Medicare A Bulletin

In This Issue...

Features

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HCFA Health Care Financing Administration

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

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The *Medicare A Bulletin* is published bimonthly by the Medicare Publications Department, to provide timely and useful information to Medicare Part A providers in Florida.

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

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A PHYSICIAN'S FOCUS

"The Value of Surfing"

The Health Care Financing Administration (HCFA) has recently implemented new procedures to allow public access to medical coverage policies that are under review by Medicare. The Internet address for this information is **www.hcfa.gov.** The site also has links to various government publications, including the Federal Register. If you click on "Medicare Coverage Process," you will find information on the Medicare Coverage Committee (MCC), town hall meetings and the review process for coverage issues. You will also find information on several new services that HCFA has approved or is considering for coverage. Among them are:

- Autologous Stem Cell Transplantation
- Electrical Stimulation for Fracture Healing
- Ferrlecit (Sodium Ferric Gluconate Complex in Sucrose Injection)
- Human Tumor Assay Systems
- Intestinal and Multivisceral Transplants
- Pressure Reducing Therapy (Support Surfaces)
- Cryosurgery of the Prostate
- Helicobactor Pylori Testing
- Transmyocardial Revascularization for Severe Angina

Please note that these policies are in various stages of development and are not effective until finalized and published. These details are included in the material available on the Web site.

There are several other Web sites that will provide you with Medicare and other medical information. One of them is **www.medicaretraining.com.** First Coast Service Options, Inc. (Florida Medicare contractor) created this new site for HCFA to provide a multi-state educational resource. There are several computer-based training courses available. All are free. Y2K readiness information, the schedule for future satellite broadcasts for various Medicare educational topics, and several related links are available to expand your exploration of Medicare related subjects.

Another site you might want to check out is **www.quackwatch.com.** There you will find articles on several procedures, tests, equipment and treatments that have been found to be lacking scientific evidence to support their use.

If you visit all of the above sites and their related links, you should be busy for a long time and gain a lot of knowledge. Hope you find the information helpful. Happy surfing!

Sincerely,

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

About *The Medicare A Bulletin*

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

- 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* is located on the last pages. Important addresses and telephone numbers are located on the back cover.

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 Local Medical Review Policy section is printed as a removable section, enabling readers to remove and file it separately, without disturbing the rest of the articles.

YEAR 2000

Notification of Millennium Rollover Year-End Claim Processing

Our goal for the year 2000 rollover is to ensure a smooth and risk free transition to the new millennium. To accomplish it, there are certain steps we must take that outside our normal processing routine. We are providing you with this information as early as possible so you may take the necessary action to adjust your processing and cash flow needs. With appropriate preparation, you will not be adversely impacted.

Year-End Claims Processing Schedule

The time frame of December 30 through 31, 1999, will be used to perform a comprehensive system backup and to complete finalized month-end, quarter-end, and year-end processing. This will begin at 6:00 a.m. (EST) December 30, 1999, and will end at 8:00 a.m. on January 1, 2000. This means that, for this period of time, you will not have electronic access to the system to complete any type of claim function (e.g., eligibility verification, direct data entry, claims correction, claims inquiry). System cycles will also not run on December 30, 1999, or December 31, 1999. The first system cycle will be Saturday, January 1. Provider payments will be mailed on Monday January 3, 2000, in accordance with the normal payment disbursement schedule. The chart below delineates these activities on a day-by-day basis.

Date	Claims Processing Impact
Wednesday, Dec. 29	• This is the last day to do any type of claims processing activity. • No claims processing activity after December 29,1999. • System cycles will run as normal. • Provider payments will be disbursed for December 29th processing. • Electronic Providers can submit claims.
Thursday, Dec. 30 - Friday, Dec. 31	• No access to the system. • No claim processing cycles will run. • No provider payments disbursed. • Electronic providers can submit claims through 10:00 a.m., December 30, 1999.
Saturday, Jan. 1	• System available for access. • System cycle will run. • Electronic providers can submit claims.
Sunday, Jan. 2	• System available for access. • System cycle will run. • Electronic providers can submit claims.
Monday, Jan. 3, & beyond	• Business as usual. • System available for access. • Provider payments disbursed. • Electronic providers can submit claims.

Provider Preparation

Providers must prepare for this period. Proper preparation will minimize impact to your claims processing functions and financial management responsibilities.

All Providers: All providers will experience a short period of time when no Medicare payments will be disbursed, December 30, 1999 through January 2, 2000. Payments from the December 29, 1999 processing cycle will be disbursed based on normal procedures. Providers should act accordingly, as advance payments will not be available for this period. In addition, system unavailability may impact our ability to respond to provider inquiries during this period.

Electronic Claim Providers: Electronic providers should access the system before 10:00 a.m. on December 30, 1999. Electronic providers who submit claims via file transfer can continue to submit claims until 10:00 a.m. on December 30, 1999; however, claims received after 6:00 p.m. on December 29, 1999, will not be read into the system until January 1, 2000. Claims received on December 30, 1999, prior to the 10:00 a.m. cutoff, will be processed on January 1, 2000. Claims cannot be received after 10:00 a.m. on December 30, 1999, through 8:00 a.m. on January 1, 2000.

Paper Claim Providers: Paper providers may continue to send paper claims to the intermediary during this period. However, the intermediary will not be able to enter claims into the system between December 30 and December 31, 1999.

Return to Normal Claims Processing Activities

On January 3, all claims processing activities will return to the normal schedule and payments will be disbursed as usual.

Reminder on Claims with Year 2000 Dates of Service

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

By law, electronic clean claims must be held for at least 14 calendar days, but no longer than 30 calendar days, before payment can be made. The period of time from receipt of year 2000 claims will count toward these requirements.

Beginning on January 17, all claims for services in the year 2000 will be released for processing, and claims are expected to be finalized for payment very quickly. Therefore, holding claims with year 2000 service dates until January 17 should only minimally affect their date of payment, if at all (because of the statutory requirement to hold claims payment for at least 14 calendar days).

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

If you have questions about this article, please contact Medicare Part A at (904) 355-8899.

This document is a year 2000 readiness disclosure made pursuant to the Year 2000 Information and Readiness Disclosure Act (U.S. Public Law 105-271). Your legal rights regarding use of the statements made herein may be substantially limited as provided in the Act.

GENERAL INFORMATION

Ambulance Services—Questions & Answers

The following question and answer article has been developed by the Health Care Financing Administration (HCFA) to clarify issues related to the ambulance coverage regulation changes.

Physician Certification

Q Assuming the physician certification cannot be obtained in the required time period, when appropriate, we assume there is no prohibition against billing the patient. Is that correct?

A Because it is unclear what is meant by "when appropriate," the answer is based on a general response. No, the assumption that a patient can be billed directly for ambulance transportation services when the physician certification cannot be obtained in the required time period is incorrect.

42 CFR 410.40(d)(2), "Special Rule for Nonemergency, Scheduled Ambulance Services," states that nonemergency ambulance services are covered "if the ambulance supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity criteria of paragraph (d)(1) of this section are met. The physician's order must be dated no earlier than 60 days before the date the service is furnished." Additionally, 42 CFR 410.40(d)(3), *"Special Rule for Nonemergency, Unscheduled Ambulance Services,"* specifies the circumstances under which Medicare will cover nonemergency, unscheduled ambulance services. For residents in facilities where they are under the direct care of a physician, ambulance suppliers can obtain written orders from the beneficiary's attending physician, certifying that the medical necessity requirements have been met, "within 48 hours after the transport." For beneficiaries residing at home or in a facility where they are not under the direct care of a physician, a physician certification is not required.

The physician certification statement is not required in cases that meet the definition of an emergency: "An emergency service is one that is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the beneficiary's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part." Any ambulance service that does not meet these criteria would be a "nonemergency service" and would require a physician certification statement.

In response to comments submitted by ambulance industry representatives, we agreed that to avoid unnecessary delays, it would be appropriate for ambulance suppliers to obtain physician certification statements within 48 hours after the ambulance service was furnished. While the 48-hour time frame is the standard required by regulation, we acknowledge that there may be instances when meeting this requirement may not be possible. Therefore, if the physician cannot be reached within the 48-hour time period it is acceptable for the ambulance supplier to obtain the physician's signature before a bill may be submitted for the service. (For further clarification of the claims submission requirement, please refer to 42 CFR 424.44, *Time Limits for Filing Claims*.)

It is also important to be aware that the limitation of liability provisions (see Medicare Carriers Manual (MCM) section 7300) must also be taken into consideration. For situations involving noncovered services, please refer to MCM section 3043.

Q Our understanding is that the certificate of medical necessity (CMN) is not needed for **any** unscheduled transports of patients residing in their home or in an extended care/assisted living facility. Is that correct?

A This is not correct. 42 CFR 410.40(d)(2) specifically addresses the "*Special Rule for Nonemergency, Scheduled Ambulance Services*." 42 CFR 410.40(d)(3) addresses the rules for nonemergency, unscheduled ambulance services. 42 CFR 410.40(d)(3)(ii) indicates that "For a beneficiary residing at home or in a facility who is not under the direct care of a physician, a physician certification is not required."

Q Is a CMN needed for emergencies by hospital based ambulances since it is currently required by sections 3322 and 3660 of the Medicare Intermediaries Manual and section 279 of the Hospital Manual or does this regulation overrule these sections?

A The requirements of the Medicare Intermediaries Manual sections 3322 and 3660 and section 279 of the Hospital Manual are **not** superseded by the final rule.

Q If a registered nurse (RN) orders the ambulance, **on behalf of the physician,** may the RN sign the CMN, on behalf of the physician?

A An RN who is employed by the attending physician or who is an employee of the hospital or facility where the patient is being treated may sign a physician certification statement on oral orders from the physician. The RN's signature is acceptable in instances where nonemergency, unscheduled ambulance transportation is required and the attending physician is not physically present in the facility, but is in consultation with the RN, at the time the medically necessary transport is required. The physician must later countersign the physician certification statement.

The ambulance supplier is responsible for obtaining the physician certification statement with the appropriate signatures as quickly as possible.

Q Since physicians are generally unavailable or working reduced hours during weekends and holidays, can the 48-hour rule for unscheduled transports be interpreted to mean 48 business hours?

A No, the 48-hour rule should be interpreted as calendar days.

Scheduled/Unscheduled Nonemergency Ambulance Transportation

Q Is it correct to assume that the new dialysis coverage, as specified in 410.40(e)(4), includes transport from an extended care/assisted living facility to a freestanding dialysis facility?

A Yes. Medicare guidelines indicate that "**A patient's residence** is the place where he/she makes his/her home and dwells permanently, or for an extended period of time. A **skilled nursing facility** is one which is listed in the Directory of Medical Facilities as a participating SNF or as an institution which meets section 1819(a)(1) of the law."

Miscellaneous

Q Does this regulation apply for hospital-based ambulance services?

A Where applicable, various provisions of this regulation do apply to hospital-based ambulance services.

Q The final rule clarifies the circumstances under which an ambulance trip is a patient transport under Medicare Part A as opposed to an ambulance service under Medicare Part B, and also allows for scheduled round-trip transportation of a beneficiary with end-stage renal disease from home to the nearest appropriate dialysis facility, whether freestanding or hospital-based. Please provide further background clarification as it relates to this issue.

A The final rule clarifies that the Part A inpatient hospital and skilled nursing facility (SNF) benefits historically have recognized and included payment for the cost of patient transportation services, such as ambulance trips, that the institution furnishes to its inpatients during the course of a covered stay. However, unlike transportation via ambulance (which involves a service that is specifically delineated in terms of vehicle type, appropriate destinations, etc.), the concept of non-ambulance transportation is a more generalized one that denotes the basic function of transporting an individual from one place to another, rather than a particular mode of transport.

For example, under the long term care facility requirements for participation at 42 CFR 483.25, an SNF's essential obligation is to provide each resident with those services that are necessary, "...to attain or maintain the [resident's] highest practicable physical, mental, and psychosocial well being...." In fulfilling this basic obligation, however, a SNF may utilize a wide variety of means either to send its residents to the offsite location of the services or, alternatively, to bring the services themselves onsite to its residents.

Moreover, in contrast to ambulance trips (for which a specific Part B benefit exists), there is no Part B benefit that provides for non-ambulance forms of transportation. Historically, SNFs themselves were under no obligation to undertake providing non-ambulance forms of transportation directly to their residents as a part of a covered Part A stay, and in actual practice, they rarely, if ever, did so. Rather, the responsibility for providing such transportation for SNF residents has generally been assumed instead by other sources, such as the Medicaid program, local community service organizations, or the resident's own family.

In this context, the preamble to the final rule on the prospective payment system (PPS) for SNFs (64 FR 41674-75, July 30, 1999) explains that it is not HCFA's intent to include within the scope of the current SNF PPS bundle any types of transportation services for which the Medicare program did not previously assume financial responsibility under either Part A or Part B. Accordingly, the final rule clarifies that the scope of the required service bundle furnished to Part A SNF residents under the PPS specifically encompasses coverage of medically necessary transportation via ambulance, rather than more general coverage of other forms of transportation. ❖

Overpayment Interest Rate

Medicare assesses interest on overpaid amounts that are not refunded timely. Interest will be assessed if the overpaid amount is not refunded within 30 days from the date of overpayment demand letter. The interest rate on overpayments is based on the higher of the private consumer rate (PCR) or the current value of funds (CVF) rate.

Effective October 28, 1999, the interest rate applied to Medicare overpayments is **13.375** percent based on the new revised PCR rate. The following table lists previous interest rates.

Period	Interest Rate
August 04 1999 - October 27, 1999	13.25%
May 05, 1999 - August 03, 1999	13.375%
February 01, 1999 - May 04, 1999	13.75%
October 23, 1998 - January 31, 1999	13.50%
July 31, 1998 - October 22, 1998	13.75%
May 13, 1998 - July 30, 1998	14.00 %
January 28, 1998 - May 12, 1998	14.50%
October 24, 1997 - January 27, 1998	13.875%
July 25, 1997 - October 23, 1997	13.75%
April 24, 1997 - July 24, 1997	13.50%
January 23, 1997 - April 23, 1997	13.625%
October 24, 1996 - January 22, 1997	13.375% ❖

HCFA Web Site for Beneficiary Outreach Events

The Health Care Financing Administration (HCFA) has established an Internet database of Medicare outreach events that feeds into a nationwide calendar of events accessable by beneficiaries on Medicare's beneficiary Web site. The address for this site is:

www.medicare.gov

HCFA is widely promoting the database as a source of information for Members of Congress, key members of the Department of Health & Human Services, and other national and corporate partners. In addition, the customer service representatives at 1-800-MEDICAR(E) will inform beneficiaries about local and national events when they call for information.

First Coast Services Options (FCSO), Inc., the Medicare fiscal intermediary for Florida, encourages providers to share this information with their Medicare patients. It is a great way for beneficiaries to find answers to their Medicare questions. Additionally, FCSO's Medicare Education and Outreach department has a number of *free* educational services available for both beneficiaries and providers. See page 38 for information regarding these *free* educational services. ❖

Third-party Web sites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

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. ❖

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Clarification to Coverage of Intermittent Catheterization

Intermittent catheterization is covered under Medicare for an individual who has a permanent impairment of urination, i.e., urinary incontinence or urinary retention. A permanent impairment of urination is considered to be a condition that is not expected to be medically or surgically corrected. This does not require a determination that there is no possibility that the individual's condition may improve sometime in the future. If the medical record, including the judgment of the attending physician, indicates that the condition is of long and indefinite duration (ordinarily at least 3 months), the test of permanence is considered met.

A urinary collection and retention system with or without a tube is covered as a prosthetic device replacing bladder function in cases of urinary incontinence or urinary retention.

There are three options for urine collection: an indwelling catheter, intermittent catheterization, or an external urinary collection device. Most individuals who have permanent urinary incontinence/retention and who perform intermittent catheterization are able to practice clean, nonsterile catheterization technique. In cases where the clean, nonsterile technique is not appropriate, intermittent catheterization using sterile technique may be covered when the following criteria are met:

- The patient resides in a nursing facility (for SNF residents who are in a covered Part A stay, prosthetic devices, including catheters, are paid for as part of the per diem payment the facility receives under PPS), or
- The patient is immunosuppressed, for example (not inclusive):
  - on a regimen of immunosuppressive drugs post-transplant;
  - on cancer chemotherapy;
  - has AIDS; or
  - has a drug induced state such as chronic oral corticosteroid use

  and requires catheterization, or
- The patient has radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization, or
- The patient is a spinal-cord injured female with neurogenic bladder who is pregnant (for duration of pregnancy only), or
- The patient has had distinct, recurrent urinary tract infections, while on a program of clean intermittent catheterization, twice within the 12-month period prior to beginning sterile intermittent catheterization.

For purposes of this policy, a patient would be considered to have a urinary tract infection if he/she has a urine culture with greater than 10,000 colony forming units of a urinary pathogen ***and*** has concurrent presence of one or more of the following signs, symptoms, or laboratory findings:

- Fever (oral temperature > 38 ºC)
- Systemic leukocytosis
- Change in urinary urgency, frequency, or incontinence
- Appearance of new or increase in autonomic dysreflexia
- (sweating, bradycardia, blood pressure elevation)
- Physical signs of prostatitis, epididymitis, orchitis
- Increased muscle spasms
- Pyuria (greater than 5 white blood cells per high-powered field)

The medical necessity for use of sterile catheterization for reasons other than the criteria listed may be presented for individual consideration. The medical necessity in these cases must be well documented by the treating physician. Such documentation may include prior year records.

Patients who currently meet the criteria for coverage of sterile intermittent catheterization as delineated in the current durable medical equipment regional carrier (DMERC) medical review policy will be deemed to have met the criteria as listed under this policy clarification. Once patients who require catheterization meet the criteria as listed in this policy clarification, they will continue to do so for purposes of future coverage. ❖

Prostate Screening Billing Correction

On page 45 of the October/November 1999 *Medicare A Bulletin*, the coverage benefit for prostate cancer screening was published. The "Reporting and Coding Requirements" section identified revenue code 32X as the appropriate revenue code to bill for prostate screening.

HCPCS codes G0102 (screening digital rectal examination) and G0103 (screening prostate specific antigen test) must be reported under revenue code **30X.** ❖

Processing Guidelines for Factor VIIa (Coagulation Factor, Recombinant)

Factor VIIa (Coagulation Factor, Recombinant), marketed under the name Novo7, is a new clotting factor used to treat hemophilia. It is packaged and dosed in terms of micrograms and not international units or units. No appropriate HCPCS code exists for this product prior to January 1, 2000. Effective January 1, 2000, claims for this product must be handled in accordance with the following rules and reported using the following national temporary code:

Q0187 Factor VIIa (Coagulation Factor, Recombinant) per 1.2 mg

Hospital Outpatient Claims

Prior to January 1, 2000, Factor VIIa is reported using revenue code 636 and HCPCS J3490, Unclassified Drug. The product must be identified in the "Remarks" field. Payment is made under the usual Medicare outpatient cost payment rules for outpatient drugs and biologicals.

Effective January 1, 2000, the national temporary code Q0187 is used to report this product.

Hospital Inpatient Claims

Medicare pays an amount for clotting factor furnished to inpatients who have hemophilia in addition to the hospital inpatient prospective payment rate for the diagnosis related group (DRG) based on 85 percent of the average wholesale price (AWP).

Effective October 1, 1999, an amount in addition to the DRG payment is payable for Factor VIIa (Coagulation Factor, Recombinant). However, because of Y2K considerations, the Health Care Financing Administration (HCFA) is unable to establish a claims process for this payment prior to January 1, 2000. Until that date, hospitals may continue to submit claims for the DRG payment, and hold claims for Factor VIIa (Coagulation Factor, Recombinant).

Effective January 1, 2000, the national temporary code Q0187 is used to report this product. Payment for Factor VIIa (Coagulation Factor, Recombinant) is based on the price of $1.19 per microgram. ❖

OUTPATIENT HOSPITAL SERVICES

Use of Modifiers for Reporting Outpatient Hospital Services

Effective April 1, 2000, the reporting of outpatient hospital services will require the use of modifiers as an integral part of the Outpatient Hospital Prospective Payment System (PPS) payment implementation. First Coast Services Options, Inc., the Florida fiscal intermediary, encourages providers to begin using modifiers now, so that any problems encountered may be adjusted prior to April 1, 2000.

The following general guidelines provide clarification on the use of modifiers when reporting outpatient hospital services.

Modifiers Are not Required if:

- The narrative definition of a CPT and or HCPCS code indicates multiple occurrences.
  Example: The code definition indicates two to four lesions. The code indicates multiple extremities.
- The narrative definition of a code indicates that the procedure applies to different body parts.
  Examples:
  - CPT code 11600 (Excision malignant lesion, trunks, arms, or legs; lesion diameter 0.5 cm. or less)
  - CPT code 11640 (Excision malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm. or less)
- Modifiers GN, GO, and GP must be used to identify the therapist performing speech language therapy, occupational therapy, and physical therapy respectively.
- Modifiers 50 (bilateral), 52 (when used to indicate a discontinued procedure), 53, 73, and 74 apply only to surgical procedures.

Modifiers Are Required if:

- The modifier adds more information regarding the anatomic site of the procedure.
  Example: Cataract surgery on the right or left eye.
- The modifier helps to eliminate the appearance of duplicate billing.
  Example: Using modifier 77 to report the same procedure performed more than once on the same date of service but at different encounters.
- The modifier helps to eliminate the appearance of unbundling.
  Examples: Codes Q0081 (Infusion therapy, using other than chemotherapeutic drugs, per visit) and 36000 (Introduction of needle or intra-catheter, vein): If procedure 36000 was performed for a reason other than as part of the IV infusion, modifier 59 would be appropriate.

Reporting Modifiers on the UB-92 (HCFA-1450)

- Modifiers are reported on the paper UB-92 (HCFA-1450) form in form locator (FL) 44 next to the HCPCS code. There is space for two modifiers on the paper form (4 of the 9 positions). On the UB-92 flat file, providers use record type 61, field numbers 6 and 7. There is space for two modifiers, one in field 6 and one in field 7.
- On the X12 837 3051.3A.01 segments SV202-03 and SV202-04 are used to report the two modifiers.
  NOTE: With the upcoming claims expansion in April 2000, up to five modifiers will fit on a line.
- The dash that is often seen preceding a modifier is never reported.
- When it is appropriate to use a modifier, the most specific modifier must be used first. That is, when modifiers E1 through E4, FA through F9, LC, LD, RC, and TA through T9 apply, they must be used before modifiers LT, RT, or 59.

Use of Modifiers 50, LT, and RT

- Modifier 50 is used to report bilateral procedures that are performed at the same operative session as a single line item. Modifiers RT and LT must **not** be used when modifier 50 applies. Do not submit two line items to report a bilateral procedure using modifier 50.
- Modifier 50 applies to any bilateral procedure performed on both sides at the same session.
- The bilateral modifier 50 is restricted to surgical procedures only (CPT codes 10040 - 69990). It is not required for radiology procedure codes or diagnostic procedure codes.
- Modifier 50 may not be used:
  - To report surgical procedures identified by their terminology as "bilateral" or
  - To report surgical procedures identified by their terminology as A unilateral or bilateral."
- "One" is the unit entry used when modifier 50 is reported.
- When modifier 50 is used, the reimbursement is for two procedures. If the procedure is an approved ambulatory surgery center (ASC) service, the multiple procedure rule applies. Since the procedures are in the same payment group, the ASC Pricer program calculates the payment at the full rate for one procedure, and 50 percent of the rate for the other procedure.

Modifiers LT and RT

- Modifiers LT or RT apply to codes identifying procedures that can be performed on paired organs, e.g., ears, eyes, nostrils, kidneys, lungs, and ovaries.
- Modifiers LT and RT must be used when a procedure is performed on only one side. Hospitals use the appropriate RT or LT modifier to identify which of the paired organs was operated upon.
- These modifiers are required when appropriate.

Use of Modifiers for Discontinued Services

In the proposed outpatient prospective payment system, reimbursement will be based on HCPCS coding. Modifiers for discontinued services were implemented so hospitals, under the new system, could be reimbursed for expenses incurred in preparing a patient for surgery and scheduling a room in which to perform the procedure.

- Modifier 52 was implemented for use when a procedure is terminated after a patient has been prepared for surgery (including sedation when provided) and taken to the room where the procedure is to be performed, but **before** the induction of anesthesia (e.g. local, regional block(s), or general anesthesia). **Effective January 1, 1999,** the new modifier 73 replaced modifier 52 for reporting these discontinued services.
- Modifier 53 was implemented for use when a procedure is terminated **after** the induction of anesthesia (e.g., local, regional block(s), or general anesthesia), or after the procedure was started (incision made, intubation started, scope inserted). **Effective January 1, 1999,** the new modifier 74 replaced modifier 53 for reporting these discontinued services. Modifier 53 will no longer be an acceptable modifier for hospital reporting.
- The elective cancellation of a procedure must not be reported.
- When used to indicate discontinued procedures, modifiers 73 and 74 (and the replaced modifiers 52 and 53) are used for surgical and certain diagnostic procedures only. These modifiers are **not** used to indicate discontinued radiology procedures.

How is Payment Affected?

If modifier 73 (52 prior to January 1, 1999) is reported and the procedure is an approved ambulatory surgery center (ASC) service, payment is based at 50 percent of the facility rate, subject to the ASC payment calculation. If modifier 74 (53 prior to January 1, 1999) is reported, there is no payment reduction. This is because the resources of the facility are consumed in essentially the same manner and the same extent as they would have been had the procedure been completed.

What if Multiple Procedures Were Planned and There Is a Termination?

- When one or more of the procedures planned is completed, the completed procedures are reported as usual.
- The other procedures that were planned, and not started, are not reported. When none of the procedures that were planned are completed, the first procedure that was planned to be done is reported with modifier 73 (52 prior to January 1, 1999) or modifier 74 (53 prior to January 1, 1999), as appropriate. The others are not reported.
- If a procedure is terminated prior to the induction of anesthesia and before the patient is wheeled into the procedure room, the procedure must not be reported. The patient has to be taken to the room where the procedure is to be performed in order to report modifier 52 or 73.

Modifiers for Repeat Procedures

Two repeat procedure modifiers have been implemented for hospital use:

- Modifier 76 is used to indicate that a procedure or service was repeated in a separate operative session on the same day by the *same* physician.
- Modifier 77 is used to indicate that a procedure or service was repeated in a separate operative session on the same day by *another* physician.

If there is a question regarding who the ordering physician was and whether or not the same physician ordered the second procedure, the coding must be based on whether or not the physician performing the procedure is the same.

The procedure must be the same procedure. It is listed once and then listed again with the appropriate modifier.

Modifiers for Radiology Services

- Modifiers 52 (for indicating a reduced services), 59, 76, and 77, and the Level II modifiers apply to radiology services.
- Modifiers 50, 52 (for indicating a terminated service based on the guidelines in transmittal 726) and 53, and the new modifiers 73 and 74 do **not** apply to radiology services.
- When a radiology procedure is reduced, the correct reporting is to code to the extent of the procedure performed. If no code exists for what has been done, the intended code with modifier 52 appended must be reported.

  Example: Code 71020 (Radiologic examination, chest, two views, frontal and lateral) is ordered. Only one view is performed. Code 71010 (Radiologic examination, chest: single view, frontal) is reported. Code 71020-52 is not reported.

At this time, payment for radiology services reported with modifier 52 (Reduced services) is not reduced. Payment will still be the least of the reasonable cost, customary charge, or blended amount.

HCPCS Level II Modifiers

- Generally, these codes are required to add specificity to the reporting of procedures performed on eyelids, fingers, toes, and arteries.
- These modifiers may be appended to CPT codes.
- If more than one level II modifier applies, repeat the HCPCS code on another line with the appropriate level II modifier:

  Example: Code 26010 (drainage of finger abscess; simple) done on the left hand thumb and second finger would be coded:
  26010FA
  26010F1

- The Level II modifiers apply whether Medicare is the primary or secondary payer. ❖

INPATIENT HOSPITAL SERVICES

Instructions for Cost Outlier Bills with Benefits Exhausted

Since day outliers and day outlier thresholds were eliminated on October 1, 1997, there has been no way for the standard claims processing system to determine the day when a cost outlier begins. Consistent with policy, the new methodology for using benefit days and reimbursing for cost outliers is based on the beneficiary having a lifetime reserve (LTR) benefit day, which he/she elects to use or a regular benefit (regular or coinsurance) day beginning the day after the day that the beneficiary incurs covered charges in an amount that results in a cost outlier payment for the provider. Additional charges will be considered covered for every day thereafter for which a beneficiary has, and elects to use, an available benefit day.

Diagnosis related group (DRG) claims with cost outlier payments and discharge dates on or after October 1, 1997, must have an occurrence code (OC) 47 on the claim, unless there are enough full and/or coinsurance days to cover all the medically necessary days or the only available benefits are LTR days and there are enough LTR days to cover all the medically necessary days. DRG claims without cost outlier payments can never have regular benefit days combined with LTR benefit days.

Any provider who in the future has a claim reject, or who currently has a claim pending because of return code 67, must determine the dollar amount of the cost outlier threshold. The dollar amount of the cost outlier threshold can be determined by using the cost outlier threshold amount returned with the remittance advice, other notice of claims returned to the provider, or direct data entry (DDE) claim correction screen for bills submitted after systems changes have been made to provide this amount.

Once the cost outlier threshold is known, providers must add the daily covered charges for the claim until they determine the day that covered charges reach the cost outlier threshold. Providers must exclude days and covered charges during noncovered spans, e.g., during occurrence span code (OSC) 74, 76, or 79 dates. Providers must then submit the date of the first full day of cost outlier status (the day after the day that covered charges reach the cost outlier threshold) on the bill using OC 47. The OC 47 date cannot be equal to or during OSC 74, 76, or 79 dates. Providers must determine the amount of regular, coinsurance, and LTR days the beneficiary has available.

Any nonutilization days after the beneficiary exhausts coinsurance or LTR days before the OC 47 date will be coded by the standard system maintainer using OSC 70. LTR days should be used as necessary and as elected by the beneficiary. If coinsurance days are exhausted during the inlier portion of the stay and there is a period of nonutilization indicated by the presence of OSC 70 and the beneficiary elects not to use LTR days, covered charges are limited to the exact amount of the cost outlier threshold and both OC A3, which shows the last covered day, and OC 47, which shows the following day which is the first full day of cost outlier status, must be shown. When coinsurance and/or LTR days are exhausted during the cost outlier portion of the stay, OC A3 should be used as appropriate to report the date benefits are exhausted. Covered charges should be accrued to reflect the entire period of the bill if the bill is fully covered or the entire period up to and including the date benefits were exhausted, if benefits were exhausted.

Interest Calculation

For debit/credit adjustments (where the DRG was previously paid by using condition code 66), the interest is computed on the outlier portion of claims with OC 47 that have discharge dates between October 1, 1997, and the date of installation of the release correcting this cost outlier fix. Interest will be calculated from the date of discharge up to the date payment is made. For pending claims which have never had any payment made, interest is payable on the entire claim.

Assumptions For All of The Following Examples

- Cost outlier threshold amount is $50,000
- Threshold amount is reached on the 25th day
- Billed charges are $1,000 each day thereafter
- 7Beneficiary elects to use any available LTR days

Example 1: LTR Days Cover Cost Outlier

Dates of service: 1/1/99 - 1/31/99 discharge
Medically necessary days: 30
Covered charges: $55,000
Benefits available: 30 LTR
Covered days: 30
Noncovered days: 0
Cost report days: 30
All charges for Medicare approved revenue codes billed as covered
No OC 47 needed
Reimbursement: Full DRG plus cost outlier based on $55,000 covered charges

Example 2: LTR Days Exhaust in The Cost Outlier

Dates of service: 1/1/99 - 2/10/99 discharge
Medically necessary days: 40
Covered charges: $65,000
Benefits available: 30 LTR
Covered days: 30
Noncovered days: 10
Cost report days: 30
30 days covered charges for Medicare approved revenue codes and 10 days noncovered charges
OC 47: 1/26/99
OC AS: 1/30/99
Reimbursement: Full DRG plus cost outlier based on $55,000 covered charges ($50,000 inlier and $5,000 outlier

Example 3: LTR Days Exhaust Prior to Cost Outlier

Dates of service: 1/1/99 - 1/31/99 discharge
Medically necessary days: 30
Covered charges: $55,000
Benefits available: 20 LTR
Covered days: 20
Noncovered days: 10
Cost report days: 25
25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges
OC 47: 1/26/99
OC A3: 1/25/99
OSC 70: 1/21/99-1/25/99
Reimbursement: Full DRG payment, no cost outlier

Example 4: Coinsurance Days Exhaust Prior to Cost Outlier and No LTR Days Are Available

Dates of service: 1/1/99 - 1/31/99 discharge
Medically necessary days: 30
Covered charges: $55,000
Benefits available: 20 coinsurance
Covered days: 20
Noncovered days: 10
Cost report days: 25
25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges
OC 47: 1/26/99
OC A3: 1/25/99
OSC 70: 1/21/99-1/25/99
Reimbursement: Full DRG payment, no cost outlier

Example 5: Coinsurance Days Exhaust Prior to Cost Outlier. LTR Days Exhaust in The Cost Outlier

Dates of service: 1/1/99 - 2/10/99 discharge
Medically necessary days: 40
Covered charges: $65,000
Benefits available: 20 coinsurance and 10 LTR
Covered days: 30
Noncovered days: 10
Cost report days: 35
35 days covered charges for Medicare approved revenue codes and 5 days noncovered charges
OC 47: 1/26/99
OC A3: 2/4/99
OSC 70: 1/21/99-1/25/99
Reimbursement: Full DRG payment plus cost outlier based on $60,000 covered charges ($50,000 inlier, $10,000 outlier, $5,000 noncovered)

Example 6: Full And Coinsurance Days Cover Cost Outlier

Dates of service: 1/1/99 - 1/31/99 discharge
Medically necessary days: 30
Covered charges: $55,000
Benefits available: 10 full and 20 coinsurance
Covered days: 30
Noncovered days: 0
Cost report days: 30
All charges for Medicare approved revenue codes billed as covered
No OC 47 needed
Reimbursement: Full DRG plus cost outlier based on $55,000 covered charges

Example 7: Coinsurance Days And Ltr Days Exhaust in The Cost Outlier

Dates of service: 1/1/99 - 2/28/99 discharge
Medically necessary days: 58
Covered charges: $83,000
Benefits available: 10 full, 30 coinsurance and 10 LTR
Covered days: 50
Noncovered days: 8
Cost report days: 50
50 days covered charges for Medicare approved revenue codes and 8 days noncovered charges
OC 47: 1/26/99
OC A3: 2/19/99
Reimbursement: Full DRG plus cost outlier based on $75,000 covered charges ($50,000 inlier, $25,000 outlier, $8,000 noncovered)

Example 8: LTR Days Exhaust Prior to Cost Outlier and Noncovered Span(s) Present

Dates of service: 1/1/99 - 1/31/99 discharge
Medically necessary days: 28
OSC 76: 1/10/99 - 1/11/99
Covered charges: $55,000
Benefits available: 20 LTR
Covered days: 20
Noncovered days: 10
Cost report days: 25
25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges
OC 47: 1/28/99
OC A3: 1/27/99
OSC 70: 1/23/99-1/27/99
Reimbursement: Full DRG payment, no cost outlier. ❖

ELECTRONIC DATA INTERCHANGE

Is Your Office Ready to Process Claims in the Year 2000?

If you file electronic claims directly to Medicare, First Coast Service Options, Inc. strongly encourages you to test and validate your claim transmission process in a future date environment. Don't wait until January 1, 2000, to "test" live claims. Test now using test claims, and correct problems now prior to the new year.

FCSO began offering future date testing to the healthcare community in September, 1999. Due to the volume of requests, FCSO will continue to offer this testing utility through December, 1999, and into the Year 2000. If you file electronic claims directly to Medicare and would like to participate in future date testing with FCSO, please contact the Medicare EDI department at (904) 791-8769, or submit a written request to the address below:

Medicare EDI Department - 7 Center
Attn: Mary Anne Zingaro
P. O. Box 44071
Jacksonville, FL 32231-4071

Don' t Delay.....Test Today!!!!!

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Health Insurance Portability and Accountability Act (HIPAA) Web Sites—Correction

In the October/November 1999 *Bulletin*, page 47 ("Adoption of Standard Electronic Health Care Transaction Formats"), the third Web site address in the last section ("How to Get More Information") has been corrected by the Health Care Financing Administratation. The correct address to access the text of the Administrative Simplification law and regulations is: **http://aspe.os.dhhs.gov/admnsimp**. ❖

Third-party Web sites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

Provider Y2K Testing—Myth Versus Reality

The following article has been developed by the Health Care Financing Administration (HCFA) to clarify some of the misunderstandings related to the future-date Y2K claim testing offered by Medicare contractors.

This is a HCFA document, which is being published at the recommendation of HCFA.

The Year 2000 statements contained in this document originally made by third parties, including information about third party vendor products are Republications pursuant to the Year 2000 Information and Readiness Disclosure Act. First Coast Service Options, Inc., is not the source of the Republication. Each Republication is based on information supplied by the third party vendor and/or manufacturers.

MYTH	REALITY
1. HCFA's systems are not Y2K ready so there is no reason for me to test systems with HCFA at this time.	All of HCFA's claims processing systems have been fully-tested and certified as compliant as of April 1999, and are processing and paying Medicare claims today. HCFA's independent verification and validation expert, with oversight from the Department of Health and Human Services (HHS) Inspector General and the General Accounting Office (GAO), has verified the readiness of these claims processing systems. Since HCFA had to make software changes to these systems this summer, HCFA is engaging in a rigorous retesting of the systems to certify that any software changes did not affect the Y2K compliance of those systems. Recertification testing is scheduled to be completed by November 1999.
2. Medicare contractors are not ready to test.	All Medicare contractors are ready and willing to test with their providers/submitters. HCFA is strongly encouraging all claims submitters to test future-dated claims with the contractors' front-end systems. To assist you in your testing process HCFA has developed a "point of contact" list of contractors that you can call when you are ready to do Y2K testing. (See the HCFA Web site at **www.hcfa.gov/y2k**)
3. If you can send a Y2K compliant claim to your contractor today as HCFA required by April 5, 1999, your systems are millennium ready.	Unfortunately, this is not true. All your systems that interface to produce a compliant claim and other electronic transactions must be renovated and tested.
4. If I cannot submit claims on January 1, 2000, HCFA will send me an advance payment.	HCFA has clearly stated it will not be making advance payments as part of its contingency plan. HCFA's contingency plan provides mechanisms to make sure that providers that submit valid claims for services rendered will be paid even if parts of HCFA's or its contractors' systems experience unanticipated failure. If a provider cannot submit a bill, that provider is not covered by the HCFA payment contingency plan. Being able to submit a valid claim to HCFA is the minimal requirement health care providers must meet to receive payment from Medicare.
5. My contractor will only test the exchange of data with me. I believe an end to end test from claim submission to payment notice is needed.	Medicare contractors have conducted stringent end-to-end testing in future-dated environments. This testing shows that claims received by the contractors will be accurately processed and paid, including the generation of back-end remittances. The data exchange you test with your contractor will show your claim can get to Medicare. Logistics and time prevent end-to-end testing with the more than 200,000 submitters in Medicare.
6. Testing doesn't uncover any problems.	Significant problems have been found by Medicare contractors in testing with providers/submitters, including dates of 2000 and beyond being read as 1900 in provider/submitter systems. That's why it's critical that submitters test and test early; it allows them time to make necessary corrections in time for the millennium rollover.
7. I made changes and renovations to my systems, so I don't need to do any testing.	Even if you believe your billing systems are compliant, you should test your entire system to make sure you can generate a future-dated claim, and then test with your contractor's front end system. Our experience shows that testing reveals additional renovations that may need to be made to be fully compliant.

MYTH	REALITY
8. I can always print paper claims if I can't generate an electronic claim.	If your systems cannot produce an electronic submission, they likely won't be able to print paper claims. Also, since the time frame for processing paper claims is about 2 weeks longer than that for electronic claims, your cash flow may suffer. Finally, HCFA's contractors will simply not be able to timely process and pay a significant increase in paper claims. An influx of paper claims may result in payment backlogs.
9. Testing will cause problems for my production system.	It is true that following testing instructions and setting future date clocks on computers requires a level of skill. Following vendor/submitter instructions is essential. There are many products available to help you test. Use your contractor as a resource.
10. If I do future date testing my system will crash and I will not be able to reset my system back to the current date.	Testing does require some level of technical knowledge. It is important to closely follow instructions from your hardware and software vendors. Use your contractors as a resource.
11. If some other provider tests using the same billing software I use, then I don't need to do so.	Yes, you do need to test that same software because that other provider may have a different hardware system than you. Just because claims from one provide went through smoothly does not mean that you won't run into problems when you do your testing.
12. Testing with Medicare means everything will be all right.	Testing with Medicare will improve the odds of your Y2K readiness, but does not assure a smooth millennium rollover with other payers. Providers/submitters should make arrangements to test with other payers as well.
13. Why should I care? Vendors test for me!	Vendors should do the testing with contractors for you, and in many cases should be testing with you as well. The best thing to do is to call your vendor to determine their Y2K readiness program.
14. Everything will be all right if I test.	Not necessarily, but testing is worth the effort. Iron-clad guarantees are difficult in computing where there are literally trillions of variables. But testing with future dated claims (i.e., the clock is set for a date in the Year 2000) will help you avoid some of the billing road blocks. And remember, if you change the hardware or software after you have tested, the test results could become invalid. Now might not be a good time to make system changes.
15. I don't need to test my hardware.	Testing hardware is just as critical as testing software. Computer hardware must be Y2K compliant just like software.
16. If I deal with many contractors, I need to only test with one.	Unfortunately, that is not true. Many contractors use different systems to receive your claims. Testing with each contractor increases your assurance level.
17. I've tested my billing software, my job is done.	Testing assures you that you can successfully submit a claim to your payers. But you need to identify all of your critical business functions and make sure they will operate in the Year 2000. And, we advise that you thoroughly check the Y2K readiness of systems and devices that go to the heart of quality care and patient safety.
18. I've talked with my billing service and have been told that testing is too expensive.	The cost of testing now is a better choice than the real potential of significant cash flow disruption starting in January, 2000. Talk to your billing service to get a clear picture of any cost. If the cost sounds prohibitive, ask why. Also, let your contractor know you would like to test but the billing service charges are too expensive.

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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 repoduced 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 **January 17, 2000**, and after, unless otherwise noted.

Medical Policy Table of Contents

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 40 for information about accessing the BBS.

88155: Pap Smears - Revision to Policy

HCPCS code 88155 was revised in 1999. According to the Current Procedural Terminology (CPT) manual, cervical

or vaginal cytopathology slides for definitive hormonal evaluation (e.g., maturation index, karyopyknotic index, estrogenic index) are listed separately, in addition to codes for other technical and interpretive pap smear services. The coding guidelines contained in the current local medical review policy for pap smears (88141) has been updated to reflect this change. For information regarding the indications and limitation of coverage and/ or medical necessity for these services, please refer to pages 56-60 in the June/July 1999 *Medicare A Bulletin.*

J9999: Antineoplastic Drugs - Additions to Policy

The policy for J9999 Antineoplastic Drugs was published on pages 24-30 of the June/July 1999 *Medicare A Bulletin!* Since the publication of that article, the following coverage criteria for the antineoplastic drugs Traztuzumab (Herceptin®) and Denileukin diftitox (Ontak®) have been added to the policy.

Trastuzumab (Herceptin®)

Indications and Limitations of Coverage and/or Medical Necessity

Trastuzumab is a monoclonal antibody, one of a group of drugs designed to attack specific cancer cells. Trastuzumab's targets are cancer cells that produce a protein called HER2 or HER2/neu, which occurs in high numbers in about 25 to 30 percent of breast cancers.

Herceptin® is indicated for the treatment of patients with metastatic breast cancer whose tumors overexpress the HER2 protein and who have received one or more chemotherapy regimens for their metastatic disease.

Herceptin®, in combination with paclitaxel, is indicated for treatment of patients with metastatic breast cancer whose tumors overexpress the HER2 protein and who have not received chemotherapy for their metastatic disease.

Herceptin® is supplied as a 440 mg multi-dose vial. The reconstituted solution is intended for administration by intravenous infusion.

The recommended initial loading dose of Herceptin® is 4 mg/kg administered as a 90-minute infusion. The recommended weekly maintenance dose for Herceptin® is 2 mg/kg and can be administered as a 30-minute infusion if the initial loading dose was well tolerated.

HCPCS Codes

J9355 Trastuzumab, 10 mg

ICD-9-CM Codes That Support Medical Necessity

174.0-174.9	Malignant neoplasm of female breast
175.0-175.9	Malignant neoplasm of male breast
196.0-196.9	Secondary and unspecified malignant neoplasm of lymph nodes
197.0-197.8	Secondary malignant neoplasm of respiratory and digestive systems
198.0	Secondary malignant neoplasm of kidney
198.1	Secondary malignant neoplasm of other urinary organs
198.2	Secondary malignant neoplasm of skin
198.4	Secondary malignant neoplasm of other parts of nervous system
198.5	Secondary malignant neoplasm of bone and bone marrow
198.6	Secondary malignant neoplasm of ovary
198.7	Secondary malignant neoplasm of adrenal; gland
198.82	Secondary malignant neoplasm of other specified sites, genital organs

Note: *The billing of Herceptin® requires dual diagnoses. To ensure reimbursement for this service, dual diagnoses must be submitted. The primary and*

or Medical Necessity

Denileukin diftitox is a fusion protein designed to direct the cytocidal action of diphtheria toxin to cells which express the IL-2 receptor.

Ontak® is indicated for the treatment of patients with persistent or recurrent cutaneous T-cell lymphoma (CTCL) whose malignant cells express the CD25 component of the IL-2 receptor.

The safety and efficacy of Ontak® in patients with CTCL whose malignant cells do not express the CD25 component of the IL-2 receptor have not been examined.

Ontak® is supplied in single use 2 ml vials (300 mcg in 2 ml) as a sterile, frozen solution intended for intravenous administration only. The recommended treatment regimen (one treatment cycle) is 9 or 18 mcg/kg/day administered intravenously for 5 consecutive days every 21 days. Ontak ® should be infused over at least 15 minutes.

HCPCS Codes

J9999 Not otherwise classified, antineoplastic drug

ICD-9-CM Codes That Support Medical Necessity

202.10-202.18 Mycosis fungoides
202.20-202.28 Sezary's disease

Reasons for Denial

The use of Herceptin® or Ontak® for any clinical indication other than those listed in each of the "Indications and Limitations of Coverage and/or Medical Necessity" sections of this policy.

Noncovered ICD-9-CM Code(s)

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

Coding Guidelines/Documentation Requirements

When billing for Trastuzumab 10 mg, use HCPCS code J9355 and include the name of the drug and the appropriate ICD-9 CM diagnosis code indicating the medical condition being treated. The primary and secondary site of the malignancy must **both** be billed to indicate the breast malignancy is metastatic (e.g., ICD-9-CM diagnosis code 174.0 **and** 198.5). Documentation demonstrating that the patient's tumor overexpresses the HER2 protein must be maintained in the patient's record.

When billing for Denileukin diftitox, use HCPCS code J9999 and include the name of the drug and the appropriate ICD-9 CM diagnosis code indicating the medical condition being treated. Documentation demonstrating that the patient's malignant cells express CD25 must be maintained in the patient's medical record.

84153: Prostate Specific Antigen

Prostate-specific antigen (PSA) is a serum glycoprotein produced by normal prostate tissue, hypertrophic prostate tissue, and malignant prostate tissue. PSA is a serum tumor marker used in early detection, staging, and monitoring of a patient's response to treatment for prostate cancer. PSA can be present in abnormal quantities in both prostate cancer and benign prostatic hypertrophy (BPH). PSA levels are measured by radioimmunoassay or enzyme immunoassay. The normal range for serum PSA is 0 to 4.0 mg/ml.

Type of Bill

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

Revenue Code

301 Chemistry

Policy Type

Local medical necessity policy

Indications and Limitations of Coverage and/or Medical Necessity

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

- Diagnostic tool for patients in which a digital rectal exam reveals a suspicious abnormal prostate, (e.g., asymmetry of the prostate gland, hard, irregular module)
- Monitor patient response to treatment in cases of a known prostate malignancy
- Detecting metastatic or persistent disease following treatment
- Prior to initiation of Proscar for patients with BPH
- Monitor patients that are taking Proscar

HCPCS Codes

84153 Prostate specific antigen (PSA); total

ICD-9-CM Codes That Support Medical Necessity

170.2	Malignant neoplasm of vertebral column, excluding sacrum and coccyx
185	Malignant neoplasm of prostate
188.5	Malignant neoplasm of bladder neck
188.8	Malignant neoplasm of other specified sites of bladder
196.5	Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb
196.6	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
196.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple sites
198.5	Secondary malignant neoplasm of bone and bone marrow
198.82	Secondary malignant neoplasm of genital organs
233.4	Carcinoma in situ of prostate
236.5	Neoplasm of uncertain behavior of prostate
239.5	Neoplasms of unspecified nature of other genitourinary organs
790.93	Elevated prostate specific antigen (PSA)
995.2	Unspecified adverse effect of drug, medicinal and biological substance
V10.46	Personal history of malignant neoplasm of prostate
V67.51	Follow-up examination following completed treatment with high risk medications, not elsewhere classified

HCPCS Section and Benefit Category

Pathology and Laboratory/Chemistry

HCFA National Coverage Policy

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Sources of Information

Tierney, L., McPhee, S., & Papadakis, M. (1996). *Current Medical Diagnosis and Treatment*. (35th Ed.). Appleton and Lange: Stanford.

U.S. Department of Health and Human Services Public Health Service. (1994*). Clinician's Handbook of Preventive Services*.

Coding Guidelines

The ICD-9-CM diagnosis code for which the service was performed must be submitted with the claim. PSA's performed for evaluation of a nodule of the prostate should be billed with the diagnosis of 236.5 (Neoplasm of uncertain behavior of prostate) or 239.5 (Neoplasm of uncertain behavior of other genitourinary organs).

For patients initiating Proscar therapy, use diagnosis 995.2 and V67.5 for follow-up monitoring of the drug.

For screening PSAs, dates of service on or after January 1, 2000, refer to Florida Medicare's medical policy G0102 (Prostate Cancer Screening).

Documentation Requirements

Medical record documentation (office/progress notes and/or hospital notes) maintained by the ordering physician/referring physician must indicate the medical necessity for performing a prostate specific antigen.

If the provider of the service is other than the ordering/referring physician, the provider of the service s must maintain hard copy documentation of the lab results along with copies of the ordering/referring physician's order for the studies. The physician must state the clinical indication/medical necessity for the prostate specific antigen in

the order for the test.

Other Comments

N/A

CAC Notes

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

Start Date of Comment Period:	N/A
Start Date of Notice Period:	December 1999/January 2000 *Bulletin*
Original Effective Date:	01/19/1995 (AI)
Revised Effective Date:	January 17, 2000 ❖

87086: Urine Bacterial Culture

Description

A culture is the propagation of microorganisms or of living tissue cells in special media that are conducive to their growth. A urine culture is performed to identify the presence of infectious microorganisms in the urinary tract. It is performed when a patient has clinical symptoms indicative of a possible urinary tract infection. These symptoms include pain and/or burning upon urination, urgency, hematuria, urine retention, elevated temperature, and urine incontinence.

Type of Bill

Hospital - 12x, 13x, 14x
Skilled Nursing Facility - 21x, 22x, 23x, 28x
Rural Health Clinic - 71x
ESRD - 72x

Revenue Codes

306 Laboratory Bacteriology and Microbiology

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider a urine bacterial culture to be medically reasonable and necessary for the following situations:

- An abnormal urinalysis suggestive of a urinary tract infection (e.g., hematuria, pyuria or proteinuria);
- Clinical symptoms indicative of a urinary tract infection (e.g., burning and/or pain on urination);
- Fever of unknown origin or suspected septicemia;
- In follow-up of a previously treated urinary tract infection to confirm effectiveness of therapy.

HCPCS Codes

87086	Culture, bacterial, urine; quantitative colony count
87087	commercial kit
87088	identification, in addition to quantitative or commercial kit

ICD-9-CM-Codes That Support Medical Necessity

038.0	Streptococcal septicemia
038.10-038.19	Staphylococcal septicemia
038.2	Pneumococcal septicemia [Streptococcus pneumoniae septicemia]
038.3	Septicemia due to anaerobes
038.40	Septicemia due to gram-negative organism, unspecified
038.41	Septicemia due to Hemophilus influenzae [H. influenzae]
038.42	Septicemia due to Escherichia coli [E. coli]
038.43	Septicemia due to Pseudomonas
038.44	Septicemia due to Serratia
038.49	Septicemia due to other gram-negative organisms
038.8	Other specified septicemias
038.9	Unspecified septicemia
580.0	Acute glomerulonephritis with lesion of proliferative glomerulonephritis
580.4	Acute glomerulonephritis with lesion of rapidly progressive glomerulonephritis
580.81	Acute glomerulonephritis in diseases classified elsewhere
580.89	Acute glomerulonephritis with other specified pathological lesion in kidney
580.9	Acute glomerulonephritis with unspecified pathological lesion in kidney
590.00	Chronic pyelonephritis without lesion of renal medullary necrosis
590.01	Chronic pyelonephritis with lesion of renal medullary necrosis
590.10	Acute pyelonephritis without lesion of renal medullary necrosis
590.11	Acute pyelonephritis with lesion of renal medullary necrosis
590.2	Renal and perinephric abscess
590.3	Pyeloureteritis cystica
590.80	Pyelonephritis, unspecified
590.81	Pyelitis or pyelonephritis in diseases classified elsewhere
590.9	Infection of kidney, unspecified
591	Hydronephrosis
592.0	Calculus of kidney
592.1	Calculus of ureter
592.9	Urinary calculus, unspecified
593.0	Nephroptosis
593.1	Hypertrophy of kidney
593.2	Cyst of kidney, acquired
593.3	Stricture or kinking of ureter
593.4	Other ureteric obstruction
593.5	Hydroureter
593.6	Postural proteinuria
593.70	Vesicoureteral reflux unspecified or without reflux nephropathy
593.71	Vesicoureteral reflux with reflux nephropathy, unilateral
593.72	Vesicoureteral reflux with reflux nephropathy, bilateral
593.73	Vesicoureteral reflux with reflux nephropathy NOS
593.81	Vascular disorders of kidney
593.82	Ureteral fistula
593.9	Unspecified disorder of kidney and ureter
594.0-594.9	Calculus of lower urinary tract
595.0-595.9	Cystitis
596.0-596.9	Other disorders of bladder
597.0-597.89	Urethritis, not sexually transmitted, and urethral syndrome
598.00-598.9	Urethral stricture
599.0-599.9	Other disorders of urethra and urinary tract
601.0	Acute prostatitis
608.0	Seminal vesiculitis
608.2	Torsion of testis
608.4	Other inflammatory disorders of male genital organs
608.81	Disorders of male genital organs in diseases classified elsewhere
608.84	Chylocele of tunica vaginalis

608.85	Stricture of male genital organs
608.86	Edema of male genital organs
608.89	Other specified disorders of male genital organs
608.9	Unspecified disorder of male genital organs
625.6	Stress incontinence, female
780.6	Fever
788.0	Renal colic
788.1	Dysuria
788.20	Retention of urine, unspecified
788.21	Incomplete bladder emptying
788.30	Urinary incontinence, unspecified
788.31	Urge incontinence
788.32	Stress incontinence, male
788.33	Mixed incontinence, (male) (female)
788.34	Incontinence without sensory awareness
788.35	Post-void dribbling
788.36	Nocturnal enuresis
788.37	Continuous leakage
788.39	Other urinary incontinence
788.41	Urinary frequency
788.42	Polyuria
788.43	Nocturia
788.61	Splitting of urinary stream
788.62	Slowing of urinary stream
788.7	Urethral discharge
788.8	Extravasation of urine
790.7	Bacteremia
791.0	Proteinuria
791.7	Other cells and casts in the urine

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.

Noncovered ICD-9-CM Code(s)

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

Sources of Information

N/A

Coding Guidelines

N/A

Documentation Requirements

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 and made available to Medicare upon request. This information can generally be found in the office/progress notes, history and physical and/or operative notes.

If the provider of the service 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 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 various medical societies.

Start Date of Comment Period:	N/A
Start Date of Notice Period:	December/January 2000 *Bulletin*
Original Effective Date:	11/24/97
Revision Date/Number	January 17, 2000

Revised for addition of ICD-9-CM code 625.6 as well as updated to reflect current policy format.

Revision History:

Start Date of Comment Period:	07/03/97
Start Date of Notice Period:	10/24/97
Original Effective Date:	11/24/97 ❖

93886: Transcranial Doppler

Description

Transcranial Doppler uses low-frequency Doppler transducers applied across the thin portions of the temporal bone (the temporal acoustic windows) to obtain flow velocity information from the basal intracerebral arteries. The transtemporal acoustic window provides access to hemodynamic data from the middle, anterior, and posterior cerebral arteries. A suboccipital approach, with insonation through the foramen magnum, provides access to the intracranial vertebral and basilar arteries, while a transorbital approach can be used to insonate the ophthalmic artery and the carotid siphon via the optic foramen. This data allows evaluation of the direction, depth, speed, and characteristics of flow in these vessels.

The transcranial Doppler examination is by far the most operator-dependent technique of all the noninvasive studies.

Type of Bill

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

Revenue Type

921 Peripheral Vascular Lab, Other Diagnostic Services

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida considers transcranial Doppler evaluation of the intracranial cerebrovascular system to be considered medically necessary in any of the following circumstances (see " ICD-9-CM Codes That Support Medical Necessity"):

- The patient has suspected severe intracranial arterial stenosis based on finite clinical evidence of focal ischemia, and knowledge of this stenosis is necessary in order to properly care for the patient.
- The patient has areas of known severe stenosis or occlusion of arteries supplying the brain and assessment of the pattern and extent of collateral circulation is necessary in order to properly care for the patient.
- The patient has suffered a subarachnoid hemorrhage and transcranial Doppler studies are necessary to assess vasoconstriction of cerebral vessels.
- The patient has suspected or confirmed arteriovenous malformation, and an assessment of the arterial supply and flow pattern is necessary.
- The patient has suspected brain death.

Headaches or dizziness are not indications for transcranial Doppler studies of the intracranial vessels unless associated with other localizing signs and symptoms such as nystagmus, limb ataxia, etc.

Transcranial Doppler studies performed to monitor cerebral vascular resistance and the effects of vasodilators and other drugs in the treatment of stroke and other brain damage is considered investigational, and therefore not covered by Medicare.

and other drugs in the treatment of stroke and other brain damage is considered investigational, and therefore not covered by Medicare.

HCPCS Codes

93886	Transcranial Doppler study of the intracranial arteries; complete study
93888	limited study

ICD-9-CM Codes That Support Medical Necessity

348.8	Other conditions of brain
430	Subarachnoid hemorrhage
433.00	Occlusion and stenosis of basilar artery without mention of cerebral infarction
433.01	Occlusion and stenosis of basilar artery with cerebral infarction
433.10	Occlusion and stenosis of carotid artery without mention of cerebral infarction
433.11	Occlusion and stenosis of carotid artery with cerebral infarction
433.20	Occlusions and stenosis of vertebral artery without mention of cerebral infarction
433.21	Occlusion and stenosis of vertebral artery with cerebral infarction
433.30	Occlusion and stenosis of multiple and bilateral precerebral arteries without mention of cerebral infarction
433.31	Occlusion and stenosis of multiple and bilateral precerebral arteries with cerebral infarction
434.00	Cerebral thrombosis without mention of cerebral infarction
434.01	Cerebral thrombosis with cerebral infarction
434.10	Cerebral embolism without mention of cerebral infarction
434.11	Cerebral embolism with cerebral infarction
434.90	Cerebral artery occlusion, unspecified without mention of cerebral infarction
434.91	Cerebral artery occlusion, unspecified with cerebral infarction
435.0	Basilar artery syndrome
435.1	Vertebral artery syndrome
747.81	Anomalies of cerebrovascular system

HCPCS Section and Benefit Category

Non-Invasive Vascular Diagnostic Studies/Medicine

HCFA National Coverage Policy

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

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Sources of Information

Comerota, A., Katz. M., Hosking, J., Hasheimi, H., Kerr, R., & Carter, A. (1995*). "Is Transcranial Doppler a Worthwhile Addition to Screening Tests for Cerebrovascular Disease?" Journal of Vascular Surgery*, 21(1), 90-97.

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

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

Illustrated Guide to Diagnostic Tests. (1998). (2nd ed.). Springhouse: Springhouse Corporation.

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

Wozniak, M., Sloan, M., Rothman, M., Burch, C., Rigamonti, D., Permutt, T., & Numaguchi, Y. (1996). "*Detection of Vasospasm by Transcranial Doppler Sonography*." *Journal of Neuroimaging*, 6(2), 87-93.

Coding Guidelines

When a transcranial Doppler study is performed to monitor and manage the effects of vasodilators and other drugs in the treatment of strokes and other brain damage, the charges should be billed as "non-covered".

Vascular studies include patient care required to perform the studies, supervision of the studies and interpretation of study results with copies for patient records of hard copy output with analysis of all data, including bidirectional vascular flow or imaging when provided.

The use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of the bidirectional vascular flow, is considered to be part of the physical examination of the vascular system and is not separately billable under procedure codes 93886 or 93888.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of transcranial Doppler studies covered by the Medicare program. Also, the results of transcranial doppler studies covered by the Medicare program 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 transcranial Doppler studies is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies. The physician must state the clinical indication/medical necessity for the study in his order for the test.

Other Comments

N/A

CAC Notes

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

Start Date of Comment Period:	07/06/99
Start Date of Notice Period:	December/January 2000 *Bulletin*
Original Effective Date:	January 17, 2000 ❖

94664: Diagnostic Aerosol or Vapor Inhalation

Description

Aerosol or vapor inhalation involves the administration of drugs or solution of drugs by the nasal or oral respiratory route for local or systemic effect. The drugs or solution of drugs commonly administered via a nebulizer or aerosol include distilled water, hypertonic saline, and bronchodilators such as anticholinergics and B-Agonists.

Inhalation therapy is used in the therapeutic treatment of patients with known lung disease, as well as for producing bronchodilation, mobilizing sputum, and inducing sputum production for diagnostic purposes.

This policy addresses the use of aerosol or vapor inhalation for sputum mobilization, bronchodilation, and sputum induction for diagnostic purposes.

If a patient is unable to produce sputum, inhalation of a nebulized solution of 3 or 4 ml of distilled water or hypertonic sodium chloride results in the induction of an adequate specimen for examination. Any type of nebulizer may be used; however, ultrasonic nebulizers, which produce a concentrated mist, are preferred. The procedure is terminated when an adequate specimen is obtained, the nebulizer solution is exhausted, or after a maximum of 15-20 minutes. The procedure is most often used for patients suspected of having tuberculosis or a lung malignancy, and to search for *Pneumocystis carinii* infection in patients with the acquired immunodeficiency syndrome (AIDS).

Type of Bill

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

Revenue Code

410 Respiratory Services, General Classification

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider the use of an aerosol or vapor inhalation for diagnostic purposes medically reasonable and necessary for the following indications:

- For the induction/mobilization of sputum in a patient who presents with signs and symptoms of a respiratory infection (e.g., fever, dyspnea, chest congestion, cough) or suspected lung malignancy, and who is unable to produce an adequate sputum specimen for examination by conventional methods;
- For the induction/mobilization of sputum in a patient who continues to demonstrate signs and symptoms of a respiratory infection (e.g., fever, dyspnea, chest congestion, cough) despite antibiotic treatment, and who is unable to produce an adequate sputum specimen for follow-up examination by conventional methods; and/or
- To produce bronchodilation prior to a pulmonary function test (PFT), when the patient's functional ability to perform the test is decreased and would otherwise result in an inconclusive finding.

HCPCS Codes

94664	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation
94665	subsequent

ICD-9-CM Codes That Support Medical Necessity

135	Sarcoidosis
162.0-162.9	Malignant neoplasm of trachea, bronchus, and lung
197.0	Secondary malignant neoplasm of lung
197.3	Secondary malignant neoplasm of other respiratory organs
212.2	Benign neoplasm of trachea
212.3	Benign neoplasm of bronchus and lung
231.2	Carcinoma in situ of bronchus and lung
446.20	Hypersensitivity angiitis, unspecified
466.0-466.19	Acute bronchitis and bronchiolitis
486	Pneumonia, organism unspecified
490	Bronchitis, not specified as acute or chronic
491.0-491.9	Chronic bronchitis
492.0-492.8	Emphysema
493.00-493.91	Asthma
494	Bronchiectasis
495.0-495.9	Extrinsic allergic alveolitis
496	Chronic airway obstruction, not elsewhere classified
508.0	Acute pulmonary manifestations due to radiation
515	Postinflammatory pulmonary fibrosis
517.1-517.8	Lung involvement in conditions classified elsewhere
518.0-518.89	Other diseases of lung
786.02-786.09	Dyspnea and respiratory abnormalities
786.2	Cough
786.3	Hemoptysis
786.4	Abnormal sputum
793.1	Nonspecific abnormal findings on radiological or other examination of lung field
E945.8	Other and unspecified respiratory drugs primarily acting on the smooth and skeletal muscles and respiratory system

HCPCS Section and Benefit Category

Pulmonary/Medicine

HCFA National Coverage Policy

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Sources of Information

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

George, R.B., Light, R.W., Matthay, M.A., Matthay, R.A. (Eds.). (1995*). Chest Medicine: Essentials of Pulmonary and Critical Care Medicine* (3rd ed.). Baltimore: Williams and Wilkins Company.

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

Coding Guidelines

HCPCS codes 94664 and/or 94665 are not to be used in addition to a bronchospasm evaluation (94060). The bronchodilation is included in the reimbursement for 94060.

HCPCS codes 94664 and/or 94665 are not to be used when performing a therapeutic inhalation treatment for a chronic or acute condition. The appropriate therapeutic HCPCS code (94640-94651) should be used.

HCPCS code 94665 should only be used when a patient continues to demonstrate signs and symptoms of a respiratory infection (e.g., fever, dyspnea, chest congestion, cough) despite antibiotic treatment, and is unable to produce an adequate sputum specimen for follow-up examination by conventional methods.

Documentation Requirements

Medical record documentation (e.g., office/progress/hospital notes) maintained by the ordering/referring physician must indicate the medical necessity for performing the service. The documentation must also support that the service was performed for sputum induction/mobilization or bronchodilation for diagnostic purposes, and according to the criteria set forth in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Other Comments

N/A

CAC Notes

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

Start Date of Comment Period:	08/23/99
Start Date of Notice Period:	December/January 2000 *Bulletin*
Original Effective Date:	January 17, 2000 ❖

G0166: Enhanced External Counterpulsation

Description

Enhanced external counterpulsation (EECP) is a non-invasive method of treatment for coronary artery disease refractory to medical and/or surgical therapy. EECP uses sequential diastolic inflation of lower extremity pneumatic cuffs to augment aortic diastolic pressure, increase venous return to the heart and decrease left ventricular afterload. Augmenting aortic diastolic pressure increases the coronary artery perfusion pressure and transmyocardial pressure gradient possibly enhancing coronary collateral development.

A full course of treatment usually consists of thirty-five (35) one-hour sessions, which may be offered once or twice daily, and covers a period of four to seven weeks.

During treatment, the patient lies on a padded table that contains electronically controlled inflation and deflation valves. These valves are connected to three compressive air cuffs that are wrapped around the patient's lower extremities (usually around the calves and lower and upper thighs). The cuffs inflate and deflate in synchronization with the patient's cardiac cycle.

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, a reduction in the number of and severity of anginal episodes, with a lasting effect for several months to two years.

Type of Bill

Hospital - 12x, 13x

Revenue Code

940 Other Therapeutic Services/General Classification

Indications and Limitations of Coverage and/or Medical Necessity

Medicare will consider EECP medically reasonable and necessary when performed for dates of service on or after July 1, 1999 for patients with disabling stable angina that meet **all** the following criteria:

- Class III or Class IV angina based on the Canadian Cardiovascular Society Classification scale or an equivalent classification scale.
- A cardiologist or cardiothoracic surgeon must indicate that the patient is not amenable to surgical intervention, such as percutaneous transluminal coronary angioplasty (PTCA) or cardiac bypass because: their condition is inoperable, or there is a high risk of operative complications or post-operative failure; their coronary anatomy is not readily amenable to such procedures, or; they have co-morbid states which create excessive risk.

This procedure must be performed under direct supervision of a physician. The physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the personnel is performing the service.

Coverage is further limited to those enhanced counterpulsation systems that have sufficiently demonstrated their medical effectiveness in treating patients with severe angina in well-designed trials.

HCPCS Codes

G0166 External counterpulsation: per treatment session

ICD-9-CM Codes That Support Medical Necessity

413.9 Other and unspecified angina pectoris (stable angina)

HCPCS Section and Benefit Category

Cardiovascular/Medicine

HCFA National Coverage Policy

Coverage Issues Manual, Section 35-74
Program Memorandum AB-99-20, Change Request 856
Program Memorandum AB-99-51, Change Request 919

Reasons for Denial

Medicare coverage is limited to its use in patients with disabling stable angina pectoris, since only that use has developed sufficient evidence to demonstrate its medical effectiveness. Other uses of this device or similar devices, i.e., for conditions such as unstable angina, acute myocardial infarction, and cardiogenic shock, remain non-covered.

Hydraulic versions of these devices are non-covered.

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

Noncovered ICD-9-CM Code(s)

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

Sources of Information

Cox, J., & Naylor, D. (1992). *The Canadian Cardiovascular Society Grading Scale for Angina Pectoris: Is it Time for Refinements? Annals of Internal Medicine*, 117(8), 677-683.

EECP fact sheet. Vasomedical, Inc. World Wide Web.

Lawson, W., Hui, J., et al. (1997*). Enhanced External Counterpulsation as an Adjunct to Revascularization in Unstable Angina. Clinical Cardiology*, 20, 178-180.

Lawson, W., Hui, J., et al. (1998*). Prior Revascularization Increases The Effectiveness of Enhanced External Counterpulsation. Clinical Cardiology,* 21, 841-844.

Lawson, W., Hui, J., et al. (1996). *"Can Angiographic Findings Predict Which Coronary Patients Will Benefit From Enhanced External Counterpulsation*?" *American Journal of Cardiology*, 77(12), 1107-1109.

Lawson, W., Hui, J., et al. (1995). *"Three-Year Sustained Benefit From Enhanced External Counterpulsation in Chronic Angina Pectoris". American Journal of Cardiology*, 75(12), 840-841.

Lawson, W., Hui, J., (1996). *"Improved Exercise Tolerance Following Enhanced External Counterpulsation: "Cardiac or Peripheral Effect?" Cardiology*, 87(4), 271-275.

Soran, O., Crawford, L., et al. (1999*). Enhanced External Counterpulsation in the Management of Patients with Cardiovascular Disease*, *Clinical Cardiology*, 22, 173-178.

Suresh, K., Simandl, S., et al. (1998). *Maximizing the Hemodynamic Benefit of Enhanced External Counterpulsation, Clinical Cardiology*, 21, 649-653.

Coding Guidelines

For services performed from July 1, 1999 through December 31, 1999, providers must report CPT code 93799.

Procedure codes for external cardiac assist (92971), ECG rhythm strip and report (93040 or 93041), pulse oximetry (94760 or 94761) and plethysmography (93922 or 93923) are not medically necessary with EECP and should not be paid on the same day, unless they occur in a clinical setting not connected with the delivery of the EECP. In addition, these services must meet the medical necessity identified in the applicable local medical review policy.

NOTE: Effective January 1, 2000, CPT codes 94760 and 94761 are considered bundled services and, therefore, not separately reimbursable.

Documentation Requirements

The medical record documentation must support that the service was ordered by the physician for a patient with Class III or Class IV angina not amenable to surgical intervention. In addition, the documentation must support that the service was performed. This information is usually found in the history and physical, progress notes, and/or hospital/office 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 Chapter of the American College of Cardiology.

Start Date of Comment Period:	08/23/99
Start Date of Notice Period:	December/January 2000 *Bulletin*
Original Effective Date:	January 17, 2000 ❖

J2355: Oprelvekin (Neumega®)

Description

Oprelvekin (Neumega®) is a thrombopoietic growth factor that directly stimulates the proliferation of hematopoietic stem cells and megakaryocyte progenitor cells, and induces megakaryocyte maturation resulting in increased platelet production.

Thrombocytopenia may compromise cancer treatment, causing a reduction in chemotherapy dosaging, alteration in schedule, or the need for platelet transfusions. Thrombopoeitic growth factors may decrease the need for platelet transfusions in patients undergoing dose-intensive chemotherapy.

Type of Bill

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

Revenue Code

636 Drugs Requiring Detailed Coding

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider the administration of Oprelvekin (Neumega®) medically reasonable and necessary for the following indications:

- To prevent severe thrombocytopenia (platelet counts of 20,000 cells/µl) and to reduce the need for platelet transfusions following myelosuppressive chemotherapy in patients with nonmyeloid malignancies who are at high risk of severe thrombocytopenia.

Medicare of Florida will consider coverage of Oprelvekin **only** for patients with nonmyeloid malignancies who have/had a platelet count of 50,000 cells/µl, or for patients with nonmyeloid malignancies who required a platelet transfusion after a previous myelosuppressive chemotherapy regimen.

Medicare of Florida will not consider coverage of Oprelvekin medically reasonable and necessary when it is administered simply because the patient has received a chemotherapeutic agent that has a high propensity to cause thrombocytopenia.

Oprelvekin is not indicated following myeloablative chemotherapy (e.g., bone marrow transplant or stem cell support). Oprelvekin is also not indicated as a "rescue" agent.

The recommended daily dosage is 50 µg/kg administered subcutaneously. Dosing should be initiated 6-24 hours following the completion of chemotherapy dosing, and discontinued at least two days before starting the next planned cycle of chemotherapy.

A single treatment course should not exceed 21 days. The safety and effectiveness of Oprelvekin immediately prior to or concurrently with cytotoxic chemotherapy has not been established.

Platelet counts should be monitored periodically to assess the optimal duration of therapy. Dosing should be continued until adequate recovery of the platelets has occurred (post-nadir platelet count 50,000 cells/µl).

Additionally, a patient should be monitored for fluid retention (e.g., weight gain, edema, shortness of breath) during the course of treatment with Oprelvekin.

HCPCS Codes

J2355 Injection, oprelvekin, 5 mg

ICD-9-CM Codes That Support Medical Necessity

140.0-149.9	Malignant neoplasm of lip, oral cavity, and pharynx
150.0-159.9	Malignant neoplasm of digestive organs and peritoneum
160.0-165.9	Malignant neoplasm of respiratory and intrathoracic organs
170.0-176.9	Malignant neoplasm of bone, connective tissue, skin, and breast
179-189.9	Malignant neoplasm of genitourinary organs
190.0-199.1	Malignant neoplasm of other and unspecified sites
200.00-200.88	Lymphosarcoma and reticulosarcoma
201.00-201.98	Hodgkin's disease
202.00-202.98	Other malignant neoplasms of lymphoid and histiocytic tissue
287.4	Secondary thrombocytopenia

Note: *The billing of Oprelvekin requires dual diagnoses. To ensure reimbursement for this service, dual diagnoses must be submitted. Providers must use ICD-9-CM codes 140.0-202.98 (nonmyeloid malignancy) and 287.4 (thrombocytopenia due to drugs) to report the approved indication for J2355.*

HCPCS Section and Benefit Category

Drugs and Biologicals

HCFA National Coverage Policy

Medicare Hospital Manual 442.7
Medicare Intermediary Manual 3101.3, 3112.4, 3627.9

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Sources of Information

1999 Physician's Desk Reference
United States Pharmacopoeia Drug Information Update, Volumes I and II (1998). The United States Pharmacopeial Convention, Inc.

Coding Guidelines

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

Providers must use ICD-9-CM codes 140.0-202.98 (nonmyeloid malignancy) **and** 287.4 (thrombocytopenia due to drugs) to report the approved indication for J2355.

Documentation Requirements

Medical record documentation (e.g., office/progress notes, medication records) maintained by the ordering/referring physician must clearly indicate the reason for the use of this drug, the platelet count, the patient's weight, and the dose administered.

Other Comments

N/A

CAC Notes

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

Start Date of Comment Period:	08/23/99
Start Date of Notice Period:	December/January 2000 *Bulletin*
Original Effective Date:	January 17, 2000 ❖

ESRD

END STAGE RENAL DISEASE DRUG PRICING UPDATE

The following revised End Stage Renal Disease (ESRD) drug pricing list updates and replaces section 22 of the Medicare Part A ESRD Processing Manual. This list may also be used as a stand-alone reference for ESRD drugs and/or pharmacy services. Prices are effective for services rendered ***on and after January 1, 2000,*** and represent the Medicare maximum reimbursement for separately billable ESRD drugs and/or pharmaceuticals.

All prices, as mandated by the Health Care Financing Administration (HCFA), are 95 percent of either:

- the lesser of the median average wholesale price of all generic forms of the drug, or
- the lowest brand name average wholesale price.

ESRD providers may order the 2000 *Drug Topics*Ò *Red Book*Ò (Pharmacy's Fundamental Reference™) for $62.95 (plus shipping and handling). Call **(800) 222-3045**, toll-free, or write to:

Drug Topics Ò Red Book Ò
5 Paragon Drive
Montvale, NJ 07645-1742

- The drugs listed in this section are arranged in alphabetical order, based on the first initial of the drug name.
- When a drug is billed on the HCFA-1450 (UB-92) billing format, an ICD-9-CM diagnosis code (excluding 585 - Chronic Renal Disease) must be reported.
- Diagnosis code 585 (Chronic Renal Disease) must be reported as principal diagnosis code on all ESRD bill types (type of bill code 72X).
- The drug prices in this revision include a 5 percent price reduction as mandated by HCFA.

LEGEND	
PROCEDURE CODE	HCFA Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) code, and locally assigned code reportable on the HCFA-1450(UB-92) billing format.
NAME	Name of drug (brand name and/or generic).
PRICE	Medicare Part A reimbursement allowance for specific drug administered via ESRD environment.

PROCEDURE CODE	NAME	PRICE	NOTES
W2490	Acthar Gel, 40 units	$4.55	
J0170	Adrenalin Epinephrine, 1 mg/1 cc ampule	$1.00	
J7090	Albumin 25%, 50 cc	$71.25	
02436	Albumin 25%, 100 cc	$164.82	
J0210 (Replaces Code X0046)	Aldomet, up to 250 mg	$8.97	This drug is included in the composite rate.
00047	Amikin, Amikacin, 100 mg/2 cc	$30.13	
J0280	Aminophylline, 250 mg	$1.27	
00061	Amphotericin B, Fungizone, 50 mg	$15.77	
J0290	Ampicillin, 500 mg	$1.06	
J0690	Ancef, Kefzol, 500 mg	$1.96	
J0360	Apresoline Hcl (Hydralazine), 20 mg	$7.62	This drug is included in the composite rate.
J3430	Aquamephyton (Vitamin K), 10 mg	$3.88	
J0380	Aramine, Metaraminol Bitartrate, 10 mg	$1.12	This drug is included in the composite rate.
J7504	Atgam, 250 mg	$249.16	
X0003	Ativan (Lorazepam), 2 mg	$8.33	
J0460	Atropine Sulfate, 0.3 mg	$1.98	
X0004	Azactam (Aztreonam), 1 gm	$15.34	
00151	Bactrim, 80 mg/ml-16 mg/ml, 5 cc	$2.64	
J1200 (Replaces Code X0005)	Benadryl, up to 50 mg	$2.78	This drug is included in the composite rate.
J0530	Bicillin C-R (Penicillin-G), 600,000 units	$6.32	
J0540	Bicillin C-R (Penicillin-G), 1,200,000 units	$12.65	
J0550	Bicillin C-R (Penicillin-G), 2,400,000 units	$25.30	
J0560	Bicillin La (Penicillin-G), 600,000 units	$7.50	
J0570	Bicillin La (Penicillin-G), 1,200,000 units	$12.24	
J0580	Bicillin La (Penicillin-G), 2,400,000 units	$24.48	
X0007	Buprenex (Buprenorphine), .3 mg/1 cc	$2.53	
J0635	Calcijex (Calcitriol), 1 mcg/ml	$12.82	
24910	Calcimar, 50 units	$4.03	

PROCEDURE CODE	NAME	PRICE	NOTES
X0014	Calcium Chloride 10%, 10 cc	$0.85	
J0610	Calcium Gluconate, 10 ml	$1.01	
X0104	Carnitine (Levocarnitine), 1 gm	$34.20	
J0710	Cefadyl (Cepharin Sodium), 1 gm	$1.55	
W2489	Cefizox (Ceftizomine), 1 gm	$12.41	
00248	Cefobid, 1 gm	$15.59	
X0016	Cefotan, 1 gm	$11.00	
J0698	Cefotaxime, Claforan, 1 gm	$12.12	
J0700	Celestone Soluspan, 3 mg	$4.39	
87000	Cipro, 400 mg	$27.37	
X0017	Cleocin Phosphate (Clindamycin), 300 mg	$5.96	
J0745	Codeine Phosphate, any dosage	$0.86	
J0780	Compazine, Prochlorperazine, up to 10 mg	$2.62	
X0018	Cortrosyn, 0.25 mg	$12.44	
X0019	Cytovene, 500 mg	$33.88	
J9070	Cytoxan (Cyclophosphamide), 100 mg	$5.97	
J9080	Cytoxan (Cyclophosphamide), 200 mg	$11.34	
J9090	Cytoxan (Cyclophosphamide), 500 mg	$23.80	
J9091	Cytoxan (Cyclophosphamide), 1 gm	$47.64	
J9092	Cytoxan (Cyclophosphamide), 2 gm	$95.26	
X0020	Ddavp (Desmopressin Acetate), 4 mcg	$18.70	
J2320 (Replaces Code J0910)	Deca Durabolin (Nandrolone Decanoate), 50 mg	$5.20	
J2321	Deca-Durabolin (Nandrolone Decanoate), 100 mg	$4.94	
J2322	Deca-Durabolin (Nandrolone Decanoate), 200 mg	$12.64	
X0021	Decadron (Dexamethasone), 8 mg	$0.95	
J3120	Delatestryl Enanthante, Testosterone, up to 100 mg	$0.57	
J3130	Delatestryl Enanthate, Testosterone, 200 mg	$1.14	
J0970	Delestrogen, 40 mg	$1.61	
J0990	Demerol (Meperidine HCL), 100 mg	$0.57	
J1050	Depo-Provera, 400 mg	$52.43	
J1090	Depo-Testosterone, 50 mg/1 cc	$0.60	
J1070	Depo-Testosterone, 100 mg/1 cc	$1.21	
J1080	Depo-Testosterone, 200 mg/1 cc	$2.25	
00429	Desferal (Deferoxamine Mesylate), 500 mg/5 cc	$11.46	
J7060	Dextrose 5%, 50 cc	$13.77	
00502	Dextrose 5%, 100 cc	$13.77	
00503	Dextrose 5%, 150 cc	$10.55	
J1730 (Replaces Code X0022)	Diazoxide, Hyperstat, 300 mg/20 ml	$93.00	This drug is included in the composite rate.
89990	Diflucan, 200 mg	$81.33	
J1160 (Replaces Code X0047)	Digoxin, up to 0.5 mg	$1.86	This drug is included in the composite rate.
J1165	Dilantin, 100 mg	$1.30	
J1170	Dilaudid, 4 mg	$1.18	
X0023	Dopamine, Intropin, 40 mg/1 cc	$0.51	This drug is included in the composite rate.
J1240	Dramamine (Dimenhydrinate),50 mg	$0.69	
X0106(Replaces Code J1350)	Erythromycin Lactobionate, 500 mg	$11.07	
X0107	Ferrlecit, 62.5 mg/5 ml	$40.85	
00623	Flagyl, Metronidazole, 500 mg	$9.61	
J9190	Fluorouracil, 500 mg	$3.04	
X0100	Folic Acid, 5 mg/cc	$1.26	
W2485	Fortaz, Ceftazidime, 500 mg	$9.67	
J1460	Gamma Globulin, 1 cc	N/A	Code cannot be used for service dates after 4/1/99.
J1470	Gamma Globulin, 2 cc	$42.75	
J1480	Gamma Globulin, 3 cc	N/A	Code cannot be used for service dates after 4/1/99.
J1490	Gamma Globulin, 4 cc	N/A	Code cannot be used for service dates after 4/1/99.
J1500	Gamma Globulin, 5 cc	N/A	Code cannot be used for service dates after 4/1/99.
J1510	Gamma Globulin, 6 cc	N/A	Code cannot be used for service dates after 4/1/99.
J1520	Gamma Globulin, 7 cc	N/A	Code cannot be used for service dates after 4/1/99.
J1530	Gamma Globulin, 8 cc	N/A	Code cannot be used for service dates after 4/1/99.

PROCEDURE CODE	NAME	PRICE	NOTES
J1540	Gamma Globulin, 9 cc	N/A	Code cannot be used for service dates after 4/1/99.
J1550	Gamma Globulin, 10 cc	$114.00	
J1580	Garamycin (Gentamicin), 80 mg	$2.16	
J1630	Haldol, 5 mg	$6.91	
J1640	Heparin 1000 u/ml, 30 ml	$6.31	This drug is included in the composite rate.
84800	Heparin (Beef & Porcine Origin) 1000 u/ml, 10 ml	$4.27	This drug is included in the composite rate.
00739	Hepatitis B Immune Globulin, 1 ml	$148.43	
00740	Hepatitis B Immune Globulin, 5 ml	$405.74	
W2390	Hepatitus B Vaccine, 40mcg/2 ml	$172.23	
J1650	Hexadrol, 4 mg/ml	$0.47	
J3410	Hydroxyzine, 25 mg	$0.62	
01891	Hydroxyzine, 50 mg	$0.47	
01892	Hydroxyzine, 100 mg	$0.87	
X0051	Immune Globulin (Gammimune N 5%, 500 mg)	$61.56	
J7501	Imuran, Azathioprine, 100 mg	$77.52	
J1790	Inapsine (Droperidol), 5 mg	$3.65	
J1800 (Replaces Code X0055)	Inderal, 1 mg/1 cc	$5.79	This drug is included in the composite rate.
J1760 (Replaces Code X0078)	Infed, 100 mg	$35.81	
90657 (Replaces Code 90724)	Influenza virus vaccine, split virus, 6-35 months dosage	$1.66	
90658 (Replaces Code 90724)	Influenza virus vaccine, split virus, 3 years and above dosage	$3.32	
90659 (Replaces Code 90724)	Influenza virus vaccine, whole virus	$3.32	
J1820	Insulin, 100 units	$1.97	This drug is included in the composite rate.
X0026	Isuprel, 0.2 mg/1 cc	$2.56	This drug is included in the composite rate.
J1840	Kantrex, Kanamycin, 500 mg	$3.19	
J1890	Keflin-Cephalothin Sodium, 1 gm	$10.26	
J3300	Kenalog (Triamcinolone Acetonide), 10 mg	$1.48	
J1880	Kenalog (Triamcinolone Acetonide), 40 mg	$1.61	
J1160	Lanoxin, 0.5 mg	$1.86	This drug is included in the composite rate.
J1940	Lasix (Furosemide), 20 mg	$0.93	
X0056	Levophed 0.1%, 4 cc	$18.20	
X0043	Levothyroxine, 0.2 mg	$12.82	
J1990	Librium, 100 mg	$16.34	
J2000	Lidocaine, 50 cc	$2.23	This drug is included in the composite rate.
00971	Mandol, Cefamandole, 1 gm	$8.60	
J2150	Mannitol 25%, 50 cc	$3.26	This drug is included in the composite rate.
00983	Mefoxin, Cefoxitin Sodium, 1 gm	$10.83	
00987	Mezlin, Mezlocillin, 1gm	$4.38	
J0695	Monocid, Cefonicid Sodium, 1 gm	$24.79	
J2270	Morphine, 10mg	$0.97	
X0027	Nafcil (Nafcillin Sodium), 500 mg	$0.35	
X0028	Narcan (Naloxone Hcl), 1 mg	$2.03	
J3260	Nebcin, Tobramycin, 80 mg	$10.80	
01076	Netromycin, Netilmicin Sulfate, 150 mg/1.5 cc	$9.94	
X0029	Nubain (Nalbuphine Hcl), 10 mg/1 cc	$1.44	
X0053	Nubain (Nalbuphine Hcl), 20 mg/1 cc	$1.50	
J7505	Orthoclone Okt 3, 5 mg/5 cc	$684.00	
X0101	Pentam, 300 mg	$92.62	Effective for service dates on or after 07/01/92.
J2550	Phenergan, Promethazine, 50 mg	$0.24	
J2560	Phenobarbital Sodium, 120 mg	$2.26	
01231	Pipracil, Piperacillin, 2 gm	$11.78	
J2610	Plasmanate 5%, 250 cc	$83.12	
90732	Pneumovax, 0.5 cc	$10.83	
X0030	Potassium Chloride, 2 meq/ml	$0.13	This drug is included in the composite rate.

PROCEDURE CODE	NAME	PRICE	NOTES
90732	Pneumovax, 0.5 cc	$10.83	
X0030	Potassium Chloride, 2 meq/ml	$0.13	This drug is included in the composite rate.
J1410	Premarin, 25 mg	$46.20	
W2493	Primaxin, 250 mg	$14.53	
X0031	Primaxin, 500 mg	$27.35	
J2510	Procaine, Penicillin, 600,000 units	$3.13	
X0076	Prolastin, 500 mg	$104.50	
J2680	Prolixin Decanoate (Fluphenazine), 25 mg	$15.20	
J2690	Pronestyl, 1 gm	$11.02	This drug is included in the composite rate.
J2700	Prostaphlin, Oxacillin Sodium, 250 mg	$2.00	
J2720	Protamine Sulfate, 5 cc	$4.45	This drug is included in the composite rate.
J2765	Reglan, Metoclorpramide, 10 mg	$1.90	
J0696	Rocephin, Ceftriaxone Sodium, 250 mg	$13.50	
W2488	Rocephin, Ceftriaxone Sodium, 500 mg	$23.18	
89991	Sandoglobulin, 1gm	$70.50	
X0102	Septra, 80 mg/ml-16 mg/ml, 5 ml	$2.19	Effective for service dates on or after 11/01/92.
X0038	Sodium Bicarbonate 8.4%, 50 cc	$3.74	
00515	Sodium Chloride 9%, 30 cc	$1.42	
00510	Sodium Chloride 9%, 50 cc	$3.01	
00511	Sodium Chloride 9%, 100 cc	$3.94	
00512	Sodium Chloride 9%, 150 cc	$9.72	
00513	Sodium Chloride 9%, 250 cc	$10.50	
00514	Sodium Chloride 9%, 500 cc	$9.18	
X0039	Solu-Cortef, 100 mg	$3.09	
X0040	Solu-Cortef, 500 mg	$12.37	
J2920	Solu-Medrol, 40 mg	$2.01	
J2930	Solu-Medrol, 125 mg	$3.54	
01478	Stadol, 1 mg	$7.68	
01479	Stadol, 2 mg	$7.99	
J2970	Staphcillan, 1 gm	$5.57	
J2995	Streptase, 250,000 units	$115.64	
J3010	Sublimaze (Fentanyl), 2 cc	$1.49	
J3070	Talwin Lactate, 30 mg	$3.17	
01601	Talwin Lactate, 60 mg	$6.72	
J3150	Testosterone Propionate, up to 100 mg	$0.95	
J3180	Tetanus Toxoid, 0.5 cc	$2.90	
J3230	Thorazine, Chlorpromazine, up to 50 mg	$1.90	
01671	Ticar, Ticarcillan, 1 gm	$4.05	
J3250	Tigan Trimethobenzamide Hydrocl, up to 200 mg	$2.39	
X0042	Timentin, 100 mg-3 gm	$14.34	
J3280	Torecan, 10 mg	$5.01	
X0103	Trobicin (Spectinomycin Hydrochloride), 2 gm	$22.12	
X0099	Unasyn, 3 gm	$22.44	
X0058	Unipen, 2 gm	$4.27	
J3364	Urokinase, 5000 I.U.	$56.61	
J3360	Valium, 5 mg	$1.71	
J3370	Vancocin, Vancomycin, 500 mg	$5.19	
X0057	Verapamil, Calan, 5 mg	$5.16	This drug is included in the composite rate.
X0060	Versed (Midazolam), 5 mg	$8.14	
X0044	Vibramycin (Doxycycline), 100 mg	$15.86	
J3420	Vitamin B-12, 1000 mcgm	$0.05	
00522	Water For Injection, 30 cc	$1.25	
00520	Water For Injection, 250 cc	$9.61	
00521	Water For Injection, 500 cc	$3.16	
X0105	Zemplar, 1 ml Fliptop vial	$25.15	
J0697	Zinacef (Cefuroxime Sodium), 750 mg	$6.09	
X0045	Zinacef (Cefuroxime Sodium), 1.5 gm	$12.14	
X0062	Zofran, 2 mg/1 cc	$12.17	
01958	Zovirax, 500 mg	$47.21	

FRAUD AND ABUSE

The Wheels of Justice Turn

In government, the wheels of justice turn constantly, though seldom at the desired pace. Many days, it seems that our Medicare work is for naught. Cases we investigate are moved on to other government agencies, and years may pass before they are resolved. However, the system does work and, when fraud, waste, or abuse exist, our efforts to eliminate them do pay off.

During this past quarter, several significant cases involving fraud, waste, or abuse were finalized through the courts. Here is an update about some of the cases in which First Coast Service Options, Inc., joining with the Health Care Financing Administration, the Federal Bureau of Investigation, the Office of the Inspector General, the Department of Justice, and the Agency for Health Care Quality, has participated:

- In large health care corporation case, two of four defendants were found guilty on six counts of Medicare cost report fraud spanning 1987 through 1992, and totaling nearly $3.5 million. Indictments in this case were issued in October 1998, and the trial concluded in August 1999.
- The owner of several mobile diagnostic laboratory companies throughout the Southern and Middle Districts of Florida pled guilty to conspiracy to defraud the United States government by paying kickbacks to clinics and physicians for the referral of Medicare patients (violation of Title 19 USC, Section 371). The individual, sentenced to three years probation and six months home detention, was also ordered to make restitution to the government in the amount of $400,000 and to pay a special assessment of $100.
- A physician was sentenced to 27 months in prison and three years supervised release, and was ordered to pay $200,504 in restitution and a $200 special assessment for conspiracy and filing false claims.
- Two defendants pled guilty to conspiracy and were sentenced to prison time and ordered to pay $444,066 in restitution and a $4,000 fine.
- A physician was ordered to pay $1,384,500 in a settlement agreement for a case that involved filing false claims from 1993 to 1996. In addition, the physician agreed to be excluded from all publicly funded health care programs for five years.
- A “patient broker” who pled guilty to violating the Medicare Anti-Kickback statute and was ordered to pay $221,850 in restitution and was sentenced to six months home detention and three years probation.
- The owner of an independent laboratory pled guilty to conspiracy to submit false claims and was sentenced to three years probation with four months in a half-way house and eight months of home confinement with electronic monitoring, and was ordered to pay a $50 special assessment.

Cases often take years to resolve, but the prevention and detention of fraud, waste, and abuse in the Medicare program pays off. Each day, when we come to work, we are rewarded by the knowledge that we are protecting and safeguarding the Medicare trust fund, now and for the future. ❖

A WORD FROM THE VICE PRESIDENT

Medicare Part A "Let's Talk" Session A Success!

First Coast Service Options, Inc. (FCSO), hosted its first quarterly "Let's Talk " session with Medicare Part A providers on October 21, 1999, in Orlando. On behalf of FCSO, I would like to thank those providers who participated in making this first session such an overwhelming success. By attending the meeting, you have allowed us to increase communication and coordination with providers so that jointly we make the Medicare program administratively more efficient and effective.

During this session, we discussed the following topics:

- FCSO's vision, strategy and key goals
- Balanced Budget Act provisions impacting the Medicare Program
- Y2K readiness and certifications
- Provider education and outreach initiatives
- Medical Review changes for 2000
- Input for the Calendar Year (CY) 2000 "Let's Talk" sessions
- Questions and Answers

We are developing a formalized process for conducting these meetings in CY 2000. These sessions will be used as an opportunity for providers to interact with senior FCSO management on overall program improvement initiatives instead of individual provider issues. If you were unable to attend this first session, we invite you to meet with us at the next "Let's Talk" session that will be held Tuesday, January 18, 2000. Remember, seating will be limited so sign up early. (See registration form on page 43.)

We look forward to working with you to enhance our business processes and our service to the Medicare beneficiaries. Thank you for all your help!

Sincerely,

F. Lamar James,
Vice President Medicare Program Management
First Coast Service Options, Inc.

Free Services Available to Help Educate Patients About Medicare

All providers want to maintain good patient relationships. Having answers to patients' Medicare questions—or knowing where to refer patients to get answers—can be crucial to those relationships. First Coast Service Options, Inc. (FCSO), Florida HCFA-contracted intermediary, has good news for providers! FCSO's **Medicare Education and Outreach (MEO)** team is dedicated to provide Medicare education to beneficiaries and to those who work with beneficiaries, such as office staff. To this end, MEO makes a number of services available to providers and beneficiaries FREE or at a small cost.

MEO's mission is to help Florida beneficiaries obtain clear and useful health care information, enabling them to access affordable and quality health care services, while protecting their benefits. MEO designs, develops, and delivers educational programs tailored to the informational needs of Florida Medicare beneficiaries, and to providers and other health and social service organizations who furnish services to beneficiaries. Working directly with beneficiaries, often in one-on-one situations, providers are uniquely able to provide needed information to Medicare patients, in a familiar and trusted environment. By maintaining strong partnership with MEO, providers can reach and educate more than 2.8 million beneficiaries in Florida.

One interactive service MEO provides is a series of free seminars. MEO's regional staff will present, at a provider's facility, half- or full-hour talks (in English or in Spanish) on any of the Medicare topics listed on the following chart. The talks can be targeted to the specific needs of a group of Medicare patients and/or staff members. MEO's primary requirement is that at least 50 beneficiaries or 25 health or social service professionals be present for each seminar.

"Seniorfest" is another popular interactive approach to beneficiary education and outreach. This is a one-day, "one-stop shopping" event, offering information to seniors about their health care benefits, through exhibits, workshops, and educational materials. Free to the public, Seniorfest is presented by MEO and local, state, and federal government agencies serving Medicare and Medicaid beneficiaries. Seniorfest usually takes place in the fall, close to the start of the influenza and pneumococcal virus vaccination campaign and the October mammography campaign. These activities encourage beneficiaries to use their preventive benefits. In fact, many of these benefits are available at Seniorfest. Sponsoring Seniorfest is a great way to bring health information to patients, plus the extra bonus of positive public relations for participating provider organizations.

MEO can also provide providers with Medicare literature to display in the office or give to patients. In addition to the *1999 Medicare and You Handbook*, brochures are available on:

- Preventive benefits, such as mammography, flu, and PPV vaccines
- Medicare + Choice
- Fraud and Abuse
- Durable Medical Equipment and more!

Copies may be ordered individually or in quantity.

Medicare video tapes are also available, for the cost of shipping and handling. Topics currently available include:

- Medicare, the Flu and You
- How to Talk to Your Doctor
- Medicare, Home Health, and Hospice
- Medicare Fraud and Abuse (English and Spanish)
- Medicare Services Available in Your Community

The advantage of patient education through video is that patients may check tapes out and view them at their leisure. Providers may also want to have copies available for patients who may be homebound or live in rural areas with poor transportation, or perhaps for training new staff.

More information about MEO services is available on Medicare's Web site: **www.medicarefla.com**.

To schedule a speaker, order materials or video tapes, or find out more about sponsoring or participating in Seniorfest, complete the "Request for Seminars or Beneficiary Materials" form (see page 42). Fax the form to the Medicare Education and Outreach (MEO) department at (904)791-8316. ❖

Module Name	Topics	Intended Audience
Medicare Overview	Complete overview of program includes eligibility, Parts A/B, Medicare + Choice and covered benefits	All audiences new to Medicare
Medicare Update	Most current policies/ benefits, changes, preventive care, hot issues, Medicare Education and Outreach services	Audiences familiar with Medicare
Managed Care Made Easy/ Medicare + Choice	Original fee for service vs. Managed Care, How to evaluate/ select/ enroll/ disenroll from a Medicare + Choice program	All audiences
Medicare Fraud and Abuse	Definition and examples of Fraud and Abuse, Operation Restore Trust, how to report Fraud and Abuse	All audiences
Medicare Preventive Care Benefits	Promote healthy living, preventive coverage: Mammography, Flu, PPV, Colorectal cancer screening, PAP smears, hepatitis B, and others	Beneficiaries, Care givers
How to Help your Patients Understand Medicare	Communicating with your patient, understanding Medicare basics, Medicare Education and Outreach services, assistance and referral, frequently asked questions and hot topics	Healthcare providers (non-physician), office managers, social workers

Medicare Offers FREE National Education Programs

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

Medicare Computer Based Training

Computer Based Training Courses via the Internet

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

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

Here's How it Works:

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

CBT System Requirements:

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

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

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

Courses via Satellite Broadcast

Medicare Satellite broadcasts

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

Steps to Promoting Wellness: Adult Immunizations
Available on Videotape from the June 1999 National Satellite Broadcast

Medicare Fraud and Abuse: Proactive Measures to Avoid Becoming a Victim
Available on Videotape from the July 1999 National Satellite Broadcast

Steps to Promoting Wellness: Women's Health
Available on Videotape from the August 1999 National Satellite Broadcast

The Medicare Resident Training Program
Available on Videotape from the September 1999 National Satellite Broadcast

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

Third party Web sites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators. ❖

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. ❖

ORDER FORM - 2000 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 2000. Please check here if this will be a Subscription Renewal [ ] or New Subscription [ ]	$ 75.00
	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:

First Coast Service Options, Inc.

Medicare Publications - ROC 6T

P.O. Box 45280

Jacksonville, FL 32232-5280

Facility Name:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Attention:_____ Area Code/Telephone Number:_____

Medicare Education and Outreach (MEO) Request for Seminars or Beneficiary Materials

For Medicare beneficiary publications or to schedule a seminar, please complete the information below and fax to the attention of:

Beneficiary Education at **(904) 791-8316**

Please contact me concerning *(check as many as apply):*

☐ Free publications for Medicare patients

☐ Scheduling a seminar on "How to Help your Patients Understand Medicare" for office staff, social workers, nurses, and others that work with Medicare patients *(suggested minimum attendance of 25)*

☐ Scheduling a Medicare Overview, Medicare Update or other courses for Medicare patients, their families and caregivers *(suggested minimum attendance of 50)*

☐ Other (see comments section below)

I can be reached at:

Facility/Organization Name: _____

Address: _____

Phone Number: ( ) _____ Fax Number: ( ) _____

Contact Person: _____

Seminar Date: _____

Topics of Interest: _____

Language: ☐ English ☐ Spanish

Comments:

"LET'S TALK" SESSION
with the Management and Leaders of
FIRST COAST SERVICE OPTIONS, INC.
January 18, 2000

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

This session will provide an opportunity to:

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

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

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

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

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

Please Fax The Registration Form to (904) 791-6035

"LET'S TALK" SESSION
with the
Management and Leaders of
FIRST COAST SERVICE OPTIONS, INC.
January 18, 2000

Registration Form for Medicare Part A Providers

Registrant's Name: _____

Registrant's Title/Position: _____

Provider's Name: _____

Medicare Billing Provider Number: _____

Address: _____

City, State, Zip Code: _____

Phone: ( ) _____ Fax: ( ) _____

Note: Please complete one form per person.

Mark your Calendar:	**Location:**
Date: Tuesday, January 18, 2000	Florida Hospital Association
Time: 12:00 p.m. - 4:00 p.m.	307 Park Lake Circle
Cost: ***None - It's Free!!***	Orlando, Florida 32803

For directions, please contact Becky Dunne at (407) 841-6230

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Addresses

CLAIMS STATUS

Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP

Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231
(904) 355-8899

APPEAL RECONSIDERATIONS

Claim Denials (outpatient services only)

Medicare Fair Hearings (Part A)
P. O. Box 45203
Jacksonville, FL

REVIEW REQUEST

Denied claims that may have been payable under the Medicare Part A program

Medicare Part A Reconsiderations
P. O. Box 45053
Jacksonville, FL 32232

OVERPAYMENT COLLECTIONS

Repayment Plans for Part A Participating Providers
Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or Program)
Interim Rate Determinations
TEFRA Target Limit and Skilled Nursing Facility Routine Cost Limit Exceptions
Freedom of Information Act Requests (relative to cost reports and audits)

Provider Audit and Reimbursement Department (PARD)
P.O. Box 45268
Jacksonville, FL 32232-5268
(904) 791-8430

ELECTRONIC CLAIM FILING

"Getting Started"

Direct Data Entry (DDE)
P. O. Box 44071
Jacksonville, FL 32231
(904) 791-8131

FRAUD AND ABUSE

Medicare Fraud Branch
P. O. Box 45087
Jacksonville, FL 32231
(904) 355-8899

MEDICARE SECONDARY PAYER (MSP)

Information on Hospital Protocols
Admission Questionnaires
Audits

Medicare Secondary Payer Hospital Review
P. O. Box 45267
Jacksonville, FL 32231

General MSP Information
Completion of UB-92 (MSP Related)
Conditional Payment

Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231
(904) 355-8899

Automobile Accident Cases
Settlements/Lawsuits
Other Liabilities

Medicare Secondary Payer Subrogation
P. O. Box 44179
Jacksonville, FL 32231

Phone Numbers

PROVIDERS

Automated Response Unit
904-355-8899

Customer Service Representatives:
904-355-8899

MEDICARE ONLINE BBS

Access
800-838-8859
904-791-6991

Technical Problems
904-791-8384

BENEFICIARY

904-355-8899

ELECTRONIC MEDIA CLAIMS

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