diastole the three sets of air cuffs are inflated sequentially (distal to proximal) compressing the vascular beds within the muscles of the calves, lower thighs, and upper thighs. This action results in an increase in diastolic pressure, generation of retrograde arterial blood flow and an increase in venous return. The cuffs are deflated simultaneously just prior to systole, which produces a rapid drop in vascular impedance, a decrease in ventricular workload, and an increase in cardiac output.

The augmented diastolic pressure and retrograde aortic flow appear to improve myocardial perfusion, while systolic unloading appears to reduce cardiac workload and oxygen requirements. The increased venous return coupled with enhanced systolic flow appears to increase cardiac output. As a result of this treatment, most patients experience increased time until onset of ischemia, increased exercise tolerance, and a reduction in the number and severity of anginal episodes. Evidence was presented that this effect lasted well beyond the immediate post-treatment phase, with patients symptom-free for several months to two years.

A full course of therapy usually consists of 35 one-hour treatments, which may be offered once or twice daily (usually 5 days per week). The patient is placed on a treatment table where their lower extremities are wrapped in a series of three compressive air cuffs that inflate and deflate in synchronization with the patient's cardiac cycle as described above.

# GENERAL COVERAGE

## Billing Instructions

\* Providers should bill on the HCFA-1450 form (or electronic equivalent), using bill type 12X, 13X, 22X, 23X, 74X, 75X, or 83X.

\* This service should be billed using Current Procedural Terminology (CPT) code 97016 (Application of a modality to one or more areas; vasopneumatic devices) and must be performed under the direct supervision of a physician.

\* The applicable revenue codes for reporting this procedure are 420 or 430.

\* Providers must report CPT code 97016 (Application of a modality to one or more areas; vasopneumatic devices) until a specific code for the EECF procedure is developed. In addition, one of the following modifiers must be reported:

- GO Service delivered personally by an occupational therapist or under an outpatient occupational therapy Plan of Care; or
- GP Service delivered personally by a physical therapist or under an outpatient physical therapy Plan of Care.

**NOTE:** For purposes of the EECF procedure, if a provider other than a therapist performs the service, the GP modifier should be reported.

\* Since this procedure is an outpatient rehabilitation service, payment is made under the Medicare Physician Fee Schedule.

\* Deductible and coinsurance apply for this service. Coinsurance for this service is 20 percent of the lower of the actual charge or the fee schedule amount.

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## Transmyocardial Revascularization (TMR) for Treatment of Severe Angina

Effective for services rendered on or after July 1, 1999, Transmyocardial Revascularization (TMR) is covered as a late or last resort for patients with severe (Canadian Cardiovascular Society Classification Classes III or IV) angina (stable or unstable), which has been found refractory to standard medical therapy, including drug therapy at the maximum tolerated or maximum safe dosages in a hospital inpatient setting. In addition, the angina symptoms must be caused by areas of the heart not amenable to surgical therapies such as percutaneous transluminal coronary angioplasty, stenting, coronary atherectomy, or coronary bypass. Coverage is further limited to those uses of the laser used in performing the procedure that have been approved by the Food and Drug Administration for the purpose for which they are being used.

Patients must meet the following additional selection guidelines:

- \* Have an ejection fraction of 25% or greater;
- \* Have areas of viable ischemic myocardium (as demonstrated by diagnostic study) that are not capable of being revascularized by direct coronary intervention; and,
- \* Have been stabilized, or have had maximal efforts to stabilize acute conditions such as severe ventricular arrhythmias, decompensated congestive heart failure, or acute myocardial infarction.

Coverage is limited to physicians who have been properly trained in the procedure. Providers of this service must also document that all ancillary personnel, including physicians, nurses, operating room personnel, and technicians, are trained in the procedure and the proper use of the equipment involved. Coverage is further limited to providers with dedicated cardiac care units, including the diagnostic and support services necessary for care of patients undergoing this therapy. In addition, these providers must conform to the standards for laser safety set by the American National Standards Institute, ANSIZ1363. (See the Coverage Issues Manual, 35-94, for more information on the coverage criteria.)

### Billing and Payment Instructions

Hospitals should bill the intermediary on Form HCFA-1450 or electronic equivalent, using bill type 11X. The procedure code must be 36.31 (open chest TMR) for this service to be covered. This procedure code is currently grouped to DRG 108.



**Radiochemicals not Covered**

Some providers are billing the Medicare program for radiochemical drugs and biologicals as if they were covered radiopharmaceuticals. Radiochemicals are not approved by the Food and Drug Administration; therefore, they are not reimbursable by the Medicare program. Radiochemical drugs or biologicals should be billed under a noncovered charge.

**Qualified Candidates for Hepatitis C Lookback**

In two previous editions of the Medicare A Bulletin (G-368 and G369), information regarding Hepatitis C Lookback was included. However, previous publications did not include the Health Care Financing Administration's description of a qualified candidate. A qualified candidate is one who is believed to have been exposed to blood infected with Hepatitis C (HCV), including those identified through the Food and Drug Administration look-back process. Patients who have been exposed are:

- \* Those receiving blood from a donor who tested negative at the time of the donation but subsequently tests repeatedly reactive for the antibody to HCV on a later donation; or
- \* Those receiving blood from a donor who tested positive on the FDA-licensed, more specific test or other follow-up testing recommended or required by FDA, and for whom the timing of seroconversion cannot be precisely estimated.

**New Waived Tests**

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

- \* Bayer Clinitek 50 Urine Chemistry Analyzer for HCG, urine
- \* Bayer Clinitek 50 Urine Chemistry Analyzer for microalbumin, creatinine
- \* Bayer DCA 2000 + glycosylated hemoglobin (Hgb A1c)
- \* GDS Diagnostics HemoSite Meter for hemoglobin
- \* ActiMed Laboratories ENA.C.T. Total Cholesterol Test (PDU)
- \* Genzyme Contrast Strep A (direct from throat swab)

A new waived CPT code, 84703QW, was assigned for the hCG urine test performed on the Bayer Clinitek 50 Urine Chemistry Analyzer.

The complete list of waived tests is below:

Test Name	Manufacturer	CPT Code(s)
Dipstick or tablet reagent urinalysis - non-automated for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen	Various	81002
Fecal occult blood	Various	82270, G0107
Ovulation tests by visual color comparison for human luteinizing hormone	Various	84830
Urine pregnancy tests by visual color comparison	Various	81025
Erythrocyte sedimentation rate - non-automated	Various	85651
Hemoglobin by copper sulfate - non-automated	Various	83026
Blood glucose by glucose monitoring devices cleared by the FDA for home use	Various	82962
Blood count; spun microhematocrit	Various	85013
Hemoglobin by single instrument with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout	HemoCue	85018QW (effective 10/1/96)
HemoCue B-Glucose Photometer	HemoCue	82947QW, 82950QW, 82951QW, 82952QW (effective 10/1/96)
ChemTrak AccuMeter	ChemTrak	82465QW
Advanced Care	Johnson & Johnson	82465QW
Boehringer Mannheim Chemstrip Micral	Boehringer Mannheim	82044QW
Cholestech LDX	Cholestech	82465QW, 83718QW, 84478QW, 82947QW, 82950QW, 82951QW, 82952QW, 80061QW

*"New Waived Tests" is continued on the next page*

# GENERAL COVERAGE

Test Name	Manufacturer	CPT Code(s)
Serim Pyloritek Test Kit	Serim	87072QW
QuickVue In-Line One-Step Strep A Test	Quidel	86588QW
Boehringer Mannheim Accu-Chek InstantPlus Cholesterol	Boehringer Mannheim	82465QW
All qualitative color comparison pH testing - body fluids (other than blood)	Various	83986QW
SmithKline Gastrocult	SmithKline	82273QW
QuickVue One-Step H. Pylori Test for Whole Blood	Quidel	86318QW
Binax NOW Strep A Test	Binax	86588QW
Delta West CLOtest	Delta West Tri-Med Specialties	87072QW
Wampole STAT-CRIT Hct	Wampole Laboratories	85014QW
SmithKline Diagnostics FlexSure HP Test for IgG Antibodies to H. pylori in Whole Blood	SmithKline Diagnostics, Inc.	86318QW
Wyntek Diagnostics OSOM Strep A Test	Wyntek Diagnostics, Inc	86588QW
GI Supply HP-FAST	Mycoscience Labs, Inc.	87072QW
Abbott FlexPak HP Test for whole blood	Abbott Laboratories	86318QW
Chemtrak AccuMeter H. pylori Test (for whole blood)	ChemTrak	Pending
BioStar Acceava Strep A Test (direct specimen only)	Wyntek Diagnostics, Inc.	86588QW
LXN Fructosamine Test System	LXN Corporation	82985QW
ITC Protime Microcoagulation System for Prothrombin Time	International Technidyne Corporation (ITC)	85610QW
CoaguChek PST for Prothrombin Time	Boehringer Mannheim Corporation	85610QW
SmithKline ICON Fx Strep A Test (from throat swab only)	Binax	86588QW
Abbott Signify Strep A Test (from throat swab only)	Wyntek Diagnostics, Inc.	86588QW
Bayer Clinitek 50 Urine Chemistry Analyzer - qualitative dipstick for glucose, bilirubin, ketone, specific gravity, blood, pH, protein, urobilinogen, nitrite, leukocytes – automated	Bayer	81003QW
Bayer DCA 2000 - glycosylated hemoglobin (Hgb A1c)	Bayer	83036QW
Wampole Mono-Plus WB	Wampole Laboratories	86308QW
LXN Duet Glucose Control Monitoring System	LXN Corporation	82962, 82985QW
ENA.C.T Total Cholesterol Test	ActiMed Laboratories, Inc.	82465QW
Genzyme Contrast Mono (whole blood)	Genzyme Diagnostics	86308QW
Applied Biotech SureStep Strep A (II) (direct from throat swab)	Applied Biotech, Inc.	86588QW
STC Diagnostics Q.E.D. A150 Saliva Alcohol Test	STC Technologies Inc.	Pending
STC Diagnostics Q.E.D. A350 Saliva Alcohol Test	STC Technologies Inc.	Pending
Micro Diagnostics Spuncrit Model DRC-40 Infrared Analyzer for hematocrit	Micro Diagnostics Corporation	Pending
Chemstrip Mini UA - qualitative dipstick for glucose, bilirubin, ketone, specific gravity, blood, pH, protein, urobilinogen, nitrite, leukocytes – automated	Boehringer Mannheim Corporation	81003QW
Litmus Concepts FemExam TestCard (from vaginal swab)	Litmus Concepts, Inc.	84999QW
Wyntek Diagnostics OSOM Mono Test (whole blood)	Wyntek Diagnostics, Inc.	86308QW
Meridian Diagnostics ImmunoCard STAT Strep A (direct from throat swab)	Applied Biotech, Inc.	86588QW
Seradyn Color Q Mono (whole blood)	Genzyme Diagnostics	86308QW
Jant Pharmacal AccuStrip Strep A (II) (direct from throat swab)	Applied Biotech, Inc.	86588QW
BioStar Acceava Mono Test (whole blood)	Wyntek Diagnostics, Inc.	86308QW
LifeSign UniStep Mono Test (whole blood)	Princeton BioMeditech Corp.	86308QW
Becton Dickinson LINK 2 Strep A Rapid Test (direct from throat swab)	Applied Biotech, Inc.	86588QW
DynaGen NicCheck I Test Strips	Dynagen, Inc.	80101QW

"New Waived Tests" is continued on the next page

**GENERAL COVERAGE**

<b>Test Name</b>	<b>Manufacturer</b>	<b>CPT Code(s)</b>
Mainline Confirms Strep A Dots Test (direct from throat swab)	Applied Biotech, Inc.	86588QW
Quidel Cards O.S. Mono (for whole blood)	Quidel Corporation	86308QW
*Bayer Clinitek 50 Urine Chemistry Analyzer - for HCG, urine	Bayer Corp	84703QW
*Bayer Clinitek 50 Urine Chemistry Analyzer - for microalbumin, creatinine	Bayer Corp.	82044QW
*Bayer DCA 2000+ - glycosylated hemoglobin (Hgb A1c)	Bayer Corp.	83036QW
*GDS Diagnostics HemoSite Meter - for hemoglobin	GDS Technology, Inc.	85018QW
*ActiMed Laboratories ENA.C.T. Total Cholesterol Test (PDU)	ActiMed Laboratories, Inc.	82465QW
Genzyme Contrast Strep A (direct from throat swab)	Genzyme Diagnostics	86588QW
<b>* Newly-added waived test system</b>		

**Hospital**

**Payment for Blood Clotting Factor Administered to Hemophilia Inpatients**

The payment method currently in use for blood clotting factor administered to hemophilia inpatients has been extended until September 30, 1999. Payment (referred to as an "add on payment") is based on a pre-determined price per unit of clotting factor multiplied by the number of units provided.

The information in this article refers to the add on payment for the costs of administering blood clotting factor to Medicare beneficiaries who have hemophilia and who are hospital inpatients, effective for discharges occurring on or after October 1, 1998.

The price per unit of clotting factor was established based on the current price listing available from the Drug Topics Red Book, the publication of pharmaceutical average wholesale prices (AWP).

The affected HCPCS codes (and the associated pricing) for discharges occurring on or after October 1, 1998 through September 30, 1999 are:

Procedure Code	Descriptor	Pricing per IU
J7190	Factor VIII (Anti-Hemophilic Factor, Human)	\$.78
J7192	Factor VIII (Anti-Hemophilic Factor, Recombinant)	\$ 1.00
J7194	Factor IX (Complex)	\$.38
J7196	Other Hemophilia clotting Factor, (anti-inhibitors)	\$ 1.10
Q0160	Factor IX (Anti-Hemophilic Factor, purified, nonrecombinant)	\$.93
Q0161	Factor IX (Anti-Hemophilic Factor, purified, recombinant)	\$ 1.00

**How to Bill**

When reporting the number of IUs administered, divide the number of IUs administered by 100 and round the answer to the nearest whole number to determine the billing unit. (An answer which includes fractions of .50 to .99 = 1 additional billing unit. An answer which includes fractions of .01 to .49 = no additional billing units). For example: <N>

A patient receives 1,200 IUs of Factor VIII (J7190) on December 1, 1993. The hospital divides the number of IUs administered by 100 to obtain the number of billing units. (1,200 divided by 100 = 12 billing units.) The hospital enters 12 in FL 46 of the HCFA-1450. The payment amount is \$912 (12 billing units x \$76 (100 IUs x \$.76)).

When the number of units of blood clotting factor administered to hemophiliac inpatients exceeds 999,999,949 (reported as 9,999,999), report the excess as a second line for revenue code 636 and repeat the HCPCS code. One billion fifty million (1,050,000,000) units are reported on one line as 9,999,999, and a second line as 500,001.

Use revenue code 636 and the appropriate HCPCS code (listed above).

- 286.0 Congenital factor VIII disorder
- 286.1 Congenital factor IX disorder
- 286.2 Congenital factor IX disorder
- 286.3 Congenital deficiency of other clotting factor
- 286.4 von Willebrands' disease

**Reopenings for Sole Community and Medicare Dependent Hospital Open Cost Reports Affected by the Cost Report Change**

The following information affects sole community hospitals and Medicare dependent hospitals. Corrected instructions have been issued for use when calculating the hospital-specific amount on Forms HCFA-552-96 and HCFA-2552-92. Following are the correct instructions:

*For sole community hospitals, Medicare dependent hospitals, and small rural hospitals, enter the applicable hospital-specific payments. The hospital-specific payment, entered on this line, is supplied by your fiscal intermediary. Calculate it by multiplying the sum of the Diagnostic Related Grouping (DRG) weights for the period, per the Provider Statistical and Reimbursement System/Report (PS&R), by the final per discharge hospital-specific rate for the period.*

$$\text{DRG X Per-discharge hospital-specific rate for period} = \text{Hospital-specific payment}$$

**Rural Health Clinic****Laboratory Tests and Venipunctures Performed in an RHC**

When the staff of a Rural Health Clinic (RHC) performs a venipuncture, and the laboratory work is performed by a laboratory separate from the RHC itself, the RHC should not file the venipuncture charge to the Part B carrier. If the venipuncture was associated with an encounter that meets the criteria of an RHC visit, it should be billed to the Intermediary accordingly. If the visit criteria was not met, a claim should not be filed for the service.

**Note:** The Florida contractor processes claims for hospital-based RHCs, but not independent RHCs. Claims for independent RHCs should be filed with Riverbend Government Benefits Administrator at:

Riverbend GBA  
730 Chestnut Street  
Chattanooga, Tennessee 37402-1790  
(423) 755-5955

**Laboratory Services****Provider-based Rural Health Clinics (RHCs)**

The Health Care Financing Administration (HCFA) has instructed Medicare intermediaries to reimburse laboratory services included in the Rural Health Clinics (RHC) benefit under the RHC all-inclusive per-visit rate.

The six basic laboratory tests listed below are required for RHCs; they should be bundled in the 52X revenue code and reimbursed at the per-visit rate:

- \* Chemical examinations of urine by stick or tablet method or both (CPT 81002)
- \* Hemoglobin or hematocrit (CPT 83026)
- \* Blood sugar (CPT 82962)
- \* Examination of stool specimens for occult blood (CPT 82270)
- \* Pregnancy tests (CPT 81025)
- \* Primary culturing for transmittal to a certified laboratory (No CPT code available).

**Other Laboratory Services****Laboratory Services Furnished By Provider-based RHCs:**

Other than the six basic tests, all laboratory services furnished by provider-based RHCs should be billed to the intermediary, using HCFA Common Procedure Coding System (HCPCS) codes; they are paid under Medicare Part B laboratory fee schedules.

**Independent RHCs:**

All laboratory services furnished by independent RHC laboratories, including the six basic laboratory tests, are included in the payment rate and billed to the assigned intermediary. This includes the six basic laboratory tests, as well as all other laboratory tests provided in the RHC laboratory. No services are separately billed. All services are reimbursed through the cost report settlement process.

**Certified Medicare Laboratory:**

If an RHC laboratory becomes a certified Medicare laboratory, with its own supplier number, all laboratory tests (except the six basic tests) furnished by that certified Medicare laboratory to RHC and non-RHC patients should be billed to the local Medicare Part B carrier, using HCPCS codes; they are paid under Part B laboratory fee schedules.

For additional information concerning the billing and payment of laboratory services for independent RHCs, see section 3628 of the Medicare Intermediary Manual, Part 3.

**Note:** The Florida contractor, First Coast Service Options, Inc., does not process Rural Health Clinic (RHC) claims. This region's RHC claims should be filed with the Riverbend Government Benefits Administrator at:

Riverbend GBA  
730 Chestnut Street  
Chattanooga, Tennessee 37402-1790  
(423) 755-5955

# 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, Bulletins, Reason Codes, etc.

**Medicare Part B** - UPIN Directory, Medigap Listing, Publications (UPDATE!), Fee Schedules, Local Medical Policies, EDI Format Specifications Manuals, Medpard Directories, etc.

**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 Requirements for Part B - HCFA-1500 and Part A - HCFA-1450.

(CBT is also available online [www.medicaretraining.com](http://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  
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. ❖

# 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
<b>Tampa</b> <i>Medifest</i> July 13-14  <i>Specialty Seminars</i> July 15	Tampa Convention Center 333 S. Franklin St. (813)274-8511  Hotel: Wyndham Harbor Island (813) 229-5000 ask for the Medicare/Medifest Seminar rate of \$81.00 until 6/13/99
<b>ORLANDO</b> <i>Medifest</i> August 17-18  <i>Specialty Seminars</i> August 19	Orlando Airport Marriott 7499 Augusta National Drive Orlando, FL 32822 (407) 851-9000  Hotel: Orlando Airport Marriott ask for the Medifest Seminar hotel rate of \$85.00 until 7/25/99
<b>MIAMI</b> <i>Medifest</i> Sept 21-22  <i>Specialty Seminars</i> Sept 23	Radisson Mart Center 711 NW 72nd Ave Miami, FL 33126 (305) 261-3800  Hotel: Radisson Mart Plaza Hotel ask for the Medicare/Medifest hotel rate of \$109.00

### 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><b>Registration</b></p> <ul style="list-style-type: none"> <li>• Pre-registration is required. Registration will not be accepted at the door.</li> </ul> <p><b>Payment</b></p> <ul style="list-style-type: none"> <li>• Prepayment is required. Your method of payment may be in the form of checks or money orders (only).</li> </ul> <p><b>Cancellations and Refunds</b></p> <ul style="list-style-type: none"> <li>• All cancellation requests must be received 7 days prior to the seminar to receive a refund.</li> <li>• 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)</li> </ul> <p><b>Substitution</b></p> <ul style="list-style-type: none"> <li>• 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)</li> <li>• Once you have signed in at the seminar, substitutions will not be permitted for the remainder of the seminar.</li> </ul> <p><b>Confirmation Number</b></p> <ul style="list-style-type: none"> <li>• Your confirmation number will be issued by fax from Seminar Registration.</li> <li>• It is <b>very important</b> that you have a confirmation number. <b>YOU MUST BRING THIS NUMBER WITH YOU.</b></li> <li>• If you do not receive a confirmation number, please call (904) 791-8299.</li> </ul> <hr/> <p style="text-align: center;"><b>FOUR IMPORTANT STEPS</b></p> <p>Please follow <b>all four</b></p> <p><b>STEP 1</b> FAX both registration form and class schedule to (904)791-6035.</p> <p><b>STEP 2</b> Make checks payable to First Coast Service Options(FCSO) Account #756240.</p> <p><b>STEP 3</b> (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><b>STEP 4</b> YOU MUST BRING YOUR CONFIRMATION NUMBER WITH YOU.</p>	<p style="text-align: center;"><b>Please Print</b></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; margin: 10px 0;"> <p style="text-align: center;"><i>Medifest/Specialty Seminar Package Deals are only valid for the same location/week</i></p> </div> <p><b>Medifest Only</b> <span style="float: right;"><i>(please fill out one form per person)</i></span></p> <p><input type="checkbox"/> One day Medifest \$149 - per person</p> <p><input type="checkbox"/> Two day Medifest \$199 - per person</p> <p><b>Specialty Seminar Only</b></p> <p><input type="checkbox"/> One Specialty Seminar \$99 - per person</p> <p><b>Medifest/Specialty Seminar Package Deals</b></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; margin: 10px 0;"> <p style="text-align: center;"><i>Please ✓ check the location and Medifest/Specialty Seminars you will be attending</i></p> </div> <p><b>Orlando Medifest - August 17 &amp; 18</b></p> <p>_____ Medifest - August 17 &amp; 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><b>Miami Medifest - September 21 &amp; 22</b></p> <p>_____ Medifest - September 21 &amp; 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>
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# 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 \_\_\_\_\_

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*Tampa - July 15, 1999*

A.M. 8:30 - 12:00

- 300  Oncology (B)
  - 301  Podiatry (B)
  - 302  Medicare Part A Symposium (A)
  - 316  Orthopaedics (B)
  - 318  CORF/ORF (A)
  - 319  Dermatology (B)
- 

*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)
  - 318  CORF/ORF (A)
  - 319  Dermatology (B)
- 

*Your registration form must accompany your class schedule*

## **PHONE NUMBERS**

### **PROVIDERS**

**Automated Response Unit:**  
904-355-8899

**Customer Service Reps:**  
904-355-8899

### **Medicare Online Bulletin Board System (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