Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Features

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

Routing Suggestions:

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

Health Care Financing Administration

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

Table of Contents

Medicare A Bulletin

Vol. 2, No. 1
February/March 2000

Publications Staff

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

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:

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

A PHYSICIAN'S FOCUS

Message from the Intermediary Medical Director

Beginning with this issue, "A Physician's Focus" article will contain a message from our new Intermediary Medical Director, James J. Corcoran, Jr., M.D., MPH.

Hello, my name is Jim Corcoran. I started with First Coast Service Options, Inc., on December 1, 1999, as Intermediary Medical Director (Medicare Part A of Florida). I will be working closely with Dr. Sid Sewell, who will continue to concentrate on the Carrier Medical Director (Medicare Part B of Florida) responsibilities. For my first column, I would like to provide you with the highlights of my credentials and professional accomplishments.

I was born in Ithaca, New York, and raised in Pennsylvania. I received my undergraduate degree from Harvard College and my medical degree from Pennsylvania State University. After an internship in the Boston area, I headed south to pursue my residency training in Internal Medicine in Augusta, Georgia. I settled in South Carolina and enjoyed a private practice in Greenville for seven years. My practice included working with hospital systems as a provider of patient care and an active member of medical staffs. The emergence of electronic networks and the potential new uses of information in health care prompted my interest in obtaining additional education and experiences in management and health care policy. At the Johns Hopkins University School of Public Health, I received a Master of Public Health degree in 1995 and completed the Preventive Medicine Residency training program in 1996. I joined the Health Care Services Division of Blue Cross Blue Shield of Florida as an Associate Medical Director in July 1996 and was advanced to a Corporate Medical Director in July 1997. My responsibilities included technology assessment and medical policy. I am board certified in Internal Medicine (September 1985) and in Public Health and General Preventive Medicine (January 1998).

I am excited about the opportunity to work in the Medicare program that in many areas is the benchmark in health care. I look forward to building relationships with our intermediary providers. Together, we can improve health care systems by increasing the understanding of how the organization and administration of care affect access, quality, and cost.

Sincerely,

James J. Corcoran, Jr., M.D., MPH
Medicare Medical Director

First Coast Service Options, Inc.
532 Riverside Avenue, 7T
Jacksonville, Florida 32202
904-791-6195 Fax 904-791-8006
Email: James.Corcoran@fcso.com

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 special issue for the HCFA Common Procedure Coding System and Medicare Outpatient Fee Schedule Database Update.

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 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 several sections addressing general and facility-specific information and coverage guidelines.

The publication always starts with a column by the Intermediary Medical Director. Following an administrative section are usually general information and coverage sections with informational and billing issues, processing guidelines, and medical coverage applicable to all Medicare Part A providers and facilities. Coverage guidelines and billing issues targeting specific facilities or Part A providers are usually included in individual sections named under the applicable facility type. These facility-specific sections are 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 is omitted.) Also, as needed, the *Bulletin* contains Electronic Data Interchange (EDI) and Fraud and Abuse sections.

The Local Medical Review Policies section contains finalized medical policies and additions, revisions, and corrections to previously published local medical review policies. Whenever possible, the Local Medical Review Policies section will be placed in the center of the *Bulletin* to allow readers to remove it separately, without disturbing the rest of the magazine.

The Educational Resources section includes educational material, such as Medifest schedules, Medicare Website information, and reproducible forms. An index and important addresses and phone numbers are on the back.

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

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

Advance Beneficiary Notice Required for Home Health Care

The Health Care Financing Administration requires home health care agencies to provide beneficiaries entitled to Medicare Part A and B with an advance beneficiary notice (ABN). An ABN is a written notice given by a provider to a Medicare beneficiary before home health care is furnished when the provider believes that Medicare will not pay for some or all of the home health care a physician ordered for the beneficiary. A provider must give a Medicare beneficiary an ABN before reducing or terminating ongoing home health care if the physician's order for such care would still continue the care, but the provider expects payment for the home health services to be denied by Medicare.

These services are processed by the regional home health care intermediary (RHHI). Any questions regarding this policy should be directed to the RHHI at the following mailing address and telephone number:

Palmetto Government Benefits Administrators, LLC
34650 U.S. Highway 19 North, Suite 202
Palm Harbor, FL 34684-2156
Customer Services telephone number: (727) 773-9225 ❖

GENERAL INFORMATION

Medicare Deductible and Coinsurance for 2000

The Health Care Financing Administration has established the new deductible and coinsurance amounts for the 2000 calendar year (CY). Effective January 1, 2000, the deductible and coinsurance amounts are:

Part A Hospital (Inpatient)	Calculation per Benefit Period	CY 2000 Benefit Period
Deductible - 1 through 60 days	Current year inpatient deductible	$776.00 per benefit period
Coinsurance - 61 through 90 days	Rate is ¼ of current year inpatient deductible amount	$194.00 per day
Lifetime Reserve - 91 through 150 days (non-renewable days)	Rate is 1/2 of current year inpatient deductible amount	$388.00 per day

Skilled Nursing Facility (SNF)	Calculation Per Benefit Period	CY 2000 Benefit Period
SNF - 1 through 20 days	No deductible or coinsurance (full days)	$0 per benefit period
SNF - 21 through 100 days	Rate is 1/8 of current year inpatient deductible amount	$97 per day

Blood Deductible	Annual Requirement	CY 2000
Part A/Part B	Satisfied via Part A and or Part B services	3 pints annually

Part B - Outpatient	Annual Requirement	CY 2000
Annual Deductible	Satisfied via Part B outpatient and or Physician/Supplier Services (Part B)	$100.00

Medicare Contractors Applying Deductible, Co-Insurance and Payment Updates Beginning January 10, 2000

The following list of questions and answers was provided by the Health Care Financing Administration (HCFA), for contractors to use in answering inquiries received due to the delayed implementation of the Year 2000 updates (see October/November Medicare A Bulletin. Pages 5-6). *It is being published here as a convenience to our readers.*

Q What kind of updates will contractors be applying to Medicare Part B payments?

A HCFA had instructed all contractors to make Part B provider/supplier payment updates and other January annual updates (including the Part A deductible and co-insurance changes) on January 17, 2000, rather than on January 1, when the updates are usually applied. The reason for this delay was to reduce the risk of systems problems impacting the Year 2000 rollover. Medicare contractors were instructed to hold all claims with dates of service of January 1, 2000 or later in order to correctly apply the Year 2000 payment update and other annual updates, including any changes in beneficiary coinsurance and deductibles. The updates will be applied to all claims for services provided on or after January 1.

Q Why did HCFA initially instruct Medicare contractors to delay making the updates and to hold Year 2000 claims until January 17, 2000, and then, in late December, notified contractors they could make the update earlier, on January 10?

A When HCFA initially decided to update pricing and the deductibles and co-payment for Year 2000 claims on January 17, we were extremely concerned about fallout from Y2K millennium rollover problems. However, as our confidence increased from the success of our extensive testing, other issues caused us to modify the instructions. Some contractors had concerns that an operational backlog could result from a 2-week "hold" on claims for claims with a Year 2000 date of service. While the volume of claim receipts for Year 2000 dates of service was likely to be relatively light during the first week of 2000, the volume was expected to increase significantly beginning with the second week of January, mainly at Part B carriers. Moving the Year 2000 production start date to January 10 would result in smaller, more manageable inventories of held claims and would reduce the associated risks. Also, the earlier implementation date would also expedite the detection and correction of any Year 2000 "date of service" claims processing problems that may be encountered.

Medicare Contractors Applying Deductible, Co-Insurance and Payment Updates (continued)

After careful consideration, HCFA decided to offer contractors the choice of updating on January 10 or 17, as long as their rollover into the first week of the Year 2000 was successful and their choice was approved by HCFA.

Q Are all contractors making the update on January 10?

A HCFA gave the contractors the option to choose which date to apply the updates, as long as they obtained final approval from HCFA during the first week in January after HCFA could assess the success of the contractor's Day One rollover operations. The Common Working File (CWF) host sites, however, were required to use the January 10 date for implementing the Year 2000 update release, since all claims must be sent to the CWF hosts for pre-payment authorization and validation. The CWF system assures that the beneficiary is (1) entitled to either or both Part A and Part B benefits; (2) that the deductible applied, if any, is accurate; and (3) that the benefits on the claim are available.

Most contractors chose the January 10 option and their choice was approved by HCFA based on the contractor's successful rollover operations. A smaller number of contractors chose the January 17 date to complete further testing of the software release.

Medicare Part A of Florida chose the January 10 implementation date.

Q Why are some contractors able to do update pricing, etc., on January 10, while others can not update until January 17?

A HCFA provided discretion to the contractors as to whether to update on the 10th or 17th of January. Contractors updating on January 17 are ***not*** experiencing any Y2K problems; these contractors are running more tests of the pricing update to make absolutely certain there are no problems.

Since claims must be held by law a minimum of 14 days before payment, providers should experience little or no difference in the timing of payments made to them by contractors who are running the pricing update in their data centers on January 17 versus those running the update on January 10.

Q Will the holding of Year 2000 claims until January 17 delay payments to providers?

A No, this should not change the timing of payment to providers. 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. When Year 2000 claims are released for processing on January 10 or 17, claims are expected to be finalized for payment very quickly. We do not believe the delay poses a burden to providers. Providers were able to start sending in claims for Year 2000 services beginning January 1, and should not experience a delay in payment.

Q Will there be interest payments made on the money owed during this period?

A As always, interest will be paid on any "clean claims" that are held more than 30 days after receipt before payment is made. No claims for service dates held until January 17 will qualify for interest unless they are not paid until after 30 days from receipt.

Q If a provider submitted a claim early in January for a Year 2000 service date, do they have to wait until after January 10 or 17 before knowing whether the contractor accepted these claims?

A Contractors put these claims through their front-end edits and providers receive an acknowledgment report or a rejection report. Providers should check with their Medicare contractor for specific procedures.

Q If providers have questions about the payment update and possible effects the delay might have on them, or if providers believe their payments are not updated timely, who should they contact?

A Providers with questions about the timing of the payment update by their contractor or the payment amounts they are receiving may contact Medicare Part A Customer Services at (904) 355-8899. ❖

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.

Two-Year Moratorium on Financial Limitation for Outpatient Rehabilitation Services

A two-year moratorium has been placed on the application of financial limitations (i.e., caps) for outpatient rehabilitation services. Therefore, providers will not be required to track incurred expenses for dates of service **January 1, 2000 through December 31, 2001**. All claims with dates of service January 1, 2000 through December 31, 2001, will **not** be subject to the $1,500 financial limitation. This includes claims for all outpatient physical therapy services, speech-language pathology services, and outpatient occupational therapy services. Although claims for therapy services will not be subject to a financial limitation, these claims may be reviewed to ensure that the services rendered are covered and medically reasonable and necessary.

In addition, **effective January 1, 2000,** optometrists may refer patients for therapy services as well as establish and review the plan of treatment. ❖

Reporting of Noncovered Charges and Related Revenue Codes

Effective for claims received on or after April 1, 2000, outpatient Part B **noncovered charges** must be reported on the UB-92 HCFA-1450 claim form, or its electronic equivalent, along with covered charges. This Medicare guideline supersedes the current instruction in the Medicare intermediary manual (MIM) stating that "noncovered charges are omitted from the bill." The following instructions address outpatient Part B noncovered charges billed in conjunction with covered charges (partial payment bill) or when all the charges on the bill are noncovered.

Billing for Part B Outpatient Claims (Partial Payment)

Providers must report on the UB-92 HCFA-1450 claim form, along with covered charges, **all** Part B outpatient noncovered charges, related revenue codes, and HCPCS codes, where applicable. Providers utilizing the UB-92 flat file use record type 61, field number 10 (Outpatient Total Charges) and field number 11 (Outpatient Noncovered Charges) to report these charges. Providers utilizing the hard copy UB-92 HCFA 1450 claim form report these charges in form locator (FL) 47 "Total Charges" and in FL 48 "Noncovered Charges." Providers utilizing the electronic file X12 institutional claim transaction 837, version 3051, report the following:

X12 837, version 3051, implementation 3A.01
2 395 SV203 - Outpatient Total Charges
2 395 SV207 - Outpatient Noncovered Charges

X12 837, version 3051, implementation 1A.C1
2 375 SV203 - Outpatient Total Charges
2 375 SV207 - Outpatient Noncovered Charges

Billing for Part B Outpatient Claims (Total Noncovered)

Providers must submit outpatient claims when **all** of the charges on the claim are noncovered (no-payment bill), and they must complete all items on a no-payment bill in accordance with instructions for completing payment bills, with the exception that all charges are reported as noncovered. ❖

30715 – The Common (but Avoidable) RTP Reason Code

By far, the most common return to provider (RTP) reason code is 30715 (the patient's last name and/or first initial does not match what is found on the beneficiary's record for this HIC number). In the recent three-month period, **over 20,000** RTPs occurred due to the beneficiary name not matching the beneficiary record, despite this being one of the most easily avoidable RTP reason codes.

How can a facility reduce the occurrence of this RTP?

- When possible, make a photocopy of the beneficiary's red, white, and blue Medicare card, perhaps when admission staff are reviewing the Medicare Secondary Payer questionnaire with the beneficiary.
- When the beneficiary is not available to provide the Medicare card, facilities that send claims electronically through direct data entry may check the beneficiary's name against Medicare's records. If necessary, a correction to the claim may be made online.

Remember, if the beneficiary's name is incorrect on a claim, that claim will be returned to the provider **even if the Medicare number is correct.** Keep the following tips in mind to reduce the occurrences of 30715:

- Submit claims to Medicare using the name **exactly** as it is printed on the beneficiary's Medicare card or as it is listed on the DDE system.
- Do not use nicknames. If the beneficiary's Medicare card or DDE system indicates James Smith, do not change the name to "Jim Smith." (bill the name as "Smith, James")
- Include hyphens as appropriate (Smith-Jones, Rebecca).
- Include any suffix of the name (Jr., Sr., III). Write the last name, leave a space, write the suffix, then write the first name. (Snyder III, Harold or Adams Jr., Glen)

Providers are responsible for ensuring that the names and Medicare numbers they bill are complete and accurate. Taking all possible steps to reduce your facility's RTP rate will help reduce the need to correct and retransmit your claims, and will help you get your claims paid more promptly. ❖

ICD-9-CM Millennium Edition

It has been noticed that some providers may be using ***proposed*** diagnoses from the 2000 edition of the PMIC ICD-9-CM book. This book contains the following statement: "***HCFA proposed change FY2000 DO NOT USE.***" These diagnoses are ***not*** to be used to file claims to Medicare at this time.

An article in the October/November 1999 *Medicare A Bulletin (*pages 5-6) titled " Submitting, Processing, and Paying Medicare Claims in the Year 2000," notified providers that the Health Care Financing Administration would not be implementing any changes to ICD-9-CM codes for fiscal year 2000. A future issue of the *Medicare A Bulletin* will advise providers when new ICD-9-CM codes are implemented into the intermediary claim processing system. Using these diagnoses now may cause claims to be rejected. ❖

GENERAL COVERAGE

Extension of Medicare Benefits for Immunosuppressive Drugs

The Balanced Budget Refinement Act of 1999 has expanded the period in which certain beneficiaries may receive prescription drugs used in immunosuppressive therapy following covered organ transplants. Beginning **January 1, 2000,** eligible beneficiaries whose coverage for drugs used in immunosuppressive therapy expires during the calendar year may receive an additional eight months of coverage beyond the current 36-month period. The number of months of the extension period for individuals whose 36-month period ends during the subsequent four years may be either more or less than eight months.

Billing Instructions

Hospitals must bill immunosupressive drugs on a UB-92 HCFA-1450 claim form or its electronic equivalent using bill type 12X, 13X, 14X, 83X, or 85X. Hospitals currently report the immunosuppressive drugs using revenue code 250 in form locator (FL) 42 (Revenue Code) with occurrence code 36 and a corresponding date (the date of discharge for the inpatient hospital stay during which the beneficiary received the transplant procedure) in FLs 32-35 (Occurrence Code/Date).

In an interim time period, any claim for immunosuppressive drugs with a date of service on or after January 1, 2000 through January 31, 2000, has been suspended in the contractor's system and released for processing on January 3l, 2000. Interest is paid on these claims when applicable.

Effective for claims with a date of service on or after April 1, 2000, hospitals must report the immunosuppressive drug using revenue code 636 in FL 42 and HCPCS code of the drug in FL 44 (HCPCS/Rates) in addition to occurrence code 36 and the discharge date. ❖

Continuous Subcutaneous Insulin Infusion (CSII) Pump Coverage

Effective for services performed on or after April 1, 2000, Medicare will provide coverage for continuous subcutaneous insulin infusion pump when this device is prescribed as medically necessary. The HCPCS codes for the CSII pump and supplies are:

E0784	External ambulatory infusion pump, insulin
J1820	injection, insulin, up to 100 units
A4230	Infusion set for external insulin pump, nonneedle cannula type
A4231	Infusion set for external insulin pump, needle type
A4232	Syringe with needle for external insulin pump, sterile, 3 cc

These services are processed by the durable medical equipment regional carrier (DMERC), region C. Any questions regarding this policy should be directed to the DMERC at the following mailing address and telephone number:

Palmetto Government Benefits Administrators, LLC
DMERC Operations
P. O. Box 100141
Columbia, SC 29202-3141
Customer Service telephone number:
(803) 691-4300 ❖

Clinical Diagnostic Laboratory Organ or Disease Panels

The American Medical Association (AMA) Common Procedural Terminology (CPT) editorial panel has approved new laboratory organ or disease panels for the calendar year CY 2000. These codes were intended to be effective January 1, 2000. Because of the Year 2000 (Y2K) programming moratorium, the implementation of these codes has been delayed until April 1, 2000.

The following billing guidelines may be used to facilitate a transition through the Y2K programming moratorium until April 1, 2000.

For a clinical diagnostic laboratory organ or disease panel test (employing an affected multi-channel code), furnished on or after January 1, 2000, **and** received prior to April 1, 2000, providers may:

- submit the claim before April 1, 2000, using 1999 CPT codes, or
- hold the claim until April 1, 2000, and then bill using 2000 CPT codes.

Claims submitted **on or after April 1, 2000,** for services furnished in CY 2000, must have the appropriate CPT codes as defined in CPT 2000. The 1999 CPT codes will not be acceptable for claims submitted after March 31, 2000, for tests performed during the first quarter of CY 2000.

Claims submitted for automated chemistry test services provided during the first quarter of the CY 2000, will be processed based on the current guidelines. Duplicate services will be identified when the panel codes submitted during this period are unbundled and the individual test codes are compared to the pending and paid claims. Reimbursement of a service or group of services will be based on the number of automated chemistry tests performed for the same beneficiary on the same day by the same provider from all claims submitted. The organ disease CPT panel codes for 2000 are: **80048, 80053, 80069 and 80076.**

1999 CPT organ or disease panel codes (80049, 80054, and 80058) will be included in the unbundling process for duplicate detection for claims submitted with dates of service January 1, 2000 through March 31, 2000

Clinical Diagnostic Laboratory Organ or Disease Panels (continued)

The following charts display the 1999 and 2000 calendar year automated multichannel organ or disease codes and the component tests.

Calendar Year 1999 Automated Multichannel Chemistry Test and Organ or Disease Panel

		Hepatic Function Panel **80058**	Basic Metabolic **80049**	Comprehensive Metabolic **80054**
Chemistry	**CPT Code**			
ALT (SGPT)	84460	X		
Albumin	82040	X		X
Alkaline phosphatase	84075	X		X
AST (SGOT)	84450	X		X
Bilirubin, total	82247	X		X
Bilirubin, direct	82248	X		
CO_2 (bicarbonate)	82374		X	X
Calcium	82310			X
Chloride	82435		X	X
Creatinine	82565		X	X
Glucose	82947		X	X
Potassium	84132		X	X
Protein, total	84155			X
Sodium	84295		X	X
Urea nitrogen (BUN)	84520		X	X
Cholesterol	82465			
CK, CPK	82550			
GGT	82977			
LDH	83615			
Phosphorus	84100			
Triglycerides	84478			
Uric Acid	84550			

Calendar Year 2000 Automated Multichannel Chemistry Test and Organ or Disease Panel

		Hepatic Function Panel **80076***	Basic Metabolic **80048****	Comprehensive Metabolic **80053*****	Renal Function Panel **80069**
Chemistry	**CPT Code**				
Albumin	82040	X		X	X
Alkaline phosphatase	84075	X		X	
ALT (SGPT)	84460	X		X	
AST (SGOT)	84450	X		X	
Bilirubin, total	82247	X		X	
Bilirubin, direct	82248	X			
Calcium	82310		X	X	X
Chloride	82435		X	X	X
Cholesterol	82465				
CK, CPK	82550				
CO_2 (bicarbonate)	82374		X	X	X
Creatinine	82565		X	X	X
GGT	82977				
Glucose	82947		X	X	X
LDH	83615				
Phosphorus	84100				X
Potassium	84132		X	X	X
Protein, total	84155			X	
Sodium	84295		X	X	X
Triglycerides	84478				
Urea nitrogen (BUN)	84520		X	X	X
Uric Acid	84550				

*CPT code 80058 was deleted from CPT 2000
**CPT code 80049 was deleted from CPT 2000
***CPT code 80054 was deleted from CPT 2000

OUTPATIENT HOSPITAL SERVICES

Billing for Apligraf™ (Graftskin) Services

Description

Apligraf™ (grafskin) is a viable, bilayered, skin construct: The epidermal layer is formed by human keratinocytes and has a well-differentiated stratum corneum. The dermal layer is composed of human fibroblasts in a bovine type 1 collagen lattice. While matrix proteins and cytokines found in human skin are present in Apligraf, Apligraf does not contain langerhans cells, melanocytes, macrophages, lymphocytes, blood vessels, or hair follicles. Apligraf is manufactured under aseptic conditions from human neonatal male foreskin tissue.

Indication

Apligraf is indicated for use with standard therapeutic compression for the treatment of non-infected partial and full-thickness skin ulcers that are due to venous insufficiency of greater than one-month duration **and** have not adequately responded to conventional ulcer therapy.

Outpatient hospitals billing for the application of Apligraf services must be billed on a 13x type bill using revenue code 272.

For services provided **prior to January 1, 2000,** outpatient hospitals billing for Apligraf services are reported using CPT-4 code 15350 (application of allograph, skin). For services provided on or after January 1, 2000, the following HCPCS codes have been implemented:

G0170 Application of tissue cultured skin grafts, including bilaminate skin substitutes or neodermis, including site preparation, initial 25 square centimeters.

G0171 Application of tissue cultured skin grafts, including bilaminate skin substitutes or neodermis, including site preparation, each additional 25 square centimeters.

NOTE: Apligraf is considered a surgical supply and not a prosthetic. The following HCPCS codes must be used to billed for apligraf:

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

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

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

INPATIENT HOSPITAL SERVICES

Medicare Coverage of Abortion Services

The Health Care Financing Administration has issued clarification of Medicare coverage on abortion services provided in a hospital inpatient setting.

Abortions are not covered under the Medicare program except for instances where the pregnancy is a result of an act of rape or incest; or the woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Inpatient hospital services for planned abortions must be billed using the UB-92 HCFA-1450 claim form or its electronic equivalent, using bill type 11x. Medicare will pay only when condition code A7 (induced abortion - danger to life) or condition code A8 (induced abortion - victim of rape/incest) is used in form locator 24-30 of the UB-92 form, along with an appropriate ICD-9-CM principal diagnosis code that will group to a diagnosis related group (DRG) of 380; or with an appropriate ICD-9-CM principal diagnosis code that will group to DRG 381 and one of the following appropriate ICD-9-CM operating room procedure codes:

69.01 69.02 69.51 74.91

ICD-9-CM codes 69.01 and 69.02 must be used to describe exactly the procedure or service performed.

ICD-9-CM 69.09 is used for any non-specific dilatation and curettage (d & c) procedure such as a miscarriage or other purposes. ICD-9-CM 69.09 may not be used on claims that group to DRG 381. ❖

SKILLED NURSING FACILITY SERVICES

Special Adjustment for SNF Prospective Payment Rates

On July 31, 1999, the Health Care Financing Administration published a ***Federal Register*** notice (64 FR 41684) detailing the schedule of skilled nursing facility (SNF) federal prospective payment rates applicable for Medicare SNF payments in fiscal year (FY) 2000. Provisions of the Balanced Budget Refinement Act (BBRA) of 1999 have modified payments under that schedule for a portion of FY 2000.

Effective for SNF services furnished **on or after April 1, 2000, through September 30, 2000,** the per diem adjusted payments under the prospective payment system are increased by 20 percent for 15 specified resource utilization groups (RUGs) falling under the categories for *extensive services, special care, clinically complex, high rehabilitation and medium rehabilitation.* This 20 percent increase is applicable only to the following RUG categories:

SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1,
CB2, CB1, CA2, CA1, RHC, RMC, RMB

This increase is effective April 1, 2000, and applies only to the federal per diem payments for the 15 RUGs identified above. ❖

ESRD

End Stage Renal Disease Blood Pricing

The following new End Stage Renal Disease (ESRD) blood pricing, effective for services rendered on and after January 1, 2000, updates the existing *Medicare Part A ESRD Processing Manual*, Section 23. Providers may use this pricing update to reconcile Medicare claim payments for applicable services rendered ***on and after January 1, 2000***. Also included in this article are the blood HCPCS crosswalk (from CPT codes to locally assigned "X" codes) and 2000 Blood Survey Input tables.

The following procedure codes for blood and blood related services are billable by ESRD providers to Medicare Part A (bill type 72x) in the UB-92 HCFA-1450 claim form or its electronic equivalent.

Blood and Blood Related Services

Legend	
Description	Name/Description of blood and/or blood related service
Procedure Code	HCFA Common Procedure Coding System (HCPCS), or locally assigned code reportable on the UB-92 HCFA-1450 claim form or its electronic equivalent
Revenue Code	Code identifying a specific accommodation, ancillary service or billing calculation (Appropriate revenue code must be used with procedure code for reimbursement)
Allowable Price	Medicare Part A reimbursement allowance for the blood and/or blood related service
NOTE: When a procedure code indicates "diagnosis code required," the diagnosis coding requirement is exclusive of diagnosis code 585 (Chronic Renal Disease).	

Description	Procedure Code	Revenue Code	Allowable Price
Blood Tubing, Arterial Or Venous, Each	A4750	390	$10.82
Blood (Whole), For Transfusion, Per Unit	P9010	382	$104.30
Leukocyte Poor Blood (Each Unit)	P9016	385	$136.00
Plasma, Single Donor, Fresh Frozen (Each Unit)	P9017	383	$59.74
Platelet Concentrate (Each Unit)	P9019	384	$65.25
Platelet-Rich Plasma, (Each Unit)	P9020	384	$53.34
Washed Red Blood Cells (Each Unit)	P9022	380	$167.95
Processing Packed RBCs	P9030	390	$73.00
Blood Typing; Antigen Screening For Compatible Blood Unit Using Reagent Serum, Per Unit Screened	X0079	390	$35.06
Blood Typing; ABO	X0080	390	$21.00
Blood Typing; RBC Antigens, Other Than ABO Or Rh(D), Each	X0081	390	$34.00
Antibody Screen, RBC, Each Serum Technique	X0086	390	$45.00
Antibody Identification, RBC Antibodies, Each Panel For Each Serum Technique	X0087	390	$70.00
Compatibility Test Each unit; immediate spin technique	X0088	390	$56.20
Blood Typing; RhD	X0089	390	$19.10
Frozen Blood, Preparation For Freezing, Each Unit; With Freezing & Thawing	X0090	390	$157.50
HTLV or HIV Antibody, Confirmatory Test (western blot)	X0091	390	$97.25
Hepatitis B Surface Antigen(HBsAg)	X0093	390	$44.30
Hepatitis C Antibody	X0094	390	$68.65
Leukocyte Transfusion	X0096	390	$538.65

The following blood HCPCS crosswalk lists the current CPT codes for blood processing and the corresponding local X codes required for proper reimbursement.

Blood HCPCS Crosswalk

Current CPT Code	Local "X" Code	Current CPT Code	Local "X" Code
86903	X0079	86901	X0089
86900	X0080	86932	X0090
86905	X0081	86689	X0091
86850	X0086	87340	X0093
86870	X0087	86803	X0094
86920	X0088	86950	X0096

Questions regarding this information may be addressed to Medicare Part A Customer Service at (904) 355-8899.

FRAUD AND ABUSE

Fraud and Abuse in the Medicare Program

In Case You Didn't Know...

In recent years, fraudulent or abusive activities in the health care industry have drawn considerable public interest, through the media and other private organizations, as well as state and federal governments, including their agencies and contractors. The Medicare program has been the focus of much of this attention, raising some questions ..... Are fraud, waste, and abuse rampant in the Medicare program? Is there a crackdown or "witch hunt" for even the smallest of offenses? These issues are discussed below.

At a national level, fraud, waste, and abuse in the Medicare program are estimated at $12.6 billion annually, representing approximately 7.1 percent of all payments made. In prior years, that estimate was as high as $23 billion annually, or 14 percent of all payments made. The decrease is due to several factors:

- **The federal government's increased focus on protecting the Medicare trust fund:** Since the early 1990s, Medicare's solvency has been unclear, intensifying concern about the propriety of program payments. Safeguarding the Medicare trust fund, thus, became a top priority, leading to additional efforts in detecting, preventing, and recovering inappropriate payments.
- **Legislation passed in the mid-1990s that specifically addresses fraud, waste, and abuse in both federal and private health care programs:** The provisions of law extend efforts in education and law enforcement, allow for more stringent fines and penalties, and more clearly defines fraud in the health care industry.
- **An increased awareness in the health care and patient communities:** Watchful health care givers and their patients often take steps to avoid becoming victims of fraudulent or abusive activities.

Significant strides have been taken to protect the Medicare trust fund; however, fraud and abuse in Medicare and other federally funded and private health benefit programs, are still a concern. Medicare is large and intricate, and it is not always easy to identify or prevent inappropriate activities; therefore, some degree of fraud and waste may be unavoidable.

Answering the second question — "Is there a 'witch hunt'?"— is both simple and complex. Simply, the answer is "No". There are more effective ways to safeguard the Medicare program.

One popular belief is that individuals or organizations identified as engaging in inappropriate activity are subject to imminent prosecution. To the contrary, stewards of the Medicare program (i.e., the federal government, its agencies and contractors, and law enforcement) must be prudent in making decisions that may adversely affect individuals and organizations.

While health care fraud was essentially overlooked until recent years, efforts are increasing in the investigation and prosecution of health care fraud cases. These actions, however, are reserved for instances of willful and intentional acts of wrongdoing that are substantiated through documented patterns of abuse. There are other effective avenues for addressing these issues. For example:

- **Education:** Health care providers have a responsibility to understand the rules governing the Medicare program from which they seek payment for services and items they furnish. The federal government, its agencies, and its contractors have an equal responsibility in ensuring that information regarding the Medicare program is made available to their customers. Sometimes, inappropriate payments are made from a lack of knowledge or misunderstanding of information. Many issues may be resolved by simple educational efforts.
- **Review of claims:** Medicare claims are routinely reviewed on a pre- and post-payment basis to establish that the services or items reported are medically documented in the patient's records and reported accurately. These reviews may result in the affirmation of payment, the identification of overpaid funds, or the denial of payments.
- **Development of clear coverage and policy guidelines:** To ensure that payments are made only for medically reasonable and necessary services, coverage, payment, and claim filing guidelines are developed so that health care providers and their patients can understand the scope and limitations of their Medicare benefits.
- **Overpayments:** Inappropriate payments are identified through various approaches; often, however, overpaid funds may not have been caused by an intentional act. In these cases, refunds of overpayments may be requested and collected without any additional punitive action.

Combating fraud, waste, and abuse in the Medicare program is a priority. Medicare fraud and abuse are steadily declining. That trend is expected to continue, with constant vigilance and improved "safeguarding" efforts — that is, better administration of the Medicare program, education of the health care community and the public, and better proactive approaches to detecting, preventing, and recovering inappropriate payments. ❖

2000 OUTPATIENT REHABILITATION SERVICES FEE SCHEDULE

Outpatient Fee Schedule for Rehabilitation Services

The Medicare Part A outpatient fee schedules for rehabilitation services are provided below. The reimbursement amounts are effective for services rendered on and after January 1, 2000. The Health Care Financing Administration (HCFA) extends a 90-day grace period where either 1999 or 2000 HCPCS codes will be accepted. Therefore, effective January 1, 2000 through March 31, 2000, providers may use either the 1999 and/or 2000 HCPCS codes. **Effective April 1, 2000, only the 2000 HCPCS codes will be accepted by Medicare.**

Locality Structure

HCFA reduced the number of localities nationally in 1997. This means that the state of Florida is now divided into three geographic localities. *Therefore, localities 01 and 02 are merged and are priced at the same fee schedule rate.*

NOTE: The Direct Data Entry (DDE) system will reflect all four (4) localities; however, localities 01 and 02 are the same fee schedule rate(s).

Questions regarding these fees may be addressed to Medicare Part A Customer Service by calling (904) 355-8899.

PROC	LOC 01/02	LOC 03	LOC 04
G0128	4.38	4.70	5.02
G0169	32.29	34.37	36.22
11040	34.58	36.72	38.51
11041	53.36	56.74	59.69
11042	71.43	76.02	80.12
11043	171.32	183.05	193.34
11044	230.72	246.88	260.98
29065	125.68	135.27	142.60
29075	110.17	118.58	125.01
29085	110.75	119.12	125.65
29105	94.44	101.46	107.11
29125	72.22	77.65	81.90
29126	88.16	94.63	99.70
29130	36.94	39.53	41.81
29131	52.61	56.38	59.44
29200	54.23	58.05	61.26
29220	51.31	54.78	57.66
29240	56.51	60.51	63.95
29260	44.62	47.74	50.37
29280	43.20	46.28	48.89
29345	169.93	182.66	192.63
29365	144.10	154.92	163.41
29405	118.03	127.02	133.95
29445	205.64	220.74	232.52
29505	93.98	101.11	106.59
29515	80.35	86.14	90.65
29520	47.81	50.95	53.41
29530	48.81	52.22	55.06
29540	34.24	36.33	38.10
29550	31.43	33.37	35.03
29580	54.71	58.61	61.76
29590	46.57	49.39	51.87

PROC	LOC 01/02	LOC 03	LOC 04
64550	23.23	24.87	26.08
90901	45.46	48.56	50.87
90911	68.56	72.91	76.42
92506	61.66	65.25	68.06
92507	44.18	46.94	49.04
92508	29.20	31.17	32.61
92510	109.08	115.44	120.38
92525	100.75	106.42	110.91
92526	49.76	52.92	55.28
92552	17.42	19.24	20.72
92553	25.68	28.43	30.72
92555	14.99	16.61	17.96
92556	22.56	25.05	27.17
92557	47.20	52.36	56.71
92561	27.77	30.69	33.09
92562	16.04	17.74	19.14
92563	14.99	16.61	17.96
92564	18.95	21.02	22.76
92565	15.69	17.36	18.75
92567	20.83	23.17	25.20
92568	14.99	16.61	17.96
92569	16.04	17.74	19.14
92571	15.34	16.98	18.35
92572	3.61	4.03	4.41
92573	13.95	15.48	16.78
92575	11.73	12.95	13.95
92576	17.91	19.89	21.58
92577	28.25	31.34	33.95
92579	28.11	31.06	33.48
92582	28.11	31.06	33.48
92583	34.99	38.75	41.91
92584	96.56	106.79	115.25

PROC	LOC 01/02	LOC 03	LOC 04
92587	58.79	64.61	69.43
92587TC	50.54	55.84	60.19
9258726	8.25	8.77	9.24
92588	79.08	86.33	92.32
92588TC	57.41	63.53	68.61
9258826	21.67	22.80	23.70
92589	21.17	23.55	25.60
92596	23.26	25.80	27.96
92597	95.95	101.43	105.66
92598	66.65	70.37	73.28
94664	18.81	20.74	22.30
94665	19.30	21.39	23.16
94667	23.46	25.90	27.89
94668	18.67	20.46	21.83
95831	22.98	24.39	25.46
95832	21.60	22.87	23.86
95833	33.72	35.73	37.33
95834	43.56	46.10	48.07
95851	18.35	19.64	20.61
95852	13.44	14.43	15.20
96105	69.77	77.41	83.89
96111	69.77	77.41	83.89
96115	69.77	77.41	83.89
97001	60.54	63.55	66.25
97002	28.64	29.95	31.12
97003	60.54	63.55	66.25
97004	28.29	29.57	30.72
97012	17.05	18.03	18.83
97014	14.55	15.48	16.22
97016	15.59	16.61	17.41

PROC	LOC 01/02	LOC 03	LOC 04
97018	10.61	11.48	12.16
97020	10.26	11.11	11.77
97022	14.54	15.49	16.25
97024	10.26	11.11	11.77
97026	9.92	10.73	11.37
97028	10.63	11.46	12.11
97032	16.35	17.28	18.04
97033	17.06	18.02	18.80
97034	14.23	15.07	15.76
97035	12.15	12.82	13.40
97036	19.85	21.01	21.91
97039	16.30	17.34	18.15
97110	22.94	24.10	25.15
97112	23.98	25.23	26.33
97113	25.36	26.74	27.93
97116	21.36	22.38	23.22
97124	19.58	20.55	21.36
97139	14.92	15.82	16.55
97140	26.04	27.50	28.74
97150	18.59	19.79	20.82
97504	24.46	25.88	27.19
97520	24.33	25.60	26.73
97530	22.58	23.74	24.78
97535	24.67	25.98	27.12
97537	24.19	25.33	26.26
97542	16.70	17.66	18.43
97703	14.96	15.78	16.46
97750	25.37	26.73	27.91
97770	25.56	26.84	27.86

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 **March 15, 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 53 for information about accessing the BBS. ❖

Correction to Local Medical Review Policies

An emergency change request was received for the 2000 Medicare Fee Schedule Database affecting the payment status of procedure codes 94760 (Noninvasive ear or pulse oximetry for oxygen saturation; single determination) and 94761 (Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations [e.g., during exercise]). As a result of this change, a revision was made to the Coding Guidelines section of the Enhanced External Counterpulsation and the Noninvasive Ear or Pulse Oximetry For Oxygen Saturation local medical review policies (LMRPs). The statement now reads:

"Effective January 1, 2000, procedure codes 94760 and 94761 are considered bundled services and, therefore, are not separately reimbursable when billed with other physician fee schedule services by the same provider on the same day."

The LMRP for pulse oximetry is being republished in its entirety in this issue. Refer to pages 28-29 of the December 1999/January 2000 *Medicare Part A Bulletin* for the LMRP on Enhanced External Counterpulsation. ❖

84436: Thyroid Function Tests - Revision to Policy

The local medical review policy (LMRP) for thyroid function tests was published in the December *Medicare A Special Issue Bulletin* (pages 29-31). Since that time, the following revisions have been added to the existing policy, due to a request for an expansion of coverage:

Indications and Limitations of Coverage and/or Medical Necessity

A thyroid function test may be performed for the monitoring of a patient's response to the administration of lithium. A thyroid function test would normally be performed six months after the initiation of lithium and yearly thereafter for monitoring purposes.

Note: **A thyroid function test performed prior to the initiation of lithium in an asymptomatic patient is considered screening and is noncovered by Medicare.**

ICD-9-CM Codes That Support Medical Necessity

296.00-296.99	Affective psychoses
E939.8	Other psychotropic agents (lithium only)

Coding Guidelines

ICD9-CM code E939.8 is to be used for the monitoring of a patient's response to administration of lithium. ❖

93268: Patient Demand Single or Multiple Event Recorder - Revision to Policy

The local medical review policy (LMRP) for Patient Demand Single or Multiple Event Recorder was published in the June/July 1999 *Medicare A Bulletin* (pages 84-88). Since that time, the following revisions have been added to the existing policy, due to a request for coverage clarification regarding the ICD-9-CM diagnosis 785.1 (palpitations):

Indications and Limitations of Coverage and/or Medical Necessity

Palpitations are extremely common in healthy individuals. Therefore, if the ICD-9-CM code 785.1 (palpitations) is billed as the diagnosis supporting medical necessity, the history and physical or other pertinent medical record documentation must support the presence of associated symptoms such as dizziness, shortness of breath, chest discomfort, or an underlying history of cardiac disease.

Documentation Requirements

If the ICD-9-CM code 785.1 (palpitations) is the diagnosis billed, the history and physical or other pertinent medical record documentation must support the presence of associated symptoms such as dizziness, shortness of breath, chest discomfort, or an underlying history of cardiac disease. ❖

93000: Electrocardiography - Revision to Policy

The local medical review policy (LMRP) for electrocardiography was published in the August/September 1999 *Medicare A Bulletin* (pages 22-23). Since that time, the following revisions have been added to the existing policy, due to a request for an expansion of coverage and coding guidelines clarification:

Indications and Limitations of Coverage and/or Medical Necessity

Evaluation of a patient's response to the administration of an agent known to result in cardiac and EKG abnormalities (for patients with suspected, or at increased risk for developing, cardiovascular disease or dysfunction). Examples of these agents are antineoplastic drugs, lithium, tranquilizers, anticonvulsants, and antidepressant agents.

Note: **An EKG performed as a baseline evaluation prior to the initiation of an agent known to result in cardiac or EKG abnormalities is considered screening and is noncovered by Medicare.**

ICD-9-CM Codes That Support Medical Necessity

E933.1	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antineoplastic drugs
E936.0-E936.3	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, anticonvulsant drugs
E939.0-E939.9	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, psychotropic agents

Coding Guidelines

When using ICD-9-CM code V72.81, the medical record is expected to contain information supporting either of the two preoperative evaluation indications listed under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy (previously published in the August/September 1999 *Medicare A Bulletin*). ❖

PAINREH: Pain Rehabilitation - Revision to Policy

The Pain Rehabilitation policy was previously published in the October/November 1999 Medicare A Bulletin on pages 41-43. Since that time, a revision has been made to the Type of Bill section of the policy. The Type of Bill section was changed to read "Hospital: 13x," instead of "Outpatient: 13x." ❖

78472: Cardiac Blood Pool Imaging

Description

Radionuclide ventriculography is one of the most widely used techniques for evaluating ventricular function. This essentially noninvasive method of assessing ventricular function can be easily performed and provides a reproducible, accurate evaluation of both right ventricular and left ventricular function. Currently, there are two techniques for assessment of ventricular performance using radionuclides: the first-pass technique and gated blood pool imaging. Information that can be derived from these studies includes assessment of left and/or right ventricular ejection fraction, regional wall motion, left ventricular volumes, and diastolic function.

Gated blood pool imaging (multigated acquisition, or MUGA), also known as equilibrium radionuclide angiocardiography, is the most widely used technique to assess ventricular function. In this technique, the patient's erythrocytes are labeled with technetium-99m, and the imaging is performed by synchronizing acquisition to the R wave of the electrocardiogram (ECG). Sampling is performed repetitively over several hundred heartbeats with physiological segregation of nuclear data according to occurrence within the cardiac cycle.

First-pass radionuclide angiocardiography utilizes a high-count-rate gamma camera and involves sampling for only seconds during the initial transient of the technetium-99m bolus through the central circulation. The high-frequency components of this radioactive passage are recorded and analyzed quantitatively. After data acquisition, right and left ventriculograms are constructed from which ejection fractions and ventricular volumes can be calculated.

Type of Bill

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

Revenue Code

341 Nuclear Medicine Diagnostic

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider cardiac blood pool imaging studies medically reasonable and necessary for the following indications:

- Evaluation of a patient with suspected or known Coronary Artery Disease (CAD). A radionuclide ventriculogram assists in stratifying patients into low and high risk, thereby providing prognostic value. However, perfusion imaging is superior to exercise radionuclide ventriculograms. Therefore, current practice is to perform stress myocardial perfusion imaging in patients with suspected CAD.
- Evaluation of a patient after a Myocardial Infarction (MI). Assessment of the impact of the MI on ventricular function, identification of the physiologic importance of coronary stenosis outside the infarct distribution (i.e., extent in which viable myocardium is jeopardized), and risk stratification for future cardiac events is determined. Normally, a resting study is recommended.
- Assessment of right ventricular function, especially in patients with cor pulmonale or an acute inferior MI caused by right ventricular infarction.
- Evaluation and monitoring of a patient with dilated or hypertrophic cardiomyopathy. Restrictive cardiomyopathy is normally diagnosed with other noninvasive methods; therefore, radionuclide studies do not have a role in the diagnosis of restrictive cardiomyopathy.
- Evaluation of a patient with suspected or known valvular heart disease to determine ventricular function and estimate the degree of valvular regurgitation. Serial evaluations may be necessary in patients with asymptomatic aortic regurgitation to determine surgical timing. In addition to obtaining a resting left ventricular ejection fraction (usually by the gated blood pool technique) in the timing of surgery, exercise duration is also a key indicator.
- Evaluation and management of a patient with congestive heart failure. The most important imaging procedure is two-dimensional echocardiography, which can evaluate ventricular chamber size, regional and global wall motion, left ventricular wall thickness, and valvular function. Radionuclide angiography provides assessment of left ventricular ejection fraction and is quantified more easily by a radionuclide rather than an echocardiographic technique.
- Evaluation and management of a patient with a neoplastic disease who will be receiving an anthracycline like neoplastic drug. Doxorubicin (an example of an arthracycline) is associated with the development of irreversible cardiotoxicity when given in doses of 450 mg/m2 or greater. Therefore, a resting left ventricular ejection fraction is recommended before starting therapy and again after receiving cumulative doses of 300 mg/m2 and 450 mg/m2. Other anthracyclines include drugs such as Daunorubicin, Epirubicin, Idarubicin, Mitoxantrone, and Valrubicin.
- Detection and quantification of intracardiac shunts for patients with congenital heart disease. The first pass technique is better than the gated technique for this indication.
- Evaluation of ventricular function during exercise to determine cardiac reserve in patients with congenital heart disease.
- To distinguish systolic from diastolic dysfunction in a patient with exertional dyspnea thought to be cardiac in etiology.
- Evaluation of a patient after cardiac surgery (e.g., coronary artery bypass graft) to determine the effect of the intervention on left ventricular function and the results are being used in the management of the patient (i.e., changes to patient's medication regime or medical intervention will occur).

78472: Cardiac Blood Pool Imaging (continued)

HCPCS Codes

78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing
78473	multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification
78481	Cardiac blood pool imaging, (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification
78483	multiple studies, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification
78494	Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing
78496	Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (List separately in addition to code for primary procedure)

ICD-9-CM Codes That Support Medical Necessity

410.00-410.92	Acute myocardial infarction
411.1	Intermediate coronary syndrome
411.81	Coronary occlusion without myocardial infarction
413.0-413.9	Angina Pectoris
414.00-414.05	Coronary atherosclerosis
414.8	Other specified forms of chronic ischemic heart disease
414.9	Chronic ischemic disease, unspecified
416.9	Chronic pulmonary heart disease, unspecified
424.0	Mitral valve disorders
424.1	Aortic valve disorders
425.1	Hypertrophic obstructive cardiomyopathy
425.4	Other primary cardiomyopathies
428.0-428.9	Heart failure
745.0-745.9	Bulbus cordis anomalies and anomalies of cardiac septal closure
746.00-746.9	Other congenital anomalies of heart
786.05	Shortness of breath
E930.7	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antineoplastic antibiotics
E933.1	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antineoplastic and immunosuppressive drugs
V67.0	Follow-up examination following surgery

HCPCS Section and Benefit Category

Cardiovascular System/Radiology

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

Braunwald, E. (Ed.). (1992). *Heart disease: A textbook of cardiovascular medicine* (4th ed.). Philadelphia: W. B. Saunders.

Gerson, M. C. (Ed.). (1997). *Cardiac nuclear medicine* (3rd ed.). New York: McGraw-Hill.

Iskandrian, A. S., & Verani, M. S. (1996). *Nuclear cardiac imaging: Principles and applications* (2nd ed.). Philadelphia: F. A. Davis Company.

Schlant, R. C. & Alexander, R. W. (Eds.). (1994). *The heart* (8th ed.). New York: McGraw-Hill.

Willerson, J. R. & Cohn, J. N. (Eds.). (1995). *Cardiovascular medicine.* New York: Churchill Livingstone.

Coding Guidelines

Procedure code 78496 (cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique) is considered an add-on code and, therefore, should only be billed in conjunction with procedure code 78472 (cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress, wall motion plus ejection fraction, with or without additional quantitative processing).

In certain indications, it is common for a patient to undergo a myocardial perfusion imaging study (78460-78465, 78478-78480) and a cardiac blood pool imaging study during the same session. However, it is not expected that two different techniques (e.g., 78478 and 78472) will be billed since the information such as wall motion and/or ejection fraction is obtained from the cardiac blood pool imaging technique. In this type of scenario, the billing of the lesser code is considered a duplicate of the cardiac blood pool imaging code.

It is not expected for a provider to bill for the multiple study procedure codes (78473 and 78483) on the same day, since the multiple study is performed using either the gated equilibrium method or the first pass technique.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of cardiac blood pool imaging studies. In addition, the results of the study must be included in the patient's medical record. This information is normally found in the office/progress notes, hospital records, and/or test results.

78472: Cardiac Blood Pool Imaging (continued)

If the provider of the service is other than the ordering/referring physician, that provider must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies. The physician must state the clinical indication/medical necessity for the service in his order for the test.

Other Comments

N/A

CAC Notes

This policy does not reflect 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: 11/15/99
Start Date of Notice Period: February/March 2000 *Bulletin*
Original Effective Date: **March 15, 2000** ❖

82607: Vitamin B-12 (Cyanocobalamin) Assay

Description

Vitamin B-12 (cyanocobalamin), is a water soluble hematopoietic vitamin found in foods of animal origin. It is necessary for the metabolism of protein, fats and carbohydrates. It is essential for normal blood formation and normal neural function. Causes of vitamin B-12 deficiency usually include the absence of intrinsic factor, which is vital for the absorption of vitamin B-12 by the gastrointestinal tract. Since vitamin B-12 is present in all foods of animal origin, dietary B-12 deficiency is rare. It is usually only seen in vegans (strict vegetarians). Deficiency of vitamin B-12 leads to macrocytic anemia. The normal adult daily intake of vitamin B-12 is between 2.0 µg and 5.0 µg.

The serum vitamin B-12 assay is intended to measure the serum vitamin B-12 level. The measurement is used to diagnose anemia due to gastrointestinal malabsorption and inadequate dietary intake of vitamin B-12. The normal adult vitamin B-12 levels are between 150 pg/mL and 350 pg/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

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider a vitamin B-12 assay level medically necessary for the following indications:

- To initially evaluate a patient presenting with signs and symptoms suggestive of vitamin B-12 deficiency. These patients could present with a megaloblastic anemia determined by other lab indices, peripheral neuropathy, and/or altered cerebral functioning such as dementia.
- To evaluate a patient with a previously identified gastrointestinal disease such as malabsorption syndromes, sprue or a patient that has undergone gastric or ileal surgery and a vitamin B-12 deficiency is suspected.

Note: Sequential vitamin B-12 testing is not necessary for the purpose of monitoring the effectiveness of vitamin B-12 therapy. Since vitamin B-12 is administered as treatment for anemia, the tests that are usually ordered for monitoring are the complete blood count (CBC), the hematocrit (HCT) and the hemoglobin (HGB).

HCPCS Codes

82607 Cyanocobalamin (Vitamin B-12)
82608 unsaturated binding capacity

ICD-9-CM Codes That Support Medical Necessity

266.2	Other B-complex deficiencies
281.0	Pernicious anemia
281.1	Other vitamin B-12 deficiency anemia
281.3	Other specified megoblastic anemias not elsewhere classified
285.8	Other specified anemias
285.9	Anemia, unspecified
294.8	Other specified organic brain syndromes (chronic)
298.9	Unspecified psychosis
311	Depressive disorder, not elsewhere classified
357.4	Polyneuropathy in other diseases classified elsewhere
555.9	Regional enteritis, unspecified site
558.9	Other and unspecified noninfectious gastroenteritis and colitis
579.0	Celiac disease
579.1	Tropical sprue
579.2	Blind loop syndrome
579.3	Other and unspecified post surgical nonabsorption
579.9	Unspecified intestinal malabsorption

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

Anderson, K., Anderson, L., & Glanze, W., et.al. (1994*). Mosby's medical dictionary.* (4th ed.). St. Louis, MO.: W.B. Saunders Co.

Braunwald, E., Fauci, A., & Isselbacher, K., et. al. (1998*). Harrison's principles of internal medicine* (14th ed.). New York: McGraw-Hill.

Deglin, J., & Vallerand, A. (1995). *Davis's drug guide for nurses* (4th ed.). Philadelphia: F.A. Davis Company.

Demott, W., Finley, P., Horvat, R., Jacobs, D., Kasten, B., & Tizler, L., et. al. (1994). *Laboratory test handbook* (3rd ed.). Cleveland, OH.: Lexi-Comp. Inc.

Henry, J. (1991). *Clinical diagnosis & management by laboratory methods* (18th ed.). Philadelphia: W.B. Saunders Co.

McPhee, S., Tierney, L., & Papadakis, M. (1998*). Current medical diagnosis & treatment* (37th ed.). Stamford, CT.: Appleton & Lange.

82607: Vitamin B-12 (Cyanocobalamin) Assay (continued)

Coding Guidelines

N/A

Documentation Requirements

Medical record documentation (e.g., history and physical, progress notes) maintained by the ordering physician/ referring physician must indicate the medical necessity for performing a vitamin B-12 assay. Additionally, a copy of the lab results should be maintained in the medical records.

If the provider of the services is other than the ordering/referring physician, that provider must maintain hard copy documentation of the lab results, along with copies of the ordering/referring physician's order for the vitamin B-12 level. The physician must state the clinical indication/medical necessity for the vitamin B-12 level in the order for the test.

Other Comments

N/A

CAC Notes

This policy does not reflect 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: 08/13/99
Start Date of Notice Period: February/March 2000 *Bulletin*
Original Effective Date: **March 15, 2000** ❖

93501: Cardiac Catheterization

Description

Cardiac catheterization is a technique in which a flexible catheter is passed along veins or arteries into the heart and associated vessels for the measurement of physiological data and imaging of the heart and great vessels. This technique is utilized when there is a need to confirm the presence of a clinically suspected condition, define its anatomical and physiological severity, and determine the presence of associated conditions. This need most commonly arises when clinical assessment suggests that the patient may benefit from an interventional procedure (e.g., coronary angioplasty, balloon valvuloplasty or heart surgery).

Type of Bill

Hospital - 12x, 13x

Revenue Code

480 Cardiology, General Classification
481 Cardiology, Cardiac Cath Lab

Indications and Limitations of Coverage and/or Medical Necessity

Left Heart Catheterization:

Florida Medicare will consider a left heart catheterization to be medically reasonable and necessary for asymptomatic patients with any of the following situations/conditions:

- There is evidence of high risk on non-invasive testing.

  Exercise electrocardiogram (ECG) testing documents an abnormal ST segment depression (magnitude equal to or greater than 1.5mm depression, persistent post-exercise changes, depression in multiple leads);
  OR
  Abnormal systolic blood pressure response during progressive exercise, with sustained decrease of greater than 10mmHg or flat blood pressure (less than or equal to 130mmHg); associated with ECG evidence of ischemia;
  OR
  Other potentially important determinants such as exercise induced ST segment elevation in leads other than aVR or exercise induced ventricular tachycardia.

  Myocardial perfusion scintigraphy documents an abnormal blood flow distribution in the anterior wall or more than one vascular region at rest or with exercise, or an abnormal distribution (ischemia) associated with increased lung uptake produced by exercise in the absence of severely depressed left ventricular function at rest.

  Radionuclide ventriculography documents a fall in ventricular ejection fraction of greater than or equal to 10% during exercise, or left ventricular ejection fraction of less than 50% at exercise or rest, when suspected to be due to coronary artery disease.

- After successful resuscitation from cardiac arrest that occurred without obvious precipitating cause, when a reasonable suspicion of coronary artery disease exists.
- The presence of two or more major risk factors and a positive exercise test in patients without known coronary heart disease.
- The presence of prior myocardial infarction with normal left ventricular function at rest, and evidence of ischemia by non-invasive testing.
- After coronary bypass surgery or percutaneous transluminal angioplasty when there is evidence of ischemia by non-invasive testing.
- Before high risk noncardiac surgery in patients who have evidence of ischemia by non-invasive testing.
- Periodic evaluation of patients after cardiac transplantation.

Florida Medicare will consider a left heart catheterization to be medically reasonable and necessary for asymptomatic patients with any of the following situations/conditions:

- Angina pectoris that has proven inadequately responsive to medical treatment, percutaneous transluminal angioplasty, thrombolytic therapy or coronary bypass surgery. "Inadequately responsive" means that the patient and physician agree that angina significantly interferes with a patient's occupation or ability to perform his or her usual activities.
- Unstable angina pectoris defined as:

  Increased severity and frequency of chronic angina pectoris within the past two months, despite medical management, including onset of angina at rest.

  New onset (within two months) of angina pectoris which is severe or increases despite medical treatment.

  Acute coronary insufficiency, with pain at rest usually of greater than or equal to 15 minutes duration, that is associated with ST-T wave changes, and has occurred within the preceding two weeks.

- Prinzmetal's or variant angina pectoris (pain experienced at rest).
- Any angina pectoris in association with any of the following:

  Evidence of high risk as manifested by exercise ECG testing, in addition to failure to complete Stage II of Bruce protocol or equivalent workload (less than or equal to 6.5 METS with other protocols) due to ischemic cardiac symptoms;
  OR
  Exercise heart rate at onset of limiting ischemia symptoms of less than 120/minute (without beta blockers);
  OR
  Evidence of high risk as manifested by radionuclide exercise testing (myocardial perfusion scintigraphy, radionuclide ventriculography, or focal metabolic abnormality or mismatch).

93501: Cardiac Catheterization (continued)

The coexistence of a history of myocardial infarction, a history of hypertension and ST segment depression on the baseline ECG.

Intolerance to medical therapy because of uncontrollable side effects.

Episodic pulmonary edema or symptoms of ventricular failure without obvious cause.

- Any angina pectoris associated with a series of progressively more abnormal exercise ECG or other non-invasive stress test.
- Any angina pectoris in a patient that cannot be risk stratified by other means as a result of an inability to exercise because of an amputation, arthritis, limb deformity, or severe peripheral vascular disease.

Florida Medicare will consider a left heart catheterization to be medically reasonable and necessary for atypical chest pain* of uncertain etiology with any of the following situations/conditions:

* *(For the purpose of this policy, atypical chest pain is defined as single or recurrent episodes of chest pain suggestive, but not typical, of the pain of myocardial ischemia. This discomfort may have some features of ischemic pain together with features of noncardiac pain. Chest pain that has no features of cardiac pain, as well as typical chest pain of myocardial ischemia or angina as determined by a careful medical history, is excluded from definition.)*

- Atypical chest pain when ECG or radionuclide stress test indicates that high risk coronary disease may be present.
- When the presence of atypical chest pain due to coronary artery spasm is suspected.
- When there are associated symptoms or signs of abnormal left ventricular function or failure.
- Atypical chest pain when non-invasive studies are questionable or cannot be adequately performed.
- When non-invasive tests are negative but symptoms are severe and management requires that significant coronary artery disease be excluded.

Florida Medicare will consider a left heart catheterization to be medically reasonable and necessary after a myocardial infarction (greater than 10 days and up to 8 weeks) with any of the following situations/conditions:

- Angina pectoris occurring at rest or with minimal activity.
- In selected patients, heart failure during the evolving phase, or left ventricular ejection fraction 45%, primarily when associated with some manifestation of recurrent myocardial ischemia or with significant ventricular arrhythmias.
- Evidence of myocardial ischemia on laboratory testing: exercise induced ischemia (with or without exercise induced angina pectoris), manifested by greater than or equal to 1 mm of ischemic ST segment depression or exercise induced reversible thallium perfusion defect or defects, or exercise induced reduction in the ejection fraction or wall motion abnormalities on radionuclide ventriculographic studies.
- Non-Q-wave myocardial infarction.
- Mild angina pectoris.
- A past history of documented myocardial infarction or unstable angina pectoris, or both, present greater than six months before the current infarction.
- Thrombolytic therapy during the evolving phase, particularly with evidence of reperfusion.

Florida Medicare will consider a left heart catheterization to be medically reasonable and necessary for valvular heart disease with any of the following situations/conditions:

- When valve surgery is being considered in a patient with chest discomfort or ECG changes, or both, suggesting coronary artery disease.
- When valve surgery is being considered in female patients who are postmenopausal.
- When aortic or mitral valve surgery is being considered.
- When one or more major risk factors for coronary artery disease are present: heavy smoking history, diabetes mellitus, hypertension, hyperlipidemia, strong family history of premature coronary artery disease.
- When reoperation for aortic or mitral valve disease is being considered in patients who have not had coronary angiography for one year or more.
- In the presence of infective endocarditis when there is evidence of coronary embolism.

Florida Medicare will consider a left heart catheterization to be medically reasonable and necessary for any of the following conditions:

- In disease affecting the aorta when knowledge of the presence or extent of coronary artery involvement is necessary for management (for example, the presence of aortic aneurysm or ascending aortic dissection), arteritis or homozygous type II hypercholesterolemia in which coronary artery involvement is suspected.
- Presence of left ventricular failure without obvious cause and demonstrates adequate left ventricular systolic function.
- When patients with hypertrophic cardiomyopathy have angina pectoris uncontrolled by medical therapy, or are to undergo surgery for outflow obstruction.

93501: Cardiac Catheterization (continued)

- Presence of dilated cardiomyopathy.
- Recent blunt trauma to the chest and evidence of acute myocardial infarction in patients who have no evidence of preexisting coronary artery disease.
- When patients are to undergo other cardiac surgical procedures, such as pericardiectomy or removal of chronic pulmonary emboli.

HCPCS Codes

93510 Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous
93511 by cutdown
93514 Left heart catheterization by left ventricular puncture
93524 Combined transseptal and retrograde left heart catheterization

ICD-9-CM Codes That Support Medical Necessity

N/A

Right Heart Catheterization:

Right heart catheterization is not routinely part of coronary angiography, but is an associated procedure in a significant number of patients. Florida Medicare will consider a right heart catheterization to be medically reasonable and necessary under the following circumstances:

- Patients with known history of congestive heart failure.
- Patients with cardiomyopathy documented by non-invasive workup.
- Patients with known or suspected valvular heart disease.
- Patients with known or suspected intracardiac shunt (e.g., atrial-septal defect [ASD], ventricular septal defect [VSD]).
- Patients with previous myocardial infarction.
- Patients with unexplained symptoms (e.g., shortness of breath), suspected to have cardiac origin.
- Patients in whom pulmonary artery disease is known or suspected (e.g., pulmonary hypertension, status post pulmonary emboli).

HCPCS Codes

93501 Right heart catheterization

ICD-9-CM Codes That Support Medical Necessity

N/A

Combined Heart Catheterization:

In conjunction with left heart catheterization, right heart catheterization can be useful in providing cardiac output and hemodynamics that may be important therapeutic directives **(see Covered ICD-9-CM Codes)**.

HCPCS Codes

93526 Combined right heart catheterization and retrograde left heart catheterization
93527 Combined right heart catheterization and transseptal left heart catheterization through intact septum (with or without retrograde left heart catheterization)
93528 Combined right heart catheterization with left ventricular puncture (with or without retrograde left heart catheterization)
93529 Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)

ICD-9-CM Codes That Support Medical Necessity

Appropriate ICD-9-CM codes for combined heart catheterization **(CPT codes 93526, 93527, 93528, 93529)** include the following:

394.0-394.9 Diseases of mitral valve
395.0-395.9 Diseases of aortic valve
396.0-396.9 Diseases of mitral and aortic valve
397.0-397.9 Diseases of other endocardial structures
398.90-398.91 Other & unspecified rheumatic heart disease
402.01 Malignant hypertensive heart disease with congestive heart failure
402.11 Benign hypertensive heart disease with congestive heart failure
402.91 Unspecified hypertensive heart disease with congestive heart failure
410.00-410.92 Acute myocardial infarction
412 Old myocardial infarction
415.11 Iatrogenic pulmonary embolism and infarction
415.19 Other pulmonary embolism and infarction
416.0 Primary pulmonary hypertension
416.8 Other chronic pulmonary heart diseases
420.0 Acute pericarditis in diseases classified elsewhere
420.90-420.99 Other and unspecified acute pericarditis
422.0 Acute myocarditis in diseases classified elsewhere
422.90-422.99 Other and unspecified acute myocarditis
423.2 Constrictive pericarditis
424.0-424.3 Other diseases of endocardium
425.0-425.9 Cardiomyopathy
428.0-428.9 Heart failure
429.71 Acquired cardiac septal defect
745.4 Ventricular septal defect
786.05 Shortness of breath
786.06 Tachypnea
V42.1 Organ or tissue replaced by transplant, hear

HCPCS Section and Benefit Category

Medicine/Cardiovascular

93501: Cardiac Catheterization (continued)

HCFA National Coverage Policy

Hospital Manual, Section 443
Intermediary Manual 3, Section 3631

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy for procedure codes 93526, 93527, 93528, or 93529.

Sources of Information

N/A

Coding Guidelines

Effective 1/1/98, to report coronary angiography without left heart catheterization, use code 93508 (Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization). **93508 is to be used only when left heart catheterization (93510, 93511, 93524, 93526) is not performed. 93508 is to be used only once per procedure.**

Effective January 1, 1998 these four new codes can be used to report cardiac catheterization for congenital cardiac anomalies:

- 93530 Right heart catheterization, for congenital cardiac anomalies
- 93531 Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies
- 93532 Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies
- 93533 Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity for performing the cardiac catheterization. Also, the hard copy test results and interpretation of the catheterization must be maintained in the patient's medical record.

If the provider of the cardiac catheterization is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the study.

Other Comments

N/A

CAC Notes

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

Start Date of Comment Period:	N/A
Start Date of Notice Period:	February/March 2000 *Bulletin*
Original Effective Date:	07/22/99
Revision Date/Number	**March 15, 2000** #1

Comments have been received to add additional diagnoses.

Revision History:

Start Date of Comment Period:	02/08/99
Start Date of Notice Period:	June/July 1999 *Bulletin*
Original Effective Date:	07/22/99 ❖

93925: Duplex Scan of Lower Extremity Arteries

Description

Duplex scanning is a technique that combines the information provided by two-dimensional imaging with pulsed-wave Doppler techniques which allows sampling of a particular imaged blood vessel with analysis of the blood flow velocity.

The purpose of this policy is to define the circumstances for which Florida Medicare will consider duplex scans of the lower extremity arteries to be medically necessary and therefore covered.

Type of Bill

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

Revenue Code

921 Other Diagnostic Services, Peripheral Vascular Lab

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider duplex scanning of lower extremity arteries to be medically necessary under any of the following circumstances (see Covered ICD-9-CM Codes):

- The patient is found on physical examination to have absence or marked diminution of pulses (suspected to be secondary to obstruction of lower extremity arteries) of one or both lower extremities.
- The patient has developed sudden pallor, numbness, and coolness of an extremity and vascular obstruction (embolism or thrombosis) is suspected.
- The patient has intermittent claudication.
- The patient has previously undergone a surgical revascularization procedure of one or both lower extremities, and follow-up non-invasive studies are necessary to evaluate the patient's condition.
- The patient has an aneurysm or arteriovenous malformation of a lower extremity artery.
- The patient has sustained lower extremity trauma with possible vascular injury, or the patient has sustained iatrogenic vascular injury.
- The patient has arteriosclerosis with claudication, rest pain, nonhealing ulcer, or gangrene.

HCPCS Codes

93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study
93926	unilateral or limited study

ICD-9-CM Codes That Support Medical Necessity

440.21	Atherosclerosis of the extremities with intermittent claudication
440.22	Atherosclerosis of the extremities with rest pain
440.23	Atherosclerosis of the extremities with ulceration
440.24	Atherosclerosis of the extremities with gangrene
442.3	Aneurysm of artery of lower extremity
443.1	Thromboangiitis obliterans (Buerger's disease)
443.9	Peripheral vascular disease, unspecified
444.0	Arterial embolism and thrombosis of abdominal aorta
444.22	Arterial embolism and thrombosis of arteries of lower extremity
444.81	Arterial embolism and thrombosis of iliac artery
447.0	Arteriovenous fistula, acquired
447.1	Stricture of artery
782.0	Disturbance of skin sensation
782.61	Pallor
820.00-820.09	Transcervical fractures, closed
820.10-820.19	Transcervical fracture, open
820.20-820.22	Pertrochanteric fracture, closed
820.30-820.32	Pertrochanteric fracture, open
820.8	Fracture of unspecified part of neck of femur, closed
820.9	Fracture of unspecified part of neck of femur, open
821.00-821.01	Fracture of shaft or unspecified part of femur, closed
821.10-821.11	Fracture of shaft or unspecified part of femur, open
821.20-821.29	Fracture of lower end of femur, closed
821.30-821.39	Fracture of lower end of femur, open
822.0-822.1	Fracture of patella
823.00-823.02	Fracture of upper end of tibia and fibula, closed
823.10-823.12	Fracture of upper end of tibia and fibula, open
823.20-823.22	Fracture of shaft of tibia and fibula, closed
823.30-823.32	Fracture of shaft of tibia and fibula, open
823.80-823.82	Fracture of unspecified part of tibia and fibula, closed
823.90-823.92	Fracture of unspecified part of tibia and fibula, open
824.0-824.9	Fracture of ankle
825.0-825.1	Fracture of calcaneus
825.20-825.29	Fracture of other tarsal and metatarsal bones, closed
825.30-825.39	Fracture of other tarsal and metatarsal bones, open
827.0-827.1	Other, multiple, and ill-defined fractures of lower limb
828.0-828.1	Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum
835.00-835.03	Closed dislocation of hip
835.10-835.13	Open dislocation of hip
836.0-836.4	Dislocation of knee
836.50-836.59	Other dislocation of knee, closed
836.60-836.69	Other dislocation of knee, open
837.0-837.1	Dislocation of ankle
838.00-838.09	Closed dislocation of foot

93925: Duplex Scan of Lower Extremity Arteries (continued)

838.10-838.19	Open dislocation of foot
904.0	Injury to common femoral artery
904.1	Injury to superficial femoral artery
904.40	Injury to popliteal vessel(s), unspecified
904.41	Injury to popliteal artery
904.50	Injury to tibial vessel(s), unspecified
904.51	Injury to anterior tibial artery
904.53	Injury to posterior tibial artery
904.6	Injury to deep plantar blood vessels
904.7	Injury to other specified blood vessels of lower extremity
904.8	Injury to unspecified blood vessel of lower extremity
904.9	Injury to blood vessels of unspecified site
924.00-924.01	Contusion of hip and thigh
924.10-924.11	Contusion of knee and lower leg
924.20-924.21	Contusion of ankle and foot, excluding toe(s)
924.4	Contusion of multiple sites of lower limb
924.5	Contusion of unspecified part of lower limb
924.8	Contusion of multiple sites of lower limb, not elsewhere classified
924.9	Contusion of unspecified site
928.00-928.01	Crushing injury of hip and thigh
928.10-928.11	Crushing injury of knee and lower leg
928.20-928.21	Crushing injury of ankle and foot, excluding toe(s) alone
928.8	Crushing injury of multiple sites of lower limb
998.11-998.13	Hemorrhage or hematoma or seroma complicating a procedure
998.2	Accidental puncture of laceration during a procedure
V67.0	Follow-up examination following surgery

HCPCS Section and Benefit Category

Medicine/Non-Invasive Vascular Diagnostic Studies

HCFA National Coverage Policy

Coverage Issues Manual, Section 50-6, 50-7
Medicare Intermediary Manual 4630

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.

Screening tests performed on asymptomatic patients without medical problems cannot be covered by Medicare.

Noncovered ICD-9-CM Code(s)

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

Sources of Information

N/A

Coding Guidelines

N/A

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of duplex scan of lower extremity arteries covered by the Medicare program. Also, the results of duplex scan of lower extremity arterial studies covered by the Medicare program must be included in the patient's medical record. This information is normally found in the history and physical, office/progress notes and hospital records.

If the provider of duplex scan of lower extremity arterial 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. When ordering duplex scan of lower extremity arterial studies from independent diagnostic testing facilities or other providers, the ordering/referring physician must state the reason for the duplex scan of lower extremity arteries in his/her order for the tests.

Other Comments

N/A

CAC Notes

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

Start Date of Comment Period:	07/06/99
Start Date of Notice Period:	February/March 2000 *Bulletin*
Original Effective Date:	**March 15, 2000** ❖

93930: Duplex Scan of Upper Extremity Arteries or Arterial By-pass Grafts

Description

Duplex scanning is a technique that combines the information provided by two-dimensional imaging with pulsed wave Doppler techniques which allows sampling of a particular imaged blood vessel with analysis of the blood flow velocity.

The purpose of this policy is to define the circumstances for which Florida Medicare will consider duplex scans of the upper extremity arteries to be medically necessary and therefore covered.

Type of Bill

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

Revenue Code

921 Other Diagnostic Services, Peripheral Vascular lab

Indications and Limitations of Coverage and/or Medical Necessity

Duplex scanning of upper extremity arteries will be considered medically necessary under any of the following conditions (see Covered ICD-9-CM Codes):

- The patient has, otherwise unexplained, diminished or absent pulses of one or both upper extremities.
- The patient has sustained an embolus or has thrombosis of an upper extremity artery.
- The patient has sustained upper extremity trauma and arterial compromise is suspected.
- The patient has an upper extremity or subclavian artery aneurysm.
- The patient has thoracic outlet syndrome.
- The patient has subclavian steal syndrome.

HCPCS Codes

93930	Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study
93931	unilateral or limited study

ICD-9-CM Codes That Support Medical Necessity

353.0	Brachial plexus lesions
435.2	Subclavian steal syndrome
442.0	Aneurysm of artery of upper extremity
442.82	Aneurysm of subclavian artery
443.0	Raynaud's syndrome
444.21	Arterial embolism and thrombosis of arteries of upper extremity
447.0	Arteriovenous fistula, acquired
747.60	Anomaly of the peripheral vascular system, unspecified site
747.63	Anomaly of upper limb vessel
747.69	Anomalies of other specified sites of peripheral vascular system
901.1	Injury to innominate and subclavian arteries
903.00-903.9	Injury to blood vessels of upper extremity
927.00-927.21	Crushing injury of upper limb
927.8	Crushing injury of multiple sites of upper limb
998.2	Accidental puncture or laceration during a procedure

HCPCS Section and Benefit Category

Medicine/Non-Invasive Vascular Diagnostic Studies

HCFA National Coverage Policy

Coverage Issues Manual, Section 50-7
Medicare Intermediary Manual 4630

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.

Florida Medicare does not provide coverage for duplex scanning of the upper extremity arteries performed as a screening test.

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

For duplex scan of hemodialysis access, bill with CPT Code 93990.

Documentation Requirements

Medical record documentation (e.g., history physical office/progress notes) maintained by the ordering/referring physician must clearly indicate the medical necessity of duplex scan of the upper extremity arteries covered by the Medicare program. Also, the results of duplex scan of the upper extremity arterial studies covered by the Medicare program must be included in the patient's medical record. This information is normally found in the history and physical, office/progress notes and hospital records.

If the provider of the upper extremity arterial 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. When ordering duplex scan of upper extremity arterial studies from independent diagnostic testing facilities or other provider, the ordering/referring physician must state the reason for the non-invasive arterial studies in his/her order for the tests.

Other Comments

N/A

CAC Notes

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

Start Date of Comment Period:	07/06/99
Start Date of Notice Period:	February/March 2000 *Bulletin*
Original Effective Date:	**March 15, 2000** ❖

93965: Non-invasive Evaluation of Extremity Veins

Description

Deep venous thrombosis cannot be accurately diagnosed by only clinical assessment. Therefore, several non-invasive tests, including continuous-wave doppler ultrasonography and various types of venous plethysmography have been used.

The purpose of this policy is to define the conditions for which Florida Medicare will consider non-invasive studies of extremity veins to be medically necessary, and therefore covered.

Type of Bill

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

Revenue Code

921 Other Diagnostic Services, Peripheral Vascular Lab

Indications and Limitations of Coverage and/or Medical Necessity

Non-invasive evaluation of extremity veins will be considered medically necessary under any of the following circumstances (see covered ICD-9-CM codes):

- The patient has deep venous thrombophlebitis or has clinical findings (otherwise unexplained limb pain, swelling) which suggest the possibility of acute deep venous thrombophlebitis.
- The patient presents with signs and symptoms of pulmonary embolism. The more common symptoms include acute onset of dyspnea, chest pain, apprehension, hemoptysis or syncope.
- The patient has acute pulmonary embolism.
- The patient has symptomatic varicose veins and non-invasive studies are needed to guide management of the patient.
- The patient has chronic venous insufficiency, post phlebitic syndrome, or lymphedema.
- The patient has sustained trauma, and injury of the venous system is suspected, making evaluation of the venous system of extremities necessary.

HCPCS Codes

93965	Non-invasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study
93971	unilateral or limited study

ICD-9-CM Codes That Support Medical Necessity

415.11	Iatrogenic pulmonary embolism and infarction
415.19	Pulmonary embolism and infarction, other
451.0	Phlebitis and thrombophlebitis of superficial vessels of lower extremities
451.11	Phlebitis and thrombophlebitis of femoral vein (deep) (superficial)
451.19	Phlebitis and thrombophlebitis of deep vessels of lower extremities, other
451.81	Phlebitis and thrombophlebitis of iliac vein
451.83	Phlebitis and thrombophlebitis of deep veins of upper extremities
451.89	Phlebitis and thrombophlebitis of other sites
453.8	Other venous embolism and thrombosis of other specified veins
454.0	Varicose veins of lower extremities with ulcer
454.1	Varicose veins of lower extremities with inflammation
454.2	Varicose veins of lower extremities with ulcer and inflammation
454.9	Varicose veins of lower extremities without mention of ulcer or inflammation
457.1	Other lymphedema
459.1	Postphlebitic syndrome
459.81	Venous (peripheral) insufficiency, unspecified
729.5	Pain in limb
729.81	Swelling of limb
757.0	Hereditary edema of legs
786.00-786.59	Symptoms involving respiratory system and other chest symptoms
901.2	Injury to superior vena cava
901.3	Injury to innominate and subclavian veins
902.10	Injury to inferior vena cava, unspecified
902.50	Injury to iliac vessel(s), unspecified
902.87	Injury to multiple blood vessels of abdomen and pelvis
903.00	Injury to axillary vessel(s), unspecified
903.02	Injury to axillary vein
903.1	Injury to brachial blood vessels
903.2	Injury to radial blood vessels
903.3	Injury to ulnar blood vessels
903.5	Injury to digital blood vessels
903.8	Injury to other specified blood vessels of upper extremity
903.9	Injury to unspecified blood vessel of upper extremity
904.2	Injury to femoral veins
904.3	Injury to saphenous veins
904.40	Injury to popliteal vessel(s), unspecified
904.42	Injury to popliteal vein
904.50	Injury to tibial vessel(s), unspecified
904.52	Injury to anterior tibial vein
904.54	Injury to posterior tibial vein
904.6	Injury to deep plantar blood vessels
904.7	Injury to other specified blood vessels of lower extremity
904.8	Injury to unspecified blood vessel of lower extremity
904.9	Injury to blood vessel of lower extremity, unspecified site

93965: Non-invasive Evaluation of Extremity Veins (continued)

HCPCS Section and Benefit Category

Medicine/Non-Invasive Vascular Diagnostic Studies

HCFA National Coverage Policy

Coverage Issues Manual 50-6

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

Goldhaber, S. (1998). Pulmonary thromboembolism. In A.S. Fauci, E. Braunwald, K. Isselbacher, J. Wilson, J. Martin, D. Kasper, S. Hauser, and D. Longo (Eds.), *Harrison's Principles of Internal Medicine* (pp. 1469-1472). New York: McGraw-Hill.

Stauffer, J. (1998). Disorders of the pulmonary circulation. In L.M. Tierney, Jr., S.J. McPhee and M.A. Papadakis (Eds.), *Current Medical Diagnosis and Treatment* (37th ed., pp 304-311). Stamford, CT: Appleton and Lange.

Coding Guidelines

N/A

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of non-invasive venous studies covered by the Medicare program. Also, the results of non-invasive venous studies covered by the Medicare program must be included in the patient's medical record. This information is normally found in the history and physical, office/ progress notes and hospital records.

If the provider of non-invasive venous 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. When ordering non-invasive venous studies from independent diagnostic testing facilities or other provider, the ordering/referring physician must state the reason for the non-invasive venous studies in his order for the tests.

Other Comments

N/A

CAC Notes

This policy does not reflect 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 and Florida Vascular Society.

Start Date of Comment Period:	07/06/99
Start Date of Notice Period:	February/March 2000 *Bulletin*
Original Effective Date:	**March 15, 2000** ❖

94760: Noninvasive Ear or Pulse Oximetry for Oxygen Saturation

Revision Overview—The policy identifier number has been changed back from 94762 to 94760. Policy has been reversed to include coverage for procedure codes 94760 and 94761.

Description

Pulse oximetry provides a simple, accurate, and noninvasive technique for the continuous or intermittent monitoring of arterial oxygen saturation. A small lightweight device attaches to the finger or toe and directs through the nailbed two wavelengths of light; a photodetector measures absorption. Arterial pulsation is used to gate the signal to the arterial component of blood contained within the nailbed.

Ear oximetry is a noninvasive method for evaluating arterial oxygenation. Ear oximeters are commonly used in sleep studies.

Type of Bill

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

Revenue Code

460 Pulmonary Function, General Classification

Indications and Limitations of Coverage and/or Medical Necessity

Single and Multiple Determinations:

Florida Medicare will consider ear or pulse oximetry for oxygen saturation (CPT Codes 94760, 94761) to be medically necessary when the patient has a condition resulting in hypoxemia and there is a need to assess the status of a chronic respiratory condition, supplemental oxygen requirements and/or a therapeutic regimen (see Covered ICD-9-CM Codes).

HCPCS Codes

94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination
94761	Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (e.g., during exercise)

ICD-9-CM Codes That Support Medical Necessity

162.2-162.9	Malignant neoplasm of lung
428.0	Congestive heart failure
428.9	Heart failure, unspecified
491.20-491.21	Obstructive chronic bronchitis
492.0-492.8	Emphysema
493.00-493.01	Extrinsic asthma
493.10-493.11	Intrinsic asthma
493.20-493.21	Chronic obstructive asthma
493.90-493.91	Asthma, unspecified
494	Bronchiectasis
496	Chronic airway obstruction, not elsewhere classified
515	Postinflammatory pulmonary fibrosis
518.5	Pulmonary insufficiency following trauma and surgery
518.81-518.89	Other diseases of lung
786.03-786.09	Dyspnea and respiratory abnormalities

Continuous Overnight Monitoring:

Florida Medicare will consider ear or pulse oximetry for oxygen saturation by continuous overnight monitoring **(CPT code 94762)** to be medically necessary in the following circumstances (see Covered ICD-9-CM Codes):

- The patient must have a condition for which intermittent arterial blood gas sampling is likely to miss important variations **and**
- The patient must have a condition resulting in hypoxemia and there is a need to assess supplemental oxygen requirements and/or a therapeutic regimen.

HCPCS Codes

94762	Noninvasive ear or pulse oximetry for oxygen saturation by continuous overnight monitoring (separate procedure)

ICD-9-CM Codes That Support Medical Necessity

Appropriate ICD-9-CM codes for ear or pulse oximetry for oxygen saturation by continuous overnight monitoring **(CPT code 94762)** include the following:

162.2-162.9	Malignant neoplasm of lung
428.0	Congestive heart failure
428.9	Heart failure, unspecified
491.20-491.21	Obstructive chronic bronchitis
492.0-492.8	Emphysema
493.00-493.01	Extrinsic asthma
493.10-493.11	Intrinsic asthma
493.20-493.21	Chronic obstructive asthma
493.90-493.91	Asthma, unspecified
494	Bronchiectasis
496	Chronic airway obstruction, not elsewhere classified
515	Postinflammatory pulmonary fibrosis
518.5	Pulmonary insufficiency following trauma and surgery
518.81-518.89	Other diseases of lung
780.51	Insomnia with sleep apnea
780.53	Hypersomnia with sleep apnea
780.57	Other and unspecified sleep apnea
786.03-786.09	Dyspnea and respiratory abnormalities

HCPCS Section and Benefit Category

Pulmonary/Medicine

HCFA National Coverage Policy

CIM 60-4C

Reasons for Denial

The use of ear or pulse oximetry for indications other than those in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9-CM Code(s)

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

94760: Noninvasive Ear or Pulse Oximetry for Oxygen Saturation (continued)

Sources of Information

N/A

Coding Guidelines

If more than a single determination is performed in a day, 94761 must be billed. A single and multiple determination should not be billed on the same day.

CPT code 94762 will not be reimbursed in Type of Bill 71x and 75x, as it represents continuous **overnight** monitoring.

Note: Effective January 1, 2000, procedure codes 94760 and 94761 are considered bundled services and, therefore, are not separately reimbursable when billed with other physician fee schedule services by the same provider on the same day**.**

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician (i.e., office/progress notes) must indicate the medical necessity for performing ear or pulse oximetry studies. Additionally, a copy of the study results should be maintained in the medical records. If the provider of oximetry studies is other than the ordering/referring physician, that provider must maintain hard copy documentation of test results and interpretation along with copies of the ordering/referring physician's order for the study. The ordering/referring physician must state the clinical indication/medical necessity for the oximetry study in his order for the test.

Other Comments

N/A

CAC Notes

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

Start Date of Comment Period:	N/A
Start Date of Notice Period:	February/March 2000 *Bulletin*
Original Effective Date:	01/21/99
Revision Date/Number:	January 1, 2000 #3

Revision 2 was not implemented due to HCFA rescinded bundling decision for CPT codes 94760 and 94761. Change request 1104 indicated codes 94760 and 94761 were changed to allow reimbursement only when these services are not billed with other phisician fee scheduled services on the same day by the same provider.

Revision History:

Start Date of Comment Period:	N/A
Start Date of Notice Period:	December 1999 Special Issue Bulletin
Original Effective Date:	January 1, 1999
Revision Date/Number:	01/01/2000 #2

Delete Type of Bill 71x and 75x

Start Date of Comment Period:	N/A
Start Date of Notice Period:	December 1999 Special Issue Bulletin
Original Effective Date:	January 1, 1999
Revision Date/Number:	01/01/2000 #1 HCPCS 2000
Start Date of Comment Period:	08/05/98
Start Date of Notice Period:	12/07/98
Original Effective Date:	01/21/99 G-354 ❖

95930: Visual Evoked Potential (VEP) Testing

Description

Visual evoked potential studies (VEP), also known as visual evoked response tests (VER), evaluate the integrity of visual nerve pathways (retina and optic nerve) by measuring the brain's response to repetitive visual stimuli. The rapidly reversing checkerboard stimuli is the most common form of this test. The patient is seated comfortably three feet from the pattern-shift stimulator. Electrodes are attached to the scalp at the occiput and parietal locations. A reference electrode is placed on the ear. One eye is occluded and the patient is instructed to fix his/her gaze on a dot in the center of the screen. A checkerboard pattern is projected and then rapidly reversed 100 times at a rate of once or twice per second. The procedure is then repeated for the other eye.

In children, the checkerboard pattern testing can be difficult. A flash technique may be used instead. In this situation, light-emitting diodes or a strobe are placed into goggles. The goggles are strapped to the patient's face.

Visual neural impulses derived from either method are recorded as they travel from the eye to the occipital cortex. A computer amplifies and averages the brain's response to each stimulus and the results are plotted in a waveform. The most significant wave on the waveform is the P100.

The two most clinically significant measurements are the time between the stimulus and peaking of the P100 wave (known as the absolute P100 latency), and the interocular latency (the difference in the P100 latencies between the right and left eye). Normally the latency difference is less than 8-10 msec. Normal P100 latencies occur approximately 100 msec after the application of the visual stimulus (normal range is 90-110 msec). Prolonged P100 latency is an abnormal finding, indicating a lesion along the visual pathway.

VER is performed in a specially-equipped electrodiagnostic procedure room. Test results vary greatly between laboratories.

Type of Bill

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

Revenue Code

920 Other Diagnostic Services, General Classification

Indications and Limitations of Coverage and/ or Medical Necessity

Information from evoked potential studies is insufficient to confirm a specific diagnosis. Test data must be interpreted in light of clinical information. Therefore, Florida Medicare considers visual evoked potential studies medically reasonable and necessary in any of the following circumstances:

- To confirm the diagnosis of multiple sclerosis that is suspected on clinical grounds. Several common early signs/symptoms are diplopia, optic neuritis, nystagmus and, occasionally, papillitis. The diagnosis of "clinically definite" multiple sclerosis can be made when the following criteria are met:
  1. past history of two or more episodes of a neurological deficit;
  2. an isolated white matter lesion demonstrated on clinical exam (this is usually an MRI study); and
  3. a second, independent lesion on laboratory testing or clinical exam; this last criterion may be fulfilled by documenting an abnormal VER (which would be suggestive of optic neuritis).
- To assess the visual function in an infant or child under the age of one. These infants or children are premature or developmentally delayed and often have no fixational ability until six or twelve months of age. The caregiver will describe a lack of visual attentiveness. Once the diagnosis of delayed visual-system maturation is confirmed, repeat testing is not indicated. Spontaneous recovery is the typical outcome (ICD-9-CM code 369.20).
- To objectively rule out hysterical blindness and suspected malingerers. An abnormal VER would indicate poor central visual acuity. A normal VER would support the presence of normal visual nerve pathway.
- To evaluate the patient who presents with blindness due to optic trauma. The VEP will provide information to the treating physician regarding the viability of the optic nerve.

Note: In the severely myopic patient, one whose corrected visual acuity is less than 20/200, the checkerboard pattern cannot be seen. VERs performed for severely myopic patients will not be reimbursed. In addition, the patient must be cooperative and attentive enough to watch the reversing checkerboard pattern for several minutes.

HCPCS Codes

95930 Visual evoked potential (VEP) testing central nervous system, checkerboard or flash

ICD-9-CM Codes That Support Medical Necessity

300.11	Conversion disorder
368.2	Diplopia
369.20	Blindness and low vision, moderate or severe impairment, not further specified
377.30	Optic neuritis, unspecified
377.31	Optic papillitis
377.32	Retrobulbar neuritis (acute)
377.39	Optic neuritis, other
379.57	Deficiencies of saccadic eye movements

HCPCS Section and Benefit Category

Medicine/ Neurology and Neuromuscular Procedures

HCFA National Coverage Policy

Coverage Issue Manual 50-31

95930: Visual Evoked Potential (VEP) Testing (continued)

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Sources of Information

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

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

Vaughan, D., Asbury, T., Riordan-Eva, P. (1999). *General Ophthalmology* (15th ed.). Stamford: Appleton and Lange

Weinstock, D., Cray J.V., Johnson, P., Moss, J. (1998). *Illustrated Guide to Diagnostic Tests* (2nd ed.). Springhouse: Springhouse Corporation

Yanoff, M. (1998). *Ophthalmic Diagnosis and Treatment*. Boston, MA: Current Medicine, Inc.

Coding Guidelines

ICD-9-CM code 369.20 indicates the beneficiary is an infant or child under the age of one. ICD-9-CM code 300.11 indicates the beneficiary has been diagnosed with hysterical blindness. ICD-9-CM code 377.39 indicates the patient presents with blindness due to optic trauma.

Documentation Requirements

Medical record documentation maintained by the ordering/ referring physician must clearly indicate the medical necessity of the test. The information must include a brief clinical history, pertinent neurological findings, and overall impression. This information is normally found in the office/progress notes, hospital notes, and /or test results.

If the provider of service is other than the ordering/ referring physician, the provider must maintain hard copy documentation of the test results and interpretation, along with copies of the ordering/ referring physician's order for the test. It is expected the referral will also contain a brief clinical history, pertinent neurological findings, and referring physician's overall impression.

Other Comments

None

CAC Notes

This policy does not reflect 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:	February/March 2000
Original Effective Date:	**March 15, 2000** ❖

G0108: Diabetes Outpatient Self-Management Training

Description

Diabetes mellitus is a chronic disorder of carbohydrate, fat and protein metabolism, characterized by hyperglycemia and glycosuria from inadequate production or utilization of insulin. The diagnosis of diabetes mellitus is made based on the test results of a random plasma glucose greater than 200 mg/dl, fasting plasma (8-14 hours) greater than or equal to 126 mg/dl on two occasions, or a two-hour plasma glucose greater than 200 mg/dl after a 75 gm glucose challenge.

Diabetes mellitus is classified according to two syndromes: Type 1 diabetes and Type 2 diabetes. Type 1 diabetes is characterized by beta cell destruction, usually leading to absolute insulin deficiency. It has two forms: Immune-mediated diabetes mellitus and idiopathic diabetes mellitus. Type 1 diabetes is usually immune-mediated. Type 2 diabetes is a term for individuals who have insulin resistance and usually have relative (rather than absolute) insulin deficiency.

Since diabetes is a chronic illness, the patient requires continual medical care and education, to prevent acute complications and reduce the risk of long-term medical problems. A critical element for the successful treatment of all patients with diabetes is participation in a comprehensive self-management care and education program. Ongoing support, maintenance, and modifications in treatment regimes and lifestyle changes all require continued patient and caregiver participation.

A diabetes outpatient self-management training service is a program that educates beneficiaries in the successful self-management of diabetes. An outpatient diabetes self-management and training program includes education about self-monitoring of blood glucose, diet and exercise, an insulin treatment plan developed specifically for the patient who is insulin-dependent, and it motivates patients to use the skills for self-management.

This policy addresses Medicare's coverage of diabetes outpatient self-management training services based on section 4105 of the Balanced Budget Act of 1997.

Type of Bill

Hospital - 12x, 13x
Rural Health Clinic - 71x
End Stage Renal Disease - 72x

Revenue Code

942 Education/Training

Indications and Limitations of Coverage and/or Medical Necessity

Prior to July 1, 1998, Medicare provided additional reimbursement for diabetic education programs that were performed in an outpatient hospital and met certain criteria outlined in Section 80-2 of the Coverage Issues Manual (CIM). Since that time further legislation regarding coverage of outpatient diabetic education has been received and is identified below.

Medicare will consider diabetes outpatient self-management training services medically reasonable and necessary for services performed on or after July 1, 1998 when the following conditions are met:

- The services are furnished by a certified provider who meets quality standards as identified by the National Diabetes Advisory Board (NDAB). To be considered a quality diabetes self-management education program, the program must provide comprehensive instruction in the content areas that impact the target population and the participants enrolled. Standard 12 of the NDAB standards identifies the 15 content areas. The curriculum, teaching strategies, and materials used should be appropriate for the audience and should consider: type and duration of diabetes, age, cultural sensitivity, and individual learning abilities and special educational needs. The NDAB standards are listed on pages 3-5.
- Education is provided by a program that is recognized by the American Diabetes Association. This is indicated by an Education Recognition Program (ERP) certificate administered through the American Diabetes Association.
- The physician who is managing the beneficiary's diabetic condition certifies that such services are needed under a comprehensive plan of care. This plan of care must be related to the beneficiary's diabetic condition to ensure therapy compliance, or to provide the individual with the necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to successfully manage his/her condition.

During the initial period of onset of the disease, diabetes self-management education is critical to the treatment and management of the illness and should be introduced within the first week of diagnosis. Normally, as a general guideline, it would not be medically necessary for a beneficiary to receive more than 10 hours of instruction for the initial training. This training should be provided within 12 weeks of the initial diagnosis. In addition, diabetes self-management training normally occurs in group sessions. However, individual training sessions may be provided for a beneficiary if his/her physician decides that it is medically necessary (e.g., language or physical challenges, such as severely impaired hearing or sight).

Self-management education starts with an assessment of the individual's educational needs that will assist in the planning of teaching/learning strategies and which will be the foundation of an education and lifestyle plan. Patient outcomes will be monitored for lifestyle changes and revised as necessary.

After completion of the initial self-management diabetes training, ongoing support and maintenance should be provided by the beneficiary's physician and/or support system. Additional self-management education training sessions may be necessary in situations where a modification has occurred in the treatment regime (e.g., a change from oral medications to insulin, inability to stabilize patient, etc.). **Training sessions performed as a refresher course (e.g., annually) without documentation supporting a change in the treatment regime are not covered.**

The National Diabetes Advisory Board (NDAB) standards are:

G0108: Diabetes Outpatient Self-Management Training (continue)

I. STRUCTURAL STANDARDS

A. Organizational Support by Sponsoring Organization

Standard 1: Maintain written policy affirming education as an integral component of diabetes care.

Standard 2: Provide education resources needed to achieve objectives for target population, including adequate space, personnel, budget and instructional materials.

Standard 3: Clearly define and document organizational relationships, lines of authority, staffing, job descriptions, and operational policies.

B. Community Needs Assessment

Standard 4: Assess service area to define target population and determine appropriate allocation of personnel and resources.

C. Program Management

Standard 5: Establish standing advisory committee including at least a physician, nurse educator, dietitian, behavioral science expert, consumer, and community representative to oversee the program.

Standard 6: The advisory committee should participate in annual planning to determine target population, program objectives, participant access, and follow-up mechanisms, instructional methods, resource requirements, and program evaluation.

Standard 7: Professional program staff should have sufficient time and resources for lesson planning, instruction, documentation, evaluation, and follow-up.

Standard 8: Assess community resources periodically.

D. Program Staff

Standard 9: Designate a coordinator responsible for program planning, implementation, and evaluation.

Standard 10: Program instructors should include at least a nurse educator and dietitian with recent didactic and experiential training in diabetes clinical and educational issues.

Standard 11: Professional program staff should obtain continuing education about diabetes, educational principles, and behavioral change strategies.

E. Curriculum

Standard 12: The program must be capable of offering, based on target population needs, instruction in the following 15 content areas:

- diabetes overview
- stress and psychosocial adjustment
- family involvement and social support
- nutrition
- exercise and activity
- medications
- monitoring and use of results
- relationships among nutrition, exercise, medication, and glucose levels
- prevention, detection and treatment of acute complications
- prevention, detection and treatment of chronic complications
- foot, skin, and dental care
- behavior change strategies, goal setting, risk factor reduction, and problem solving
- benefits, risks and management options for improving glucose control
- preconception care, pregnancy, and gestational diabetes
- use of health care systems and community resources.

Standard 13: Use instructional methods and materials appropriate for the target population.

F. Participant Access

Standard 14: Establish a system to inform the target population and potential referral sources of availability and benefits of the program.

Standard 15: The program must be conveniently and regularly available.

Standard 16: The program must be responsive to requests for information and referrals from consumers, health professionals, and health agencies.

II. PROCESS STANDARDS

A. Assessment

Standard 17: Develop and update an individualized assessment for each participant, including medical history and health status; health services utilization; risk factors; diabetes knowledge and skills; cultural influences; health beliefs, attitudes, behavior and goals; support systems; barrier to learning; and socioeconomic factors.

B. Plan and Implementation

Standard 18: Develop an individualized education plan, based on the individualized assessment, in collaboration with each participant.

Standard 19: Document the assessment, intervention, evaluation, and follow-up for each participant, and collaboration and coordination among program staff and other providers, in a permanent record.

C. Follow-up

Standard 20: Offer appropriate and timely educational intervention based on periodic assessments of health status, knowledge, skills, attitude, goals, and self-care behaviors.

G0108: Diabetes Outpatient Self-Management Training (continued)

III. OUTCOME STANDARDS

A. Program

Standard 21: The advisory committee should review program performance annually, and use the results in subsequent planning and program modification.

B. Participant

Standard 22: The advisory committee should annually review and evaluate predetermined outcomes for program participants.

HCPCS Codes

G0108 Diabetes outpatient self-management training services, individual session, per 60 minutes

G0109 Diabetes outpatient self-management training session, group session, per 60 minutes

ICD-9-CM Codes That Support Medical Necessity

250.00-250.93 Diabetes mellitus

HCPCS Section and Benefit Category

Medicine

HCFA National Coverage Policy

Program Memorandum AB99-46
Program Memorandum AB99-30
Program Memorandum AB98-36
Program Memorandum AB98-51

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.

Diabetic self-management training performed as a refresher course without a change in the patient's treatment regime is not covered.

The diabetic self-management training benefit is not payable for inpatients in a hospital or a skilled nursing facility because disease management is included in their care.

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

Diabetes Medical Practice Guidelines. (1998*). The Journal of the Florida Medical Association*, 85 (2), 39-62.

Thomas, C. L. (Ed.). (1993). *Taber's Cyclopedic Medical Dictionary* (17th ed.). Philadelphia: F. A. Davis.

Coding Guidelines

Hospital outpatient diabetic self-management programs that do not have ADA Education Recognition and had billed the Medicare program prior to July 1, 1998, may continue to bill on a reasonable cost basis, without obtaining ADA recognition until the final outpatient diabetes self-management rule is published. Any new hospital outpatient diabetes self-management training programs (i.e., those that provide and bill for services on or after July 1, 1998) must have an ADA certificate that demonstrates that the educational standards are met.

Prior to billing for diabetes outpatient self-management training services, all applicable providers (outpatient hospital after 6/30/98 and non-hospital based programs) must submit to the Medicare contractor an Education Recognition Program (ERP) certificate from the American Diabetes Association.

Services for diabetes outpatient self-management training must be billed with the appropriate HCPCS code, G0108 or G0109, in one-hour increments only. If the training session lasts 90 minutes, only one hour may be billed for that session. The extra 30 minutes could count toward future sessions. These HCPCS should be listed with a line item date of service.

The number of patients in a group does not need to be identified when billing for procedure code G0109.

Payment for diabetes outpatient self-management training services rendered in a Federal Qualified Health Center (FQHC) or a Rural Health Center (RHC) setting by a nonphysician practitioner is bundled under the facility cost payment that is made by the intermediary under the all-inclusive rate.

Documentation Requirements

Outpatient hospital diabetic self-management programs that do not have ADA Education Recognition may continue to bill on a reasonable cost basis as long as documentation is available supporting the billing of the Medicare program for diabetic training prior to July 1, 1998.

For new outpatient hospital diabetic programs (for services on or after 7/1/98) and non-hospital based programs, documentation must be submitted prior to program payment supporting that the educational program is certified by the American Diabetes Association as evidenced by the Education Recognition Program (ERP) certificate.

In addition to the above requirement, the following documentation must be maintained in the patient's medical record:

- A physician order, referral, or attestation for the diabetic self-management training sessions. This order must certify that the beneficiary's diabetic condition warrants this comprehensive plan of care.
- An individualized assessment with updated information, including medical history and health status; health services utilization; risk factors; diabetes knowledge and skills; cultural influences; health beliefs, attitudes, behavior and goals; support systems; barrier to learning; and socioeconomic factors.
- An individualized mutually agreed upon education plan established by the team (i.e., patient, physician, and health care team members) based on the individualized assessment, including but not limited to the specific problems to be addressed, specific educational modalities, specific goals of the educational session, and the amount, frequency, and duration of each educational modality.

G0108: Diabetes Outpatient Self-Management Training (continued)

- Documentation (e.g., progress notes) for each date of service that reflect the service(s) provided and instruction given. In addition, the documentation should indicate the patient's response to the service and the progress toward the goals. The daily note must be signed and dated by the qualified team member who rendered the service.
- Documentation supporting the continuation of the diabetic self-management training session beyond the expected 10 hours during the initial phase must be available. In addition, repeat sessions during the follow-up phase must indicate the patient's treatment regime has changed and that additional training sessions are needed to educate the patient for continual self-management of the disease.

Also, since diabetes self-management training normally occurs in group sessions, the documentation maintained on file must be available to support the medical necessity for performing individual training sessions.

Other Comments

Terms defined:

Glycosuria—the presence of glucose in the urine. Traces of sugar, particularly glucose, may occur in normal urine but are not detected by ordinary qualitative methods. In routine urinalyses, the presence of a reducing sugar is suspicious of diabetes mellitus.

Hyperglycemia—increase in blood sugar.

CAC Notes

This policy does not reflect 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:	February/March 2000 *Bulletin*
Original Effective Date:	**March 15, 2000** ❖

EDUCATIONAL RESOURCES

MEDICARE AND THE MILLENNIUM - A NEW DAWNING

MEDIFEST 2000
The Cutting Edge Training Conference

Medifest Symposiums are back by popular demand; however, the Medicare Education and Outreach department will only host three– yes, **three— Medifest Symposiums** this year! Don't be left out of this training extravaganza! Register now – Seating is limited!

- Learn how to integrate efficiency techniques into the workplace
- Find out proven ways to resolve Medicare denials
- Receive coding advice from the experts
- Discover new Medicare technologies and different avenues of education
- Become a top Medicare performer
- Obtain a one-of-a-kind resource document
- Leave with a toolbox of strategies based on successful claim processing techniques

Provider Education and Training (PET) Advisory Council Meetings for Medicare Part A and B Providers
Education – A Team Effort

- Effect change by contributing to the development of user-friendly, high-quality curricula and reference materials
- Partner with Medicare to review and create materials that meet your educational needs
- Network with other providers, members of state medical/hospital associations, and Medicare consultants

Let's Talk With Medicare: Part A Sessions
Providers and Medicare – Working Together to Achieve Results

- Receive information about the latest Medicare regulations – Hot Topics
- Have your questions answered by Medicare experts
- Find out proven ways to resolve Medicare denials
- Meet your Medicare representatives
- Discover new Medicare technologies and different avenues of education
- Make contacts and network with other providers who face some of the same challenges you do
- Obtain tips to avoid claim processing denials and/or RTPs

Let's Talk With Medicare: Part B Sessions
Providers and Medicare – Working Together to Achieve Results

- Receive the latest Medicare News – Hot Topics
- Have your questions answered by Medicare experts
- Find out proven ways to resolve Medicare denials
- Meet your Medicare representatives
- Discover new Medicare technologies and different avenues of education
- Make contacts and network with other providers who face some of the same challenges you do
- Obtain tips to avoid electronic rejects, claim filing denials, and unprocessable claims

Additional Medicare Part A and B Educational Events
Coming Soon to a location near You!

- **Focused Viewpoints —** Customized Seminars to Meet Your Educational Needs
- **Medicare 101 for Part A Providers —** The ABCs of Medicare, Your Building Blocks for Success
- **Medicare 101 for Part B Providers —** The ABCs of Medicare, Your Building Blocks for Success
- **Teleconferences/Video Training —** Education at Your Fingertips
- **Specialty Seminars —** Everything You Need to Know About Your Specialty

HCFA
Health Care Financing Administration

Medifest 2000 Registration

$199
per person

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

Registration
- **Pre-registration is required. Registration will not be accepted at the door.**

Payment
- **Prepayment is required. Your method of payment may be in the form of checks or money orders (only).**

Cancellations and Refunds
- **All cancellation requests must be received 7 days prior to the seminar to receive a refund.**
- **All refunds are subject to a $20 per person cancellation fee. NO refunds or rainchecks will be issued for cancellations received fewer than 7 days prior to the event. (Also see substitution policy below.)**

Substitution
- **If you cannot attend, your company may send one substitute to take your place for the entire seminar. (Registration must be informed of any changes)**
- **Medifest has a per person price. Once you have signed in at the seminar, substitutions will not be permitted for the remainder of the seminar.**

Confirmation Number
- **Your confirmation number will be issued by fax from Seminar Registration.**
- **It is <u>very important</u> that you have a confirmation number. YOU <u>MUST</u> BRING THIS NUMBER WITH YOU.**
- **If you do not receive a confirmation number, please call (904) 791-8299.**

For hotel reservations -ask for the Medicare Medifest rate.
Miami - Radisson Mart Plaza Hotel
(305) 261-3800

St. Petersburg - St Petersburg Hilton
(727) 894-5000

Orlando - Omni Rosen Hotel
(407) 996-9840

Complete the Registration Form (one form per person)

Please Print

Registrant's Name _____

Provider's Name _____

Title/Position _____

Medicare billing provider # _____ Group billing # _____
(leave blank if you do not have one)

Address _____

City, State, ZIP code _____

Phone ( ) _____ Fax ( ) _____

How did you learn about Medifest? *Medicare B Update!*_____ *Medicare A Bulletin* _____

BBS _____ Co-worker _____ Other _____ Attended Previously _____ - ____times

Meeting Dates and Locations

☐ **Miami - March 28 & 29, 2000**
(registration & payment must be received by March 20)
Radisson Mart Center
711 NW 72nd Ave. • Miami, FL • 33126

☐ **Tampa/St. Petersburg - July 11 & 12, 2000**
(registration & payment must be received by July 3)
St. Petersburg Hilton
333 1st Street South • St. Petersburg, FL • 33701

☐ **Orlando - August 8 & 9, 2000**
(registration & payment must be received by July 31)
Orange County Convention Center
9800 International Dr. • Orlando, FL • 32819

FOUR IMPORTANT STEPS

Please follow <u>all four</u>

STEP 1 FAX both registration form <u>and</u> class schedule to (904)791-6035.

STEP 2 Make checks payable to First Coast Service Options(FCSO) Account <u>#756240</u>.

STEP 3 (After you have faxed your form) Mail the form and payment to:

Seminar Registration
PO Box 45157
Jacksonville, FL 32231

STEP 4 You must bring your confirmation number with you.

Your class schedule must accompany your registration

Medifest Class Schedule 2000

(A) - Part A Class
(B) - Part B Class
(A/B) - Both Parts A & B

Registrant's name: _____

Please register for only one class per time slot.

Day 1

March 28
July 11
August 8

8:30 - 10:00

01 ☐ General Session (A/B)
Participants are encouraged to attend this session.
Topics to be discussed include:
- Medifest registration packet
- Incident to
- Advanced Beneficiary Notice
- ARNP/PA services
- Latest program changes

10:30 - 12:00

02 ☐ E/M Documentation (A/B)
03 ☐ Global Surgery (B)
04 ☐ Primary Care (B)
05 ☐ Medicare Part C (A/B)
06 ☐ Inquiries, Appeals and Overpayment (B)
07 ☐ Partial Hospitalization Program (A)
08 ☐ Reimbursement Efficiency for Part A Providers (A)
09 ☐ PC-ACE™ for HCFA-1500 Claims Filing (B)
10 ☐ Direct Data Entry (A)

1:30 - 3:00

11 ☐ Reimbursement Efficiency for Part B Providers (B)
12 ☐ Fraud and Abuse (A/B)
13 ☐ Medical Review (A/B)
14 ☐ PC-ACE™ for UB-92 Claims Filing (A)
15 ☐ Direct Data Entry (A)

1:30 - 5:00*

16 ☐ HCFA-1500 Claims Filing (B)
17 ☐ E/M Documentation & Coding (A/B)
18 ☐ CPT Coding for Beginners (B)
19 ☐ ICD-9-CM for Beginners (A/B)

3:30 - 5:00

20 ☐ Reimbursement Efficiency for Part B Providers (B)
21 ☐ Fraud and Abuse (A/B)
22 ☐ Inquiries, Appeals and Overpayment (B)
23 ☐ Medicaid (A/B)
24 ☐ Electronic Media Claims (B)

Day 2

March 29
July 12
August 9

8:30 - 10:00

25 ☐ Global Surgery (B)
26 ☐ Primary Care (B)
27 ☐ Reimbursement Efficiency for Part B Providers (B)
28 ☐ Fraud and Abuse (A/B)
29 ☐ Medicaid (A/B)

8:30 - 12:00*

30 ☐ HCFA-1500 Claims Filing (B)
31 ☐ ICD-9-CM for Beginners (A/B)
32 ☐ UB-92 Claims Filing (A)

10:30 - 12:00

33 ☐ Global Surgery (B)
34 ☐ Reimbursement Efficiency for Part B Providers (B)
35 ☐ Medical Review (A/B)
36 ☐ Fraud and Abuse (A/B)
37 ☐ How to Help Your Patients Understand Medicare (A/B)
38 ☐ Electronic Media Claims (B)

1:30 - 3:00

39 ☐ Inquiries, Appeals and Overpayment (B)
40 ☐ Medicare Part C (A/B)
41 ☐ Medicare Secondary Payer (B)
42 ☐ CORF/ORF (A)
43 ☐ Inpatient/Outpatient PPS (A)
44 ☐ Electronic Media Claims (B)

1:30 - 5:00*

45 ☐ E/M Documentation & Coding (A/B)
46 ☐ CPT Coding for Beginners (B)

3:30 - 5:00

47 ☐ Inquiries, Appeals and Overpayment (B)
48 ☐ Medicare Part C (A/B)
49 ☐ Reimbursement Efficiency for Part A Providers (A)
50 ☐ Skilled Nursing Facilities (A)
51 ☐ How to Help Your Patients Understand Medicare (A/B)

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

Please Note: The Medifest price is not a class or day charge but is $199 per person.
Please see substitution policy if you are unable to attend this event once you have registered.

MEDIFEST COURSE DESCRIPTIONS

Comprehensive Outpatient Rehabilitation Facilities (CORF) and Outpatient Rehabilitation Facilities (ORF)

Audience: Part A CORF and ORF medical coding and billing personnel, as well as other rehabilitation professionals.

Description: The course considers HCFA and local medical policy guidelines on Medicare benefits relating to CORF/ORF providers and services; reimbursement guidelines and payment limitations; key HCFA-1450 (UB-92) form locators and billing elements; and the Prospective Payment System as it applies to CORF/ORF providers.

CPT-4 Coding

Audience: *New* Part A and Part B medical coding and billing personnel.

Description: This course provides the beginning coder with techniques to perform concise and accurate coding, including (1) a step-by-step review of the format and contents of the CPT book (e.g., overview/ history of CPT, appendixes, alphabetical index, cross reference tools), and (2) practical application relating to identifying additions/deletions/revisions and appropriate procedure codes. Participants must bring the latest edition of the CPT manual to the session.

Direct Data Entry (DDE)

Audience: Part A billing personnel.

Description: This course introduces and demonstrates the First Coast Service Options (FCSO) Medicare Part A Direct Data Entry (DDE) system, including claims entry, claims correction, online adjustments, inquiry functions, and online claims status.

Electronic Media Claims

Audience: New and experienced Part B office staff who send electronic claims.

Description: This course considers reports that providers receive from Medicare Part B (e.g., confirmation messages, front-end edits, and reject letters) that help them monitor the status of claims submitted; the various electronic applications available to help improve office efficiency; requirements for each application; and who to contact to gain access to these applications.

Evaluation and Management (E/M) Coding and Documentation

Audience: Part B physicians, medical coders, and office managers.

Description: This course presents comprehensive instructions based on the latest Medicare guidelines for selecting and documenting the appropriate level of E/M code for office, hospital, home, and nursing home visits; guidelines for concurrent care situations, hospital observations, and care oversight; and practical application of instructions and guidelines, using a sample medical record. Note: A separate session on E/M Documentation *only* will also be offered.

Fraud and Abuse

Audience: New and experienced Part A and Part B office administrators, medical staff and billing/coding personnel.

Description: This course considers government legislation relating to fraud and abuse; what constitutes Medicare fraud and abuse; penalties associated with fraud and abuse; and proactive measures providers can take to protect their organization from possible fraudulent activities.

Global Surgery

Audience: Part B medical coding and billing personnel.

Description: This course considers the Global Surgery concept; the correct use of modifiers for visits and other procedures during the global period; other frequently used common modifiers; and the billing/ reimbursement for specific surgical situations (e.g., multiple surgery, bilateral surgery, secondary procedures, split care, site of service reductions, co-surgery, surgical assistant, surgery team, Physician Assistants that assist at surgery).

HCFA-1500 Claims Filing

Audience: New and experienced Part B billing personnel.

Description: This course provides background of the HCFA-1500 claims form, rules for mandatory claims submission, how to avoid claim denials, how to read the Medicare Summary Notice, and comprehensive instructions for completing the HCFA-1500.

How to Help Your Patients Understand Medicare

Audience: Primarily those who work directly with Medicare patients, but beneficial to any Part A and Part B provider staff.

Description: This course provides information on how to assist people on Medicare to understand fee-for-service and managed care, preventive benefits, eligibility, enrollment/disenrollment, benefit guidelines, agencies/resources available for patient referral, and other current Medicare and health care issues.

ICD-9-CM Coding

Audience: New Part A and Part B medical coding and billing personnel.

Description: This course provides an introduction to the International Classification of Diseases, (9th Revision), Clinical Modification (ICD-9-CM) manual, including a brief overview of Volume III coding for Part A providers; a lengthy discussion of Volumes I and II; practical application of coding to the "highest level of specificity"; claim completion requirements for reporting diagnoses; and the importance of diagnosis coding as it relates to medical documentation. Participants must bring their ICD-9-CM manual.

Inpatient/Outpatient Prospective Payment System

Audience: Part A office managers and medical coding/ billing personnel.

Description: This course presents a review of the Prospective Payment System (PPS); and considers HCFA's implementation of PPS for hospital outpatient services; changes to beneficiary coinsurance determination for services under PPS; and the use of HCFA's Common Procedure Coding System (HCPCS) for reporting outpatient services on the HCFA-1450 (UB-92) claim form.

Inquiries, Appeals, and Overpayments

Audience: New and experienced Part B billing personnel.

Description: This course considers who to contact to resolve issues relating to claims; the steps necessary to request a review; the four levels of the appeals process; and how to detect and refund overpayments.

Medical Review

Audience: Medicare Part A and Part B providers and their office/billing staff.

Description: This course considers the medical review process from both the Carrier and Fiscal Intermediary viewpoints, including the benefits of the review process; how providers participate in the process; and how providers can decrease the level and number of reviews.

Medicare Secondary Payer

Audience: Medicare Part A and Part B providers, billing staff, and suppliers who submit claims to Medicare Secondary Payer.

Description: This course provides an introduction to the many situations where Medicare will pay only as secondary insurer; a review of regulations regarding "no-fault" (or cases where a liability insurer is involved); rules around the working aged and disabled Medicare patients; special processing for End Stage Renal Disease (ESRD); and Medicare's methodology for MSP calculation of payment and proper method for MSP claim filing.

Medicare Part C

Audience: Medicare Part A and B providers and billing staff.

Description: This course (1) provides an overview of new Medicare Part C plan options; coverage election policies; and plan/provider relationship issues (e.g., inclusion in medical policy development); and (2) includes a discussion of provider compensation guidelines for each type of Medicare Part C plan.

Partial Hospitalization Program

Audience: Part A providers and facilities involved in the delivery of Partial Hospitalization services to Medicare beneficiaries, as well as billing personnel for Partial Hospitalization Programs.

Description: This course provides an introduction to the partial hospitalization benefit under Medicare, including coverage and billing issues; information on the history of partial hospitalization; when and for whom this benefit is intended; the difference between appropriate and inappropriate utilization of this benefit; and the Prospective Payment System as it applies to PHP.

PC-ACE™ for HCFA-1500 Claim Filing

Audience: Part B individuals who currently use or are considering using Blue Cross and Blue Shield of Florida's software package to submit HCFA-1500 claims.

Description: This course includes an overview of PC-ACE™ HCFA-1500 software features; hardware/software requirements; the ease of patient and claim entry; claim flow through PC-ACE™; recent and future enhancements; a live demonstration; and a question/answer session.

PC-ACE™ for UB-92 Claim Filing

Audience: Part A individuals who currently use or are considering using Blue Cross and Blue Shield of Florida's software package to submit HCFA-1450 (UB-92) claims.

Description: This course includes an overview of PC-ACE™ HCFA-1450 (UB-92) software features; hardware/software requirements; the ease of patient and claim entry; claim flow through PC-ACE™; recent and future enhancements; a live demonstration; and a question/answer session.

Primary Care

Audience: Part B physicians, billers, and coders who bill primary care services to the Medicare program.

Description: This course considers procedures applicable to primary care practitioners, with an emphasis on preventive services, laboratory and pathology services, programs changes, and ways to avoid common claim denials.

Reimbursement Efficiency for Part A Providers

Audience: Office personnel responsible for the day-to-day operations of a Medicare Part A facility.

Description: This course presents some of the tools utilized to enhance office efficiency and considers key Medicare Part A reports that can help providers reduce their claim return rate.

Reimbursement Efficiency for Part B Providers

Audience: Part B providers and billing staff.

Description: This course (1) recommends efficient ways to partner with the Medicare Carrier (e.g., send/track/edit/receive payment for claims); (2) considers how to analyze the effectiveness of current billing practice by reviewing practice-specific MED 598 reports (three-month claim submission history); and (3) identifies the most frequent claim filing errors and ways to avoid them. Participants must indicate their provider/group billing number at time of initial registration to ensure availability of MED 598 reports.

Skilled Nursing Facility

Audience: Part A Skilled Nursing Facility providers, as well as vendors providing ancillary services to skilled nursing facility residents.

Description: This course considers the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Final Rules, with an emphasis on Consolidated Billing from both the SNF perspective as well as the outside vendor; clinical criteria required for the Minimum Data Set Assessment (MDS); and key UB-92 form locators and billing elements.

UB-92 Claims Filing

Audience: *New* Part A medical coding and billing personnel.

Description: This course includes a detailed review of the HCFA-1450 (UB-92) claim form; billing requirements; and how to apply the proper codes to the UB-92 claim for specific types of facility and Medicare entry requirements.

MEDICARE EDUCATION AND OUTREACH NEEDS YOUR HELP!!

You are cordially invited to attend a **Medicare Part A and Part B Provider Education and Training (PET) Advisory Meeting**.

PLEASE NOTE: ***THESE SESSIONS ARE NOT TRAINING SEMINARS.***

First Coast Service Options, Inc., is excited about receiving your input. With the help of providers like you, we have proven that partnership works. Providers input and feedback have been very instrumental in helping us make operational improvements.

Some examples:

- Improvements to our *Medicare A Bulletin* or *Medicare B Update!*
- Enhancements to our customer service automated response unit (ARU)
- The development of new Medicare educational courses

HOW TO PREPARE FOR THE MEETING

1. Upon registration you will receive course curriculum to review.
2. Write down three ideas for improving, changing and/or enhancing each of the courses.
3. Write down any general improvements, course additions, or course deletions.
4. Submit a copy of your ideas when you arrive at the meeting.
5. Be prepared to discuss your ideas during the curricula review session.
6. Select one session from the breakout groups listed below that you will attend on the day of the meeting.

To thank you for your participation, three lucky winners will receive a FREE Medifest 2000 tuition voucher. To be eligible for the drawing, bring three ***written*** ideas for any of the courses and submit them upon arrival.

Please select one group of interest from the groups listed below

Group 1: Medicare Part A and B Topics	Group 2: Medicare Part B Topics
Included in this group would be topics such as: • **Inpatient/ Outpatient Prospective Payment System** • **Ambulance** • **Rural Health Clinics** • **Home Health Services** • **End Stage Renal Disease/Nephrology** • **Partial Hospital Programs/Mental Health** • **CORF/ORF Services/ Physical Therapy/Occupational Therapy** • **Federal Register Rules** • **Revenue/Line Item Billing Guidelines**	**Included in this group would be topics such as:** • **Chiropractic Services** • **Radiology** • **Ophthalmology** • **Oncology** • **Pathology** • **ARNP/PA Services** • **Podiatry** • **Federal Register Rules** • **Anesthesia**

Please COME and spend an exciting half-day with us. You will not be disappointed! Your input, feedback, and partnership are vital to the success of this meeting!!

Register TODAY! Seating is limited.

To register, use the registration form on the following page.

FOR MORE INFORMATION CALL (904) 791-8299

REGISTRATION FORM FOR QUARTERLY MEDICARE PART A and PART B PROVIDER EDUCATION AND TRAINING ADVISORY MEETING

(PLEASE NOTE: This event is not a training seminar)

HOW TO PREPARE FOR THE MEETING!

1. Review the Medicare course curriculum.
2. Write down three ideas for improving, changing and/or enhancing each of the courses.
3. Write down any general improvements, course additions, or course deletions.
4. Submit a copy of your ideas when you arrive at the meeting.
5. Be prepared to discuss your ideas during the curricula review session.
6. Select one session from the breakout groups that you will attend on the day of the meeting and write in the space below.

Please complete one form per person

Registrant's Name:_____

Registrant's Title/Position:_____

Provider's Name:_____

Specialty Association Name:_____

Medicare Billing Provider Number:_____

Address:_____

City, State, Zip Code:_____

Phone: ( )_____ Fax: ( )_____

List Choice of one group:
Group 1: Medicare Part A and B Topics ○ **OR Group 2: Medicare Part B Topics** ○

Cost: FREE!!

Please fax your registration form to (904) 791-6035

Location: First Coast Service Options, Inc.
532 Riverside Avenue
Jacksonville, FL 32202

Directions to our building will be faxed with your confirmation

Time: 8:30 a.m. - 12:30 a.m.
Check one of the following dates.

- ☐ **February 18, 2000**
- ☐ **June 23, 2000**
- ☐ **September 27, 2000**

Please RSVP 10 days prior to the event

"Let's Talk With Medicare": Part A Session

MEDICARE PART A PROVIDERS

Would You Like to Discuss Billing and/or Program Issues With Your Medicare Part A Representatives?

First Coast Service Options, Inc., is offering you the opportunity to discuss your questions or concerns (face-to-face) with representatives from the many departments within Medicare. Help us help you! We are excited about the opportunity to meet you and address/resolve your inquiries. Register for one of Medicare's "Let's Talk" Sessions.

To help us address your questions and/or concerns, we need them **ten (10) days prior to the event**. Please complete this survey and fax it to:
Medicare Education and Outreach at (904) 791-6035

Describe specific topics that require further clarification. Include examples and/or any supporting documentation.
Claims Submission *(e.g., claim filing, return to provider reason codes, denial reason codes)*

Direct Data Entry *(e.g., screens, field values, navigation, onilne reports)*

Medicare Part A Reports *(e.g., consolidated provider profile report, 201 report)*

Medical Policy *(e.g., medical review process, additional development correspondence)*

Questions Concerning Your Specialty *(e.g., Skilled Nursing Facility, End Stage Renal Disease, etc.)*

Other

"Let's Talk With Medicare: Part A Session"

FOUR IMPORTANT STEPS

Four Easy Steps to Register:

STEP 1: FAX registration form to (904)791-6035.

STEP 2: Make checks payable to:
First Coast Service Options(FCSO)
Account #756240. $49 per person.

STEP 3: Mail this form and your payment to:
Seminar Registration
PO Box 45157
Jacksonville, FL 32231

STEP 4: Directions to the facility and a confirmation number will be faxed within 10 days of receiving your registration.
Please bring this with you the day of the event. If you do not receive a confirmation number, please call (904) 791-8299

All cancellation requests must be received seven days prior to the seminar to be eligible for a refund. *All refunds are subject to a $20.00 administrative fee, per person.*

Only $49.00 per person!

MEDICARE PART A PROVIDER - REGISTRATION FORM

Registrant's Name: _____

Registrant's Title/Position _____

Provider's Name: _____

Medicare Billing Provider/Group Number: _____

Address: _____

City, State, Zip Code: _____

Phone: ( ) _____ Fax: ( ) _____

Please select one of the following dates.

Time: 8:30 a.m. - 12:00 p.m.

- ☐ **March 17, 2000** **$49 per person**
- ☐ **May 19, 2000**
- ☐ **July 28, 2000**

Location: FCSO/Blue Cross Blue Shield of FL
532 Riverside Ave.
Jacksonville, FL 32202

"Let's Talk With Medicare": Part B Session

MEDICARE PART B PROVIDERS

Would You Like to Discuss Billing and/or Program Issues With Your Medicare Part B Representatives?

First Coast Service Options, Inc., is offering you the opportunity to discuss your questions or concerns (face-to-face) with representatives from the many departments within Medicare. Help us help you! We are excited about the opportunity to meet you and address/resolve your inquiries. Register for one of Medicare's "Let's Talk" Sessions.

To help us address your questions and/or concerns, we need them **ten (10) days prior to the event**. Please complete this survey and fax it to:
Medicare Education and Outreach at (904) 791-6035

Describe specific topics that require further clarification. Include examples and/or any supporting documentation.
Claims Submission *(e.g., claim filing questions, unprocessible claims, denials, etc.)*

Electronic Claims Submission *(e.g., electronic funds transfer, mailbox questions, PC-ACE™, etc.)*

Inquiries, Appeals and Overpayments: *(e.g., questions about reviews, customer service, returning money to Medicare, etc.)*

Medical Policy/Review: *(e.g., medical review process, utilization denials, etc.)*

Questions Concerning Your Specialty *(e.g., chiropractic, radiology, pathology, etc.)*

Other

"Let's Talk With Medicare: Part B Session"

FOUR IMPORTANT STEPS	MEDICARE PART B PROVIDER - REGISTRATION FORM

Four Easy Steps to Register:

STEP 1: FAX registration form to (904)791-6035.

STEP 2: Make checks payable to:
First Coast Service Options(FCSO)
Account #756240. $49 per person.

STEP 3: Mail this form and your payment to:
Seminar Registration
PO Box 45157
Jacksonville, FL 32231

STEP 4: Directions to the facility and a confirmation number will be faxed within 10 days of receiving your registration. Please bring this with you the day of the event. If you do not receive a confirmation number, please call (904) 791-8299

All cancellation requests must be received seven days prior to the seminar to be eligible for a refund. *All refunds are subject to a $20.00 administrative fee, per person.*

Only $49.00 per person!

Registrant's Name: _____

Registrant's Title/ Position _____

Provider's Name: _____

Medicare Billing Provider/Group Number: _____

Address: _____

City, State, Zip Code: _____

Phone: ( ) _____ Fax: ( ) _____

Please select one of the following dates.

Time: 1:00 p.m. - 4:30 p.m.

☐ March 17, 2000 **$49 per person**
☐ May 19, 2000
☐ July 28, 2000

Location: FCSO/Blue Cross Blue Shield of FL
532 Riverside Ave.
Jacksonville, FL 32202

Medicare Offers FREE National Education Programs

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

Medicare Computer Based Training

Computer Based Training Courses via the Internet

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

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

Here's How it Works:

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

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**.

Medicare Satellite broadcasts

Courses via Satellite Broadcast

When everyone better understands Medicare guidelines, appropriate services are rendered, claims are filed correctly, providers are paid timely (and accurately), and beneficiaries obtain the care and good service they are entitled to receive. The use of satellite technology gives healthcare providers the opportunity to share a nationwide "virtual" classroom and participate in "live" presentations. Participants retain the interactivity offered in a live seminar, as most programs offer a tollfree 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.

NEW! Medicare Provider Website Replaces BBS

A new Website for Medicare providers serviced by First Coast Service Options, Inc. (FCSO) is now available at ***www.floridamedicare.com***. Medicare is migrating (gradually moving) *all* information currently on the Medicare Online Bulletin Board System (BBS) to the Website. Once the migration is complete, the BBS will be phased out within *three to six months*. Therefore, BBS users may wish to start becoming familiar with the new Website.

Information Available on *www.floridamedicare.com*

- Medicare Part A: final and draft LMRPs, reason code list
- Medicare Part B: Medigap list, crossover information, final LMRPs
- Shared information (pertains to Medicare Part A and B): EDI forms and programming specifications, UPIN, HMO, Medpard listings
- And more coming soon!

Features

- Search through documents for specific information
- Download any file to your own computer for future offline access

Most files on the site are in PDF® format

PDF® (Portable Document Format) is an Adobe® Systems, Inc. file format that preserves the look and feel of an original document, complete with fonts, colors, images, and layout. Because PDF® lets a user view and print a document exactly as the author designed it, regardless of the original application, it has become an Internet standard for electronic distribution.

Providers wishing to view files on ***www.floridamedicare.com*** need *Adobe Acrobat Reader*®on their computers. Acrobat Reader® is free (and freely distributable) software that lets users view and print PDF® documents. Most Internet browsers and new computers come with Acrobat Reader®; it can also be downloaded from the Adobe® Website at ***www.adobe.com.***

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?

Florida Medicare online bulletin board system (BBS) enables you to access Medicare claims processing information from anywhere, even outside Florida, 24 hours a day, 7 days a week. Access can be obtained via a tollfree telephone number, through a computer, phone line, modem, and communications software. Instructions follow for using a communications program included in Windows 95/NT/98 operating systems.

Using HyperTerminal

W95/NT/98 include a program called HyperTerminal that allows you to establish a connection to the Medicare Online BBS through a simple setup "wizard."

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 on this icon to start the setup wizard.

Step 3: Connection Description

The 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 by clicking on it, and click OK. Any icon will work; you can change it again later.

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 under "How I dial from this location": how your location accesses an outside line (e.g., "9" for an outside line), long distance (e.g., "1"), and disable call waiting (click on selections available and choose appropriately: e.g., "*70"). When complete, click OK.

Step 6: Connect

The setup wizard asks 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 new to the BBS, type *NEW* when asked for your User ID. You will complete a brief questionnaire (registration) about your practice/office, along with assigning your own User ID and password. It's important that you write your User ID and password down exactly as you entered it (including any special characters); you will need it for future access to the BBS.

That's it! - When you sign off the Medicare Online BBS and exit HyperTerminal, be sure to save this new connection when prompted. Next time you open HyperTerminal, you will see 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 questions or need assistance with the BBS, contact our BBS Help Line at (904)791-8384. 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 more user friendly than the terminal access (which HyperTerminal uses) and makes downloading 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.	$ 30.00
	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.	$ 30.00
	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.	$ 30.00
	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.	$ 30.00
	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:_____

P

Q

R

S

T

V

W

Y

CPT CODES

00100-69979, Anesthesia/Surgery

70010-89399, Diagnostic Tests

90281-99199, Medicine

HCPCS CODES

* Special *Bulletins*

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