Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

Special Issue

2000 HCFA Common Procedure Coding System and Medicare Outpatient Fee Schedule Database Update

In This Issue...

The *Medicare A Bulletin Special Issue HCPCS and 2000 Outpatient Services Fee Schedule* is published annually 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 Publications
P.O. Box 2078
Jacksonville, FL 32231-0048

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

Routing Suggestions:

- ☐ Medicare Manager
- ☐ Reimbursement Director
- ☐ Chief Financial Officer
- ☐ Compliance Officer
- ☐ Y2K Officer
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HCFA
Health Care Financing Administration

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

Notification of Millennium Rollover Year-End Claims Processing

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

Year-End Claims Processing Schedule

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

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

Provider Preparation

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

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

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

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

Return to Normal Claims Processing Activities

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

Reminder on Claims with Year 2000 Dates of Service

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

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

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

Claims with Service Dates Prior to Year 2000

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

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

Annual Procedure Code Update

Effective for Services Rendered on or After January 1, 2000

The Health Care Financing Administration's Common Procedure Coding System (HCPCS) is a collection of codes and descriptors that represent procedures, supplies, products and services that may be provided to Medicare beneficiaries. HCPCS is designed to promote uniform reporting and statistical data collection of medical procedure, supplies and services.

HCPCS is used to administer the Medicare program for all fiscal intermediaries and carriers. HCPCS is updated annually to reflect changes in the practice of medicine and provisions of health care. When filing claims to Medicare Part A of Florida for dates of service beginning January 1, 2000, refer to the coding changes in this publication. For dates of service in 1999, continue to use 1999 procedure codes.

HCPCS also contains modifiers, which are two-position codes or descriptors used to indicate that a service or procedure that has been performed has been altered by some specific circumstance but not change in its definition or code.

This special issue provides an overview of changes to the HCPCS coding structure for 2000. This publication only covers specific coding changes. This information will also be shared with the Florida Medical Association, all county medical societies and all active specialty associations. Stay in contact with these organizations and read their bulletins for additional HCPCS information.

Description of HCPCS Coding Levels

Procedure code additions, deletions and revisions are being made to all three levels of the HCPCS coding structure for 2000. The three levels of procedure codes are:

Level I - Numeric Codes (CPT)

Level I codes and modifiers include five-digit numeric codes. These codes describe various physician and laboratory procedures and are contained in the American Medical Association's *Physicians' Current Procedural Terminology (CPT).*

Level II - Alpha Numeric (HCFA-Assigned)

Level II codes and modifiers include alpha-numeric codes (for example, procedure code A6255) assigned by the Health Care Financing Administration. These codes describe various non-physician and a relatively few number of physician services. These procedure codes begin with an alpha character in the A-V range and are used for Durable Medical Equipment (DME), ambulance services, prosthetics, orthotics, ostomy supplies, etc.

Level III - Alpha Numeric (Locally-Assigned)

Level III codes and modifiers include alpha-numeric codes assigned locally by Medicare of Florida. Level III codes describe procedures not included in Level I or Level II and begin with an alpha prefix of W-Z. Many Level III, or locally assigned, codes are being discontinued as part of the standardization of the Medicare program.

How to Use This Section

The 2000 HCPCS update is divided into the following major sections:

Additions

The procedure/modifier codes listed in the "Modifiers and Procedure Codes Added for 2000" section (pages 5-11) are newly identified procedure codes and should be used only for services rendered on or after January 1, 2000.

Reactivations

The procedure/modifier codes listed in the "Modifiers and Procedure Codes Reactivated for 2000" section (page 11) identify previously discontinued procedure codes that are being reactivated and should be used only for services rendered on or after January 1, 2000

Revisions

The procedure/modifier codes listed in the "Modifiers and Procedure Codes Revised for 2000" section (pages 11-15) include procedure codes for which the descriptor has changed for 2000. When using these codes, refer to the *2000 CPT* to ensure the correct procedure code is billed for the service performed.

Discontinued Procedures

The procedure codes listed in the "Modifiers and Procedure Codes Discontinued for 2000" section (pages 15-16) should not be used for service dates after December 31, 1999. However, Medicare contractors will continue to accept claims with discontinued procedure codes with 2000 service dates received prior to April 1, 2000. Services rendered in 2000 that are billed with discontinued procedure codes, will be allowed at 2000 payment rates (see the *2000 Fee Schedule*) when received between January 1, 2000, and March 31, 2000.

Effective for claims received on or after April 1, 2000, services for 2000 billed using discontinued codes will be denied payment when submitted to Medicare Part A. Providers will be notified that a discontinued procedure code was submitted and a valid procedure code must be used.

When billing for services listed in the discontinued code section, the procedure code(s) indicated in the "Codes to Report" column must be used. If more than one replacement code or no replacement code exists, refer to the appropriate coding book for additional guidelines. Note that since the procedure codes discontinued for 2000 will include an updated payment rate if billed during the grace period, inequities between the old and new procedure codes will not exist. As a result, corrected billings to change a discontinued or invalid code to a new code (or vice versa) for additional payment will not be honored.

A Word About Coverage

Procedure codes that are non-covered by Medicare due to statute are not represented on these lists. However, inclusion of a code on the lists does not necessarily constitute Medicare coverage. For example, a code may be noncovered on the basis of local medical review policy (LMRP).

Jurisdiction

The lists of added, revised, or discontinued procedure codes for 2000 are complete with no regard to contractor jurisdiction. The majority of procedure codes in HCPCS are processed in Florida by the local Medicare Part A fiscal intermediary, First Coast Service Options, Inc. (FCSO). However, some procedure codes listed represent services processed by the Durable Medical Equipment Regional Carrier (DMERC). It is the responsibility of the billing provider to submit claims to the appropriate contractor. The DMERC for this region is Palmetto Government Benefits Association (Palmetto GBA).

Use of Unlisted Procedure Codes

If a procedure code cannot be found that closely relates to the actual service rendered, an "unlisted or not otherwise classified" procedure code may be submitted with a complete narrative description of the service provided in the "Remarks" field of the UB-92 HCFA - 1450 claim form or its electronic equivalent.

Every effort should be made to locate a specific replacement code, since the use of unlisted procedure codes may result in delays in the claim processing.

Reminder for EMC Billers

Unlisted and not otherwise classified procedure codes may be submitted:

- If the unlisted or not otherwise classified procedure code can be submitted with a brief descriptor, the required information may be indicated in the appropriate narrative record. If you are unsure if your system has this capability, contact your vendor.

Questions or Concerns?

Providers are encouraged to refer to all available resource materials for specific procedure coding instructions and claims filing information. Medicare Part A reference materials include the *Medicare A Bulletin* and special bulletins.

However, if the information cannot be found in any of the reference materials, contact the Medicare Part A Customer Service department at (904) 355-8899.

Obtaining the 2000 Coding Books

Because of the many changes to the HCPCS coding structure, providers are strongly encouraged to purchase the 2000 *CPT* (Level I) book and/or the *2000 HCPCS Level II* coding book. Providers may purchase the 2000 edition of the *CPT* (Level I codes) from the American Medical Association by writing:

American Medical Association
P.O. Box 109050
Chicago, IL 60610-0946

The price for the 2000 *CPT* book is $39.95 per copy for American Medical Association members, and $49.95 per copy for non-members. The 2000 HCPCS Level II coding book can be purchased for $31.95 per copy for American Medical Association members, and $44.95 per copy for non-members. There is an additional charge of $6.95 for postage and handling for each book. American Medical Association members must provide their American Medical Association number in order to obtain the discounted rate. Make checks payable to the American Medical Association. For credit card orders, call (800) 621-8335.

Allow four to six weeks for delivery.

The *2000 CPT* book is also available on diskette. For additional information, call the toll-free number listed above.

Obtaining the 2000 HCPCS Alphanumeric Hardcopy

The 2000 alphanumeric hardcopy, titled *2000 Alphanumeric HCFA Common Procedure Coding System,* may be obtained from:

Superintendent of Documents
U.S. Government Printing Office
Washington D.C. 20402
Telephone: (202) 512-1800

Grace Period Established for 2000 HCPCS Update

The 2000 HCFA Common Procedure Coding System (HCPCS) Update is effective for services provided **on or after January 1, 2000.** However, the Health Care Financing Administration extends a 90-day grace period where either 1999 or 2000 HCPCS codes are accepted. This grace period applies to claims received prior to April 1, 2000, which include 1999 discontinued codes for dates of service January 1, 2000 or later. The 3-month grace period also applies to discontinued HCPCS codes.

Therefore, effective January 1, 2000 through March 31, 2000, providers may use either 1999 and/or 2000 HCPCS codes. **Effective April 1, 2000, only the 2000 HCPCS codes will be accepted by Medicare.** ❖

Modifiers and Procedure Codes Added for 2000

MODIFIERS

G7	Pregnancy resulted from rape or incest or pregnancy certified by physician as life threatening
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure
G9	Monitored anesthesia care for patient who has history of severe cardio-pulmonary condition
91	Repeat clinical diagnostic laboratory test: In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of the modifier '-91'. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing).this modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

LEVEL I—CPT CODES

11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
13102	Repair, complex, trunk; each additional 5 cm or less (list separately in addition to code for primary procedure)
13122	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (list separately in addition to code for primary procedure)
13133	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (list separately in addition to code for primary procedure)
13153	Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (list separately in addition to code for primary procedure)
20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)
22318	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; without grafting
22319	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; with grafting
27096	Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid
32997	Total lung lavage (unilateral)
33140	Transmyocardial laser revascularization, by thoracotomy (separate procedure)
33282	Implantation of patient-activated cardiac event recorder
33284	Removal of an implantable, patient-activated cardiac event recorder
33410	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve
35879	Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplasty
35881	Revision, lower extremity arterial bypass, without thrombectomy, open; with segmental vein interposition
36521	Therapeutic apheresis; with extracorporeal affinity column adsorption and plasma reinfusion
36550	Declotting by thrombolytic agent of implanted vascular access device or catheter
36819	Arteriovenous anastomosis, open; by basilic vein transposition
38120	Laparoscopy, surgical, splenectomy
38129	Unlisted laparoscopy procedure, spleen
38570	Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple
38571	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy
38572	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple
38589	Unlisted laparoscopy procedure, lymphatic system
39560	Resection, diaphragm; with simple repair (eg., primary suture)
39561	Resection, diaphragm; with complex repair (eg., prosthetic material, local muscle flap)
43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg., Nissen, Toupet procedures)
43289	Unlisted laparoscopy procedure, esophagus
43651	Laparoscopy, surgical; transection of vagus nerves, truncal
43652	Laparoscopy, surgical; transection of vagus nerves, selective or highly selective
43653	Laparoscopy, surgical; gastrostomy, without construction of gastric tube (eg., stamm procedure) (separate procedure)
43659	Unlisted laparoscopy procedure, stomach
44200	Laparoscopy, surgical; enterolysis (freeing of intestinal adhesion) (separate procedure)
44201	Laparoscopy, surgical; jejunostomy (eg., for decompression or feeding)
44202	Laparoscopy, surgical; intestinal resection, with anastomosis (intra or extracorporeal)
44209	Unlisted laparoscopy procedure, intestine (except rectum)
44970	Laparoscopy, surgical, appendectomy

Modifiers and Procedure Codes Added for 2000

44979	Unlisted laparoscopy procedure, appendix
47560	Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy
47561	Laparoscopy, surgical; with guided transhepatic cholangiography with biopsy
47562	Laparoscopy, surgical; cholecystectomy
47563	Laparoscopy, surgical; cholecystectomy with cholangiography
47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct
47570	Laparoscopy, surgical; cholecystoenterostomy
47579	Unlisted laparoscopy procedure, biliary tract
49320	Laparoscopy, surgical, abdomen, peritoneum, and omentum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
49321	Laparoscopy, surgical, abdomen, peritoneum, and omentum; with biopsy (single or multiple)
49322	Laparoscopy, surgical, abdomen, peritoneum, and omentum; with aspiration of cavity or cyst (eg., ovarian cyst) (single or multiple)
49323	Laparoscopy, surgical, abdomen, peritoneum, and omentum; with drainage of lymphocele to peritoneal cavity
49329	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum
49650	Laparoscopy, surgical; repair initial inguinal hernia
49651	Laparoscopy, surgical; repair recurrent inguinal hernia
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy
50541	Laparoscopy, surgical; ablation of renal cysts
50544	Laparoscopy, surgical; pyeloplasty
50546	Laparoscopy, surgical; nephrectomy
50547	Laparoscopy, surgical; donor nephrectomy from living donor (excluding preparation and maintenance of allograft)
50548	Laparoscopically assisted nephroureterectomy
50549	Unlisted laparoscopy procedure, renal
50945	Laparoscopy, surgical, ureterolithotomy
51990	Laparoscopy, surgical; urethral suspension for stress incontinence
51992	Laparoscopy, surgical; sling operation for stress incontinence (eg., fascia or synthetic)
54690	Laparoscopy, surgical; orchiectomy
54692	Laparoscopy, surgical; orchiopexy for intra-abdominal testis
54699	Unlisted laparoscopy procedure, testis
55550	Laparoscopy, surgical, with ligation of spermatic veins for varicocele
55559	Unlisted laparoscopy procedure, spermatic cord
58550	Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)
58551	Laparoscopy, surgical; with removal of leiomyomata (single or multiple)
58555	Hysteroscopy, diagnostic (separate procedure)
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C
58559	Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)
58560	Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)
58561	Hysteroscopy, surgical; with removal of leiomyomata
58562	Hysteroscopy, surgical; with removal of impacted foreign body
58563	Hysteroscopy, surgical; with endometrial ablation (any method)
58578	Unlisted laparoscopy procedure, uterus
58579	Unlisted hysteroscopy procedure, uterus
58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58662	Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (eg., band, clip, or Falope ring)
58672	Laparoscopy, surgical; with fimbrioplasty
58673	Laparoscopy, surgical; with salpingostomy (salpingoneostomy)
58679	Unlisted laparoscopy procedure, oviduct, ovary
59898	Unlisted laparoscopy procedure, maternity care and delivery
60650	Laparoscopy, surgical, with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal
60659	Unlisted laparoscopy procedure, endocrine system
61862	Twist drill, burr hole, craniotomy, or craniectomy for stereotactic implantation of one neurostimulator array in subcortical site (eg., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray)
61886	Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays
62263	Percutaneous lysis of epidural adhesions using solution injection (eg., hypertonic saline, enzyme) or mechanical means (eg., spring-wound catheter) including radiologic localization (includes contrast when administered)
62310	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic

Modifiers and Procedure Codes Added for 2000

62311	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)
62318	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic
62319	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)
64470	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level
64472	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, each additional level (list separately in addition to code for primary procedure)
64475	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level
64476	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, each additional level (list separately in addition to code for primary procedure)
64479	Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, single level (list separately in addition to code for primary procedure)
64480	Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, each additional level
64483	Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level
64484	Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level (list separately in addition to code for primary procedure)
64626	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level
64627	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (list separately in addition to code for primary procedure)
72275	Epidurography, radiological supervision and interpretation
73542	Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation
76005	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction
76873	Echography, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)
77427	Radiation treatment management, five treatments
77520	Proton beam delivery to a single treatment area, single port, custom block, with or without compensation, with treatment setup and verification images
77523	Proton beam delivery to one or two treatment areas, two or more ports, two or more custom blocks, and two or more compensators, with treatment setup and verification images
78267	Urea breath test, C-14; acquisition for analysis
78268	Urea breath test, C-14; analysis
78456	Acute venous thrombosis imaging, peptide
80048	Basic metabolic panel
80053	Comprehensive metabolic panel
80069	Renal function panel
80074	Acute hepatitis panel
80076	Hepatic function panel
87338	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Helicobacter pylori, stool
90378	Respiratory syncytial virus immune globulin (RSV-IgIM), for intramuscular use
92961	Cardioversion, elective, electrical conversion of arrhythmia; internal (separate procedure)
93727	Electronic analysis of implantable loop recorder (ILR) system (includes retrieval of recorded and stored ECG data, physician review and interpretation of retrieved ECG data and reprogramming)
93741	Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber, without reprogramming
93742	Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber, with reprogramming

Modifiers and Procedure Codes Added for 2000

93743	Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); dual chamber, without reprogramming
93744	Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); dual chamber, with reprogramming
96570	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (list separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)
96571	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (list separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)
99170	Anogenital examination with colposcopic magnification in childhood for suspected trauma

LEVEL II—HCFA ASSIGNED CODES

A4369	Ostomy skin barrier, liquid (spray, brush, etc), per oz.
A4370	Ostomy skin barrier, paste, per oz.
A4371	Ostomy skin barrier, powder, per oz.
A4372	Ostomy skin barrier, solid 4x4 or equivalent, standard wear, with built-in convexity, each
A4373	Ostomy skin barrier, with flange (solid, flexible or accordion), standard wear, with built-in convexity, any size, each
A4374	Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, any size, each
A4375	Ostomy pouch, drainable, with faceplate attached, plastic, each
A4376	Ostomy pouch, drainable, with faceplate attached, rubber, each
A4377	Ostomy pouch, drainable, for use on faceplate, plastic, each
A4378	Ostomy pouch, drainable, for use on faceplate, rubber, each
A4379	Ostomy pouch, urinary, with faceplate attached, plastic, each
A4380	Ostomy pouch, urinary, with faceplate attached, rubber, each
A4381	Ostomy pouch, urinary, with faceplate attached, rubber, each
A4382	Ostomy pouch, urinary, for use on faceplate, heavy plastic, each
A4383	Ostomy pouch, urinary, for use on faceplate, rubber, each
A4384	Ostomy faceplate equivalent, silicone ring, each
A4385	Ostomy skin barrier, solid 4x4 or equivalent, extended wear, without built-in convexity, each
A4386	Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, any size, each
A4387	Ostomy pouch closed, with standard wear barrier attached, with built-in convexity (1 piece), each
A4388	Ostomy pouch, drainable, with extended wear barrier attached, without built-in convexity (1 piece)
A4389	Ostomy pouch, drainable, with standard wear barrier attached, with built-in convexity (1 piece), each
A4390	Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each
A4391	Ostomy pouch, urinary, with extended wear barrier attached, without built-in convexity (1 piece), each
A4392	Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each
A4393	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each
A4394	Ostomy deodorant for use in ostomy pouch, liquid, per fluid ounce
A4395	Ostomy deodorant for use in ostomy pouch, solid, per tablet
A5508	For diabetics only, deluxe feature of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe
A7000	Canister, disposable, used with suction pump, each
A7001	Canister, non-disposable, used with suction pump, each
A7002	Tubing, used with suction pump, each
A7003	Administration set, with small volume nonfiltered pneumatic nebulizer, disposable
A7004	Small volume nonfiltered pneumatic nebulizer, disposable
A7005	Administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable
A7006	Administration set, with small volume filtered pneumatic nebulizer
A7007	Large volume nebulizer, disposable, unfilled, used with aerosol compressor
A7008	Large volume nebulizer, disposable, prefilled, used with aerosol compressor

Modifiers and Procedure Codes Added for 2000

A7009	Reservoir bottle, non-disposable, used with large voume ultrasonic nebulizer
A7010	Corrugated tubing, disposable, used with large volume nebulizer, 100 feet
A7011	Corrugated tubing, non-disposable, used with large volume nebulizer, 10 feet
A7012	Water collection device, used with large volume nebulizer
A7013	Filter, disposable, used with aerosol compressor
A7014	Filter, nondisposable, used with aerosol compressor or ultrasonic generator
A7015	Aerosol mask, used with DME nebulizer
A7016	Dome and mouthpiece, used with small volume ultrasonic nebulizer
A7017	Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen
A9504	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc 99 m apcitide
A9900	Miscellaneous supply, accessory, and/or service component of another HCPCS code
A9901	Delivery, set up, and/or dispensing service component of another HCPCS code
D0472	Accession of tissue, gross examination, preparation and transmission of written report
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report
D0480	Processing and interpretation of cytologic smears, including the preparation and transmission of written report
D4268	Surgical revision procedure, per tooth
E0144	Enclosed, framed folding walker, wheeled, with posterior seat
E0590	Dispensing fee covered drug administered through DME nebulizer
E0616	Implantable cardiac event recorder with memory, activator and programmer
E0779	Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater
E0780	Ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours
E1390	Oxygen concentrator, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1900	Synthesized speech augmentative communication device with dynamic display
G0102	Prostate cancer screening; digital rectal examination
G0103	Prostate cancer screening; prostate specific antigen test (PSA), total
G0129	Occupational therapy requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day
G0151	Services of physical therapist in home health setting, each 15 minutes
G0152	Services of occupational therapist in home health setting, each 15 minutes
G0153	Services of speech and language pathologist in home health setting, each 15 minutes
G0154	Services of skilled nurse in home health setting, each 15 minutes
G0155	services of clinical social worker in home health setting, each 15 minutes
G0156	Services of home health aide in home health setting, each 15 minutes
G0159	Percutaneous thrombectomy and/or revision, arteriovenous fistula, autogenous or nonautogenous dialysis graft
G0160	Cryosurgical ablation of localized prostate cancer, primary treatment only (post-operative irrigations and aspiration of sloughing tissue included)
G0161	Ultrasonic guidance for interstitial placement of cryosurgical probes
G0163	Positron emission tomography (PET), whole body, for recurrence of colorectal metastatic cancer
G0164	Positron emission tomography (PET), whole body, for staging and characterization of lymphoma
G0165	Positron emission tomography (PET), whole body, for recurrence of melanoma or melanoma metastatic cancer
G0166	External counterpulsation, per treatment session
G0167	Hyperbaric oxygen treatment not requiring physician attendance, per treatment session
G0168	Wound closure utilizing tissue adhesive(s) only
G0169	Removal of devitalized tissue, without use of anesthesia (conscious sedation, local, regional, general)
G0170	Application of tissue cultured skin grafts, including bilaminate skin substitutes or neodermis, including site preparation, initial 25 sq cms
G0171	Application of tissue cultured skin grafts, including bilaminate skin substitutes or neodermis, including site preparation, each additional 25 sq cms
G0172	Training and educational services furnished as a componentof a partial hospitalization treatment program, per day
J0200	Injection, alatrofloxacin mesylate, 100 mg
J0456	Injection, azithromycin, 500 mg
J1327	Injection, eptifibatide, 5 mg
J1438	Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)
J1450	Injection fluconazole, 200 mg
J1745	Injection infliximab, 10 mg

Modifiers and Procedure Codes Added for 2000

J1750	Injection, iron dextran, 50 mg
J2352	Injection, octreotide acetate, 1 mg
J2500	Injection, paricalcitol, 5 mcg
J2543	Injection, piperacillin sodium/tazobactam sodium, 1 gram 0.125 grams (1.125 grams)
J2780	Injection, ranitidine hydrochloride, 25 mg
J3245	Injection, tirofiban hydrochloride, 12.5 mg
J7198	Anti-inhibitor, per i.u.
J7199	Hemophilia clotting factor, not otherwise classified
J7515	Cyclosporine, oral, 25 mg
J7516	Cyclosporin, parenteral, 250 mg
J7517	Mycophenolate mofetil, oral, 250 mg
J7608	Acetylcysteine, inhalation solution administered through DME, unit dose form, per gram
J7618	Albuterol, inhalation solution administered through DME, concentrated form, per milligram
J7619	Albuterol, inhalation solution administered through DME, unit dose form, per milligram
J7628	Bitolterol mesylate, inhalation solution administered through DME, concentrated form, per milligram
J7629	Bitolterol mesylate, inhalation solution administered through DME, unit dose form, per milligram
J7631	Cromolyn sodium, inhalation solution administered through DME, unit dose form, per 10 milligrams
J7635	Atropine, inhalation solution administered through DME, concentrated form, per milligram
J7636	Atropine, inhalation solution administered through DME, unit dose form, per milligram
J7637	Dexamethasone, inhalation solution administered through DME, concentrated form, per milligram
J7638	Dexamethasone, inhalation solution administered through DME, unit dose form, per milligram
J7639	Dornase alpha, inhalation solution administered through DME, unit dose form, per milligram
J7642	Glycopyrrolate, inhalation solution administered through DME, concentrated form, per milligram
J7643	Glycopyrrolate, inhalation solution administered through DME, unit dose form, per milligram
J7644	Ipratropium bromide, inhalation solution administered through DME, unit dose form, per milligram
J7648	Isoetharine HCL, inhalation solution administered through DME, concentrated form, per milligram
J7649	Isoetharine HCL, inhalation solution administered through DME, unit dose form, per milligram
J7658	Isoproterenol HCL, inhalation solution administered through DME, concentrated form, per milligram
J7659	Isoproterenol HCL, inhalation solution administered through DME, unit dose form, per milligram
J7668	Metaproterenol sulfate, inhalation solution administered through DME, concentrated form, per 10 milligrams
J7669	Metaproterenol sulfate, inhalation solution administered through DME, unit dose form, per 10 milligrams
J7680	Terbutaline sulfate, inhalation solution administered through DME, concentrated form, per milligram
J7681	Terbutaline sulfate, inhalation solution administered through DME, unit dose form, per milligram
J7682	Tobramycin, unit dose form, 300 mg, inhalation solution, administered through DME
J7683	Triamcinolone, inhalation solution administered through DME, concentrated form, per milligram
J7684	Triamcinolone, inhalation solution administered through DME, unit dose form, per milligram
J8510	Busulfan; oral, 2 mg
J8520	Capecitabine, oral, 150 mg
J8521	Capecitabine, oral, 500 mg
J9355	Trastuzumab, 10 mg
J9357	Valrubicin, intravesical, 200 mg
K0462	Temporary replacement for patient owned equipment being repaired, any type
K0531	Humidifier, heated, used with positive airway pressure device
K0532	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
K0533	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
K0534	Respiratory assist device, bi-level pressure capacity, with back up rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)
L3807	WHFO, extension assist, with inflatable Palmer air support, with or without thumb extension
L9900	Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS "l" code
P9023	Plasma, pooled multiple donor, solvent/detergent treated, frozen, each unit

Modifiers and Procedure Codes Added for 2000

Q0186	Paramedic intercept, rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers
Q0187	Factor VIIa (coagulation factor, recombinant) per 1.2 mg
Q1001	New technology intraocular lense category 1 as defined in the *Federal Register* notice
Q1002	New technology intraocular lense category 2 as defined in federal register notice
Q1003	New technology intraocular lense category 3 as defined in federal register notice
Q1004	New technology intraocular lense category 4 as defined in federal register notice
Q1005	New technology intraocular lense category 5 as defined in federal register notice

Modifiers and Procedure Codes Reactivated for 2000

LEVEL II—HCFA ASSIGNED CODES

J7502	Cyclosporine, oral, 100 mg

Modifiers and Procedure Codes Revised for 2000

MODIFIERS

32	Mandated services: Services related to mandated consultation and/or related services (eg., pro, third party payer, governmental, legislative or regulatory requirement) may be identified by adding the modifier '-32' to the basic procedure or the service may be reported by use of the five digit modifier 09932.
EJ	Subsequent claims for a defined course of therapy, e.g., EPO, sodium hyaluronate, infliximab

LEVEL I—CPT CODES

00100	Anesthesia for procedures on salivary glands, including biopsy
00102	Anesthesia for procedures on plastic repair of cleft lip
00103	Anesthesia for reconstructive procedures of eyelid (eg., blepharoplasty, ptosis surgery)
00214	Anesthesia for intracranial procedures; burr holes, including ventriculography
00300	Anesthesia for all procedures on the integumentary system, muscles and nerves of head, neck, and posterior trunk, not otherwise specified
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified
00520	Anesthesia for closed chest procedures; (including bronchoscopy) not otherwise specified
00528	Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy
00740	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum
00810	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum
00857	Neuraxial analgesia/anesthesia for labor ending in a cesarean delivery (includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)
00918	Anesthesia for transurethral procedures (including urethrocystoscopy); with fragmentation, manipulation and/or removal of ureteral calculus
00952	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography
00955	Neuraxial analgesia/anesthesia for labor ending in a vaginal delivery (includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or diskectomy to prepare interspace (other than for decompression), single interspace; lumbar
22840	Posterior non-segmental instrumentation (eg., Harrington rod technique), pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation
22851	Application of intervertebral biomechanical device(s) (eg., synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace
26416	Removal of prosthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each tendon
29879	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture
31622	Bronchoscopy, (rigid or flexible); diagnostic, with or without cell washing (separate procedure)

Modifiers and Procedure Codes Revised for 2000

33216	Insertion or repositioning of a transvenous electrode (15 days or more after initial insertion); single chamber (one electrode) permanent pacemaker or single chamber pacing cardioverter-defibrillator
33217	Insertion or repositioning of a transvenous electrode (15 days or more after initial insertion); dual chamber (two electrodes) permanent pacemaker or dual chamber pacing cardioverter-defibrillator
33218	Repair of single transvenous electrode for a single chamber, permanent pacemaker or single chamber pacing cardioverter-defibrillator
33220	Repair of two transvenous electrodes for a dual chamber permanent pacemaker or dual chamber pacing cardioverter-defibrillator
33243	Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by thoracotomy
33244	Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by transvenous extraction
33246	Insertion of epicardial single or dual chamber pacing cardioverter-defibrillator electrodes by thoracotomy; with insertion of pulse generator
33249	Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve
35500	Harvest of upper extremity vein, one segment, for lower extremity or coronary artery bypass procedure (list separately in addition to code for primary procedure)
36533	Insertion of implantable venous access device, with or without subcutaneous reservoir
36534	Revision of implantable venous access device, and/or subcutaneous reservoir
36535	Removal of implantable venous access device, and/or subcutaneous reservoir
36821	Arteriovenous anastomosis, open; direct, any site (eg., Cimino type) (separate procedure)
37250	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (list separately in addition to code for primary procedure)
43761	Repositioning of the gastric feeding tube, any method, through the duodenum for enteric nutrition
43830	Gastrostomy, open; without construction of gastric tube (eg., Stamm procedure) (separate procedure)
43832	Gastrostomy, open; with construction of gastric tube (eg., Janeway procedure)
48554	Transplantation of pancreatic allograft
50320	Donor nephrectomy, open from living donor (excluding preparation and maintenance of allograft)
54100	Biopsy of penis; (separate procedure)
59866	Multifetal pregnancy reduction(s) (MPR)
61751	Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computerized axial tomography and/or magnetic resonance guidance
61795	Stereotactic computer assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal (list separately in addition to code for primary procedure)
61885	Incision and subcutaneous placement of cranial neurostim-ulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
62273	Injection, epidural, of blood or clot patch
62280	Injection/infusion of neurolytic substance (eg., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid
62282	Injection/infusion of neurolytic substance (eg., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar (eg., manual or automated percutaneous diskectomy, percutaneous laser diskectomy)
62291	Injection procedure for diskography, each level; cervical or thoracic
62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term pain management via an external pump or implantable reservoir/infusion pump; without laminectomy
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar (including open or endoscopically-assisted approach)
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg., herniated intervertebral disk), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg., far lateral herniated intervertebral disk)
64622	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level
64623	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (list separately in addition to code for primary procedure)
67220	Destruction of localized lesion of choroid (eg., choroidal neo-vascularization),one or more session, photocoagulation (eg., laser, ocular photodynamic therapy)
72285	Diskography, cervical or thoracic, radiological supervision and interpretation
76513	Ophthalmic ultrasound, echography, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy

Modifiers and Procedure Codes Revised for 2000

77499 Unlisted procedure, therapeutic radiology treatment management
78457 Venous thrombosis imaging, venogram; unilateral
83013 Helicobacter pylori, breath test analysis (mass spectrometry);
86915 Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (eg., T-cells, metastatic carcinoma)
88148 Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision
90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)
90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); each additional vaccine (single or combination vaccine/ toxoid) (list separately in addition to code for primary procedure)
90632 Hepatitis a vaccine, adult dosage, for intramuscular use
90633 Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90634 Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use
90636 Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
90708 Measles and rubella virus vaccine, live, for subcutaneous or jet injection use
90709 Rubella and mumps virus vaccine, live, for subcutaneous use
90744 Hepatitis B vaccine, pediatric/adolescent dosage, for intramuscular use
90746 Hepatitis B vaccine, adult dosage, for intramuscular use
90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, for intramuscular use
90748 Hepatitis B and Hemophilus influenza B vaccine (HepB-Hib), for intramuscular use
90782 Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular
90799 Unlisted therapeutic, prophylactic or diagnostic injection
92960 Cardioversion, elective, electrical conversion of arrhythmia; external
92978 Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (list separately in addition to code for primary procedure)
93640 Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement;
93642 Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic
95816 Electroencephalogram (EEG) including recording awake and drowsy (including hyperventilation and/or photic stimulation when appropriate)
95819 Electroencephalogram (EEG) including recording awake and asleep (including hyperventilation and/or photic stimulation when appropriate)
95831 Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk
95870 Needle electromyography; limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters
95900 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study
95904 Nerve conduction, amplitude and latency/velocity study, each nerve; sensory or mixed
95923 Testing of autonomic nervous system function; sudomotor, including one or more of the following: Quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential
95961 Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of physician attendance
95970 Electronic analysis of implanted neurostimulator pulse generator system (eg., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie., cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming
95971 Electronic analysis of implanted neurostimulator pulse generator system (eg., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measure-

Modifiers and Procedure Codes Revised for 2000

ments); simple brain, spinal cord, or peripheral (ie., peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

95972 Electronic analysis of implanted neurostimulator pulse generator system (eg., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex brain, spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour

95973 Electronic analysis of implanted neurostimulator pulse generator system (eg., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex brain, spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (list separately in addition to code for primary procedure)

99199 Unlisted special service, procedure or report

99285 Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

99291 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

99295 Initial neonatal intensive care, per day, for the evaluation and management of a critically ill neonate or infant

This code is reserved for the date of admission for neonates who are critically ill. Critically ill neonates require cardiac and/or respiratory support (including ventilator or nasal CPAP when indicated), continuous or frequent vital sign monitoring, laboratory and blood gas interpretations, follow-up physician reevaluations, and constant observation by the health care team under direct physician supervision. Immediate preoperative evaluation and stabilization of neonates with life threatening surgical or cardiac conditions are included under this code.

99296 Subsequent neonatal intensive care, per day, for the evaluation and management of a critically ill and unstable neonate or infant

A critically ill and unstable neonate will require cardiac and/or respiratory support (including ventilator or nasal CPAP when indicated), continuous or frequent vital sign monitoring, laboratory and blood gas interpretations, follow-up physician re-evaluations throughout a 24-hour period, and constant observation by the health care team under direct physician supervision. In addition, most will require frequent ventilator changes, intravenous fluid alterations, and/or early initiation of parenteral nutrition. Neonates in the immediate post-operative period or those who become critically ill and unstable during the hospital stay will commonly qualify for this level of care.

This code encompasses intensive care provided on dates subsequent to the admission date.

99297 Subsequent neonatal intensive care, per day, for the evaluation and management of a critically ill though stable neonate or infant

Critically ill though stable neonates require cardiac and/ or respiratory support (including ventilator and nasal CPAP when indicated), continuous or frequent vital sign monitoring, laboratory and blood gas interpretations, follow-up physician re-evaluations throughout a 24 hour period, and constant observation by the health care team under direct physician supervision. Neonates at this level of care would be expected to require less frequent changes in respiratory, cardiovascular and fluid and electrolyte therapy as those included under code 99296.

This code encompasses intensive care provided on dates subsequent to the admission date.

LEVEL II—HCFA ASSIGNED CODES

A4556 Electrodes, (e.g., apnea monitor), per pair

A4557 Lead wires, (e.g., apnea monitor), per pair

A5126 Adhesive or non-adhesive; disk or foam pad

E0155 Wheel attachment, rigid pick-up walker, per pair

E0158 Leg extensions for walker, per set of four (4)

E0450 Volume ventilator, stationary or portable, with backup rate feature, used with invasive interface (e.g., tracheostomy tube)

E0781 Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient

J0270 Injection, alprostadil, 1.25 mcg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)

Modifiers and Procedure Codes Revised for 2000

J0275	Alprostadil urethral suppository (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)
J0290	Injection, ampicillin sodium, 500 mg
J0690	Injection, cefazolin sodium, 500 mg
J1100	Injection, dexamethosone sodium phosphate, up to 4mg/ml
J1260	Injection, dolasetron mesylate, 10 mg
J1825	Injection, interferon beta-1a, 33 mcg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)
J1830	Injection interferon beta-1b, 0.25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)
J3030	Injection, sumatriptan succinate, 6 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)
J3240	Injection, thyrotropin alfa, 0.9 mg
J3370	Injection, vancomycin hcl, 500 mg
J7500	Azathioprine, oral, 50 mg
J7501	Azathioprine, parenteral, 100 mg
J7504	Lymphocyte immune globulin, antithymocyte globulin, parenteral, 250 mg
K0028	Manual, fully reclining back
K0031	Safety belt/pelvic strap, each
K0065	Spoke protectors, each
K0099	Front caster for power wheelchair, each
K0100	Wheelchair adapter for amputee, pair (device used to compensate for transfer of weight due to lost limbs to maintain proper balance)
K0101	One-arm drive attachment, each
K0102	Crutch and cane holder, each
K0104	Cylinder tank carrier, each
K0105	IV hanger, each
K0108	Wheelchair component or accessory, not otherwise specified
L4392	Replace soft interface material, static AFO
L4396	Static AFO for positioning, pressure reduction, may be used for minimal ambulation
L5925	Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual lock
L5968	Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature
L5988	Addition to lower limb prosthesis, vertical shock reducing pylon feature
L6693	Upper extremity addition, locking elbow, forearm counterbalance
L8435	Prosthetic sock, multipleply, upper limb, each

Modifiers and Procedure Codes Discontinued for 2000

Discontinued Code	Code(s) to Report
MODIFIERS	
AB	no replacement
AC	no replacement
AE	no replacement
AF	no replacement
AG	no replacement
QR	see 91
LEVEL I—CPT CODES	
00420	see 00300
01000	see 00400
01110	see 00300
01240	see 00400
01300	see 00400
01460	see 00400
01600	see 00400
01700	see 00400
01800	see 00400
01900	see 00952
01902	see 00214
13300	see 13102, 13122, 13133, 13153
15580	see 15574
15625	see 15620
32001	see 32997
33242	see 33218, 33220
33247	see 33216
56300	see 49320
56301	see 58670
56302	see 58671
56303	see 58662
56304	see 58660
56305	see 49321
56306	see 49322
56307	see 58661
56308	see 58550
56309	see 58551
56310	see 44200
56311	see 38570
56312	see 38571
56313	see 38572
56314	see 49323
56315	see 44970
56316	see 49650
56317	see 49651
56318	see 54690
56320	see 55550
56321	see 60650
56322	see 43651
56323	see 43652
56324	see 47570
56340	see 47562
56341	see 47563
56342	see 47564
56343	see 58673
56344	see 58672
56345	see 38120
56346	see 43653
56347	see 44201
56348	see 44202
56349	see 43280
56350	see 58555
56351	see 58558
56352	see 58559
56353	see 58560
56354	see 58561
56355	see 58562
56356	see 58563
56362	see 47560
56363	see 47561
56399	see site-specific unlisted laparoscopy/hysterectomy codes

Modifiers and Procedure Codes Discontinued for 2000

Discontinued Code	Code(s) to Report
61855	see 61862
61865	see 61862
62274	see 62310, 62311
62275	see 62310
62276	see 62318, 62319
62277	see 62318, 62319
62278	see 62311
62279	see 62319
62288	see 62310, 62311
62289	see 62311
62298	see 62310
64440	see 64479, 64483
64441	see 64480, 64484
64442	see 64475
64443	see 64476
77380	see 77520
77381	see 77523
77419	see 77427
77420	see 77427
77425	see 77427
77430	see 77427
80049	see 80048
80054	see 80053
80058	see 80076
80059	see 80074
80091	see codes for specific tests
80092	see codes for specific tests
86588	see 86403, 87081, 87430, 87880
86588QW	87880QW
90592	no replacement
90745	no replacement

LEVEL II—HCFA ASSIGNED CODES

Discontinued Code	Code(s) to Report
A4363	see A4369, A4370, A4371
D0471	no replacement
D4250	no replacement
E0452	no replacement
E0453	no replacement
E1400	see E1390
E1401	see E1390
E1402	see E1390
E1403	see E1390
E1404	see E1390
J1760	see J1750
J1770	see J1750
J1780	see J1750
J7196	no replacement
J7503	see J7516
K0109	no replacement
K0119	see J7500
K0120	see J7501
K0121	see J7515
K0122	see J7516
K0123	see J7504
K0137	see A4369
K0138	see A4370
K0139	see A4371
K0168	see A7003
K0169	see A7004
K0170	see A7005
K0171	see A7006
K0172	see A7007
K0173	see A7008
K0174	see A7009
K0175	see A7010
K0176	see A7011
K0177	see A7012
K0178	see A7013
K0179	see A7014
K0180	see A7015
K0181	see A7016
K0190	see A7000
K0191	see A7001
K0192	see A7002
K0193	no replacement
K0194	no replacement
K0277	see A4372
K0278	see A4373
K0279	see A4374
K0284	see E0779
K0400	see A4280
K0401	see A5508
K0412	see J7517
K0417	see E0780
K0418	see J7502
K0419	see A4375
K0420	see A4376
K0421	see A4377
K0422	see A4378
K0423	see A4379
K0424	see A4380
K0425	see A4381
K0426	see A4382
K0427	see A4383
K0428	see A4384
K0429	see A4385
K0430	see A4386
K0431	see A4387
K0432	see A4388
K0433	see A4389
K0434	see A4390
K0435	see A4391
K0436	see A4392
K0437	see A4393
K0438	see A4394
K0439	see A4395
K0503	see J7608
K0504	see J7618
K0505	see J7619
K0506	see J7635
K0507	see J7636
K0508	see J7628
K0509	see J7629
K0511	see J7631
K0512	see J7637
K0513	see J7638
K0514	see J7639
K0515	see J7642
K0516	see J7643
K0518	see J7644
K0519	see J7648
K0520	see J7649
K0521	see J7658
K0522	see J7659
K0523	see J7668
K0524	see J7669
K0525	see J7680
K0526	see J7681
K0527	see J7683
K0528	see J7684
K0530	see A7017
Q0068	see 36521
Q0132	see E0590

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 LMRPs." In the absence of statute, regulations, or national coverage policy, Medicare contractors 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

LMRPs affected solely by the 2000 HCPCS update are effective for services furnished **January 1, 2000** (grace period applies).

The final LMRPs (not affected by the 2000 HCPCS update) 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 **February 25, 2000**, and after, unless otherwise noted in the policy.

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 LMRP.

Maintaining Local Medical Review Policies For Reference

Providers are encouraged to maintain all published Medical Policy Procedures on file (i.e., the policies published in this document); perhaps placing them in a manual/binder where they may be accessed/referenced by facility staff.

All final LMRPs are available in their entirety on the Medicare Onlinebulletin board system. Please refer to previously published Bulletins for information about accessing the BBS. ❖

A4644: Low Osmolar Contrast Media (LOCM) - Revision to Policy

The final version of the A4644 Low Osmolar Contrast Media (LOCM) Policy was published in the Medicare Part A Bulletin G-348, September 18, 1998. Since that time, the policy has been revised to include the following indication:

Medicare of Florida may make separate payment for Low Osmolar Contrast Media (LOCM) under the following circumstance:

> For all medically necessary intrathecal radiological procedures furnished to nonhospital patients. The applicable HCPCS codes for such injections are: 70010, 70015, 72240, 72255, 72265, 72270, 72285, and 72295.

33216: Implantation Of Automatic Defibrillators

Revision Overview—The policy identifier number has been changed from 33223 to 33216. Descriptors for procedure codes 33223, 33240, 33241, 33243, 33244, 33245, 33246, and 33249 have been changed. Procedure codes 33216, 33217, 33218 and 33220 have been added. Procedure codes 33242 and 33247 have been deleted from the policy.

Description

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

Type of Bill

Hospital - 13x
Skilled Nursing Facility - 21x

Revenue Code

361 Minor Surgery

Indications and Limitations of Coverage and/or Medical Necessity

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

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

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

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

HCPCS Codes

33216	Insertion or repositioning of a transvenous electrode (15 days or more after initial insertion); single chamber (one electrode) permanent pacemaker or single chamber pacing cardioverter-defibrillator
33217	dual chamber (two electrodes) permanent pacemaker or dual chamber pacing cardioverter-defibrillator
33218	Repair of single transvenous electrode for a single chamber, permanent pacemaker or single chamber pacing cardioverter-defibrillator
33220	Repair of two transvenous electrodes for a dual chamber permanent pacemaker or dual chamber pacing cardioverter-defibrillator
33223	Revision of skin pocket for single or dual chamber pacing cardioverter-defibrillator
33240	Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator
33241	Subcutaneous removal of single or dual chamber pacing cardioverter-defibrillator pulse generator
33243	Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by thoracotomy
33244	by transvenous extraction
33245	Insertion of epicardial single or dual chamber pacing cardioverter-defibrillator electrodes by thoracotomy;
33246	with insertion of pulse generator
33249	Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator

ICD-9-CM Codes That Support Medical Necessity

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

HCPCS Section and Benefit Category

Cardiovascular System/Surgery

HCFA National Coverage Policy

Coverage Issues Manual, Section 35-85

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Sources of Information

N/A

Coding Guidelines

N/A

Documentation Requirements

Medical record documentation maintained by the performing physician must clearly indicate the medical necessity of the services being billed. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the office/progress notes, hospital notes, and/or operative report.

Other Comments

N/A

CAC Notes

N/A

Start Date of Comment Period:	N/A
Start Date of Notice Period:	**December 1999 Special Issue *Bulletin***
Original Effective Date:	11/15/1999
Revision Date/Number:	**01/01/2000** (2000 HCPCS)

Revision History:

Start Date of Comment Period:	07/06/1999
Start Date of Notice Period:	October/November 1999
Original Effective Date:	11/15/1999 ❖

33282: Insertable Loop Recorder (ILR)

Description

A 510 (k) approval (substantially equivalent device) was granted for the Medtronic Reveal® ILR on January 16, 1998, for use as "an implantable patient-activated monitoring system that records subcutaneous electrocardiogram and is indicated for patients who experience transient symptoms that may suggest a cardiac arrhythmia".

The Reveal® ILR device is implanted subcutaneously in a single incision procedure in the left pectoral or mammary location. It measures 61mm x 19mm x 8mm and weighs 17 grams. Its projected longevity is 14 months, due to a low battery condition. The manufacturer recommends that the device be removed when it is no longer clinically necessary or when the battery is depleted.

SYSTEM

Reveal® ILR: Subcutaneously placed, programmable cardiac event recorder with looping memory

Reveal® Activator: Hand-held, telemetry unit used by the patient to activate ECG storage

9790 Programmer: Used to program Reveal® ILR and retrieve, display, and print stored data

Type of Bill

Hospital - 13x

Revenue Code

278 Medical/Surgical Supplies and Devices, Other Implants

361 Minor Surgery

739 Other EKG/ECG

Indications and Limitations of Coverage and/or Medical Necessity

An insertable loop recorder (ILR) is indicated in patients with syncope or presyncope who have had recurrent but infrequent syncopal or presyncopal episodes that have defied diagnosis by conventional means. These patients will frequently have a history of injury or even hospitalization directly attributed to prior syncopal or presyncopal events. Syncope, for the purpose of this policy, is defined as a sudden but transient total loss of consciousness with spontaneous resolution.

Medicare of Florida will consider an ILR medically reasonable and necessary only if a definitive diagnosis has not been made after ALL of the following conditions have been met:

- Complete history and physical examination;
- An appropriate selective diagnostic work-up;
- Electrocardiogram; and
- A 2 to 4 week period of long-term electrocardiographic monitoring with an external loop recorder that fails to determine whether cardiac arrhythmia is the cause of recurrent syncope or presyncope.

HCPCS Codes

33282 Implantation of patient-activated cardiac event recorder (Initial implantation includes programming. For subsequent electronic analysis and/or reprogramming, use 93727)

33284 Removal of an implantable, patient-activated cardiac event recorder

93727 Electronic analysis of implantable loop recorder (ILR) system (Includes retrieval of recorded and stored ECG data, physician review and interpretation of retrieved ECG data and reprogramming)

E0616 Implantable cardiac event recorder with memory, activator and programmer

ICD-9-CM Codes That Support Medical Necessity

780.2 Syncope and collapse

HCPCS Section and Benefit Category

Cardiovascular System/Surgery/Medicine

HCFA National Coverage Policy

N/A

Reasons for Denial

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

The insertion of the ILR device for patients in whom the prerequisite studies have not been completed due to patient noncompliance.

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

Crawford, M.H., Bernstein, S.J., Deedwania, P.C., DiMarco, J.P., et. al. (1999). ACC/AHA Guidelines for Ambulatory Electrocardiography: Executive Summary and Recommendations: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Revise the Guidelines for Ambulatory Electrocardiography). *Circulation,* 100, 886-893.

Krahn, A.D., Klein, G.J., Norris, C., Yee, R. & Manda, V. (1999). The High Cost of Syncope: Cost Implications of a New Insertable Loop Recorder in the Investigation of Recurrent Syncope. *American Heart Journal,* 137 (5), 870-877.

Krahn, A.D., Klein, G.J., Norris, C., Yee, R. (1995). The Etiology of Syncope in Patients with Negative Tilt Table and Electrophysiological Testing. *Circulation,* 92, 1819-1824.

Krahn, A.D., Klein, G.J., Yee, R. (1997). Recurrent syncope. Experience with an Insertable Loop Recorder. *Cardiology Clinics,* 2, 313-326.

Krahn, A.D., Klein, G.J., Yee, R., Norris, C. (1998). The Etiology of Syncope in Patients with Negative Noninvasive and Invasive Testing: Final Results from a Pilot Study with an Implantable Loop Recorder. *American Journal of Cardiology,* 82, 117-119.

Krahn, A.D., Klein, G.J., Yee, R., Takle-Newhouse, T., Norris, C. (1999). Use of an Extended Monitoring Strategy in Patients with Problematic Syncope. *Circulation,* 99, 406-410.

Krahn, A.D., Yee, R., Klein, G.J., Skanes, AC. (1999). Syncope: Experience with the Implantable Loop Recorder. *The American College of Cardiology Current Journal Review,* 80-84.

Coding Guidelines

ILR device implantation should be coded as 33282, with revenue code 361.

IRL device removal should be coded as 33284, with revenue code 361.

ILR interrogation should be coded as 93727, with revenue code 739.

The ILR device itself should be coded as with revenue code 278.

Electrocardiogram analyses obtained during device insertion for signal quality and amplification purposes are considered part of the implant procedure and should not be separately billed.

Removal of an ILR device on the same day as the insertion of a cardiac pacemaker in any given patient is considered to be part of the pacemaker insertion procedure and will not be reimbursed separately. This limitation applies whether or not the ILR implantation site is used for the pacemaker pocket.

Documentation Requirements

Medical record documentation (e.g., office/progress notes) must be maintained by the ordering/referring physician and must support that all of the conditions for ILR coverage as set forth under the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy have been met (e.g., the prior testing performed and the results, the patient history of the syncopal or presyncopal incident and symptomatology). Additionally, documentation must also support that the service billed was actually performed (e.g., an operative note/report).

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:	08/23/99
Start Date of Notice Period:	**December 1999 Special Issue *Bulletin***
Original Effective Date:	**02/25/2000** ❖

64573: Vagus Nerve Stimulation

Revision Overview—Descriptor for procedure codes 61885, 95970, and 95971 have been changed. Procedure code 61886 has been added to the applicable sections of the policy.

Description

Vagus nerve stimulation has been shown to be an effective adjunctive therapy for persons with medically refractory partial seizures. The precise antiseizure mechanism of vagal nerve stimulation (VNS) is not clearly understood. A few theories have emerged. One theory is that general afferent projections of the vagus nerve into the limbic system produce desynchronization of brain waves, making seizures less likely to occur. Another theory is derived from the concept that chronic stimulation of the vagus nerve increases the amount of inhibitory neurotransmitters and decreases that amount of excitatory neurotransmitters.

Vagus nerve stimulation is accomplished by inserting a pulse generator into the subcutaneous pocket of the patient's chest wall, similar to a cardiac pacemaker. Another incision is made in the neck for placement of the bipolar lead. The bipolar lead has electrodes (platinum wires) that are attached around the left vagus nerve in the neck area inside the carotid sheath. The lead is then tunneled under the skin and connected to the pulse generator. The stimulating electrodes conduct signals from the generator to the vagus nerve. The implantation of the system usually takes one to three hours and is generally done under general anesthesia.

Once implanted, the generator may be programmed externally with a programming wand attached to a standard personal computer. The generator is programmed to deliver electrical current to the vagus nerve. The generator delivers intermittent stimulations, 24 hours a day, in accordance with its programming. In addition, the patient may use an external magnet to activate the generator and deliver additional stimulations.

After battery depletion, the pulse generator must be replaced. The projected battery life is approximately 3-5 years at the recommended stimulation parameters. Replacement surgery of the pulse generator usually takes about one hour and is typically done with local anesthesia. Pulse generator replacement does not of itself require lead replacement unless a lead fracture is suspected.

Type of Bill

Hospital - Outpatient 13X
Skilled Nursing Facility - 21X
Rural Health Clinic - 71X

Revenue Code

361 Minor Surgery

Indications and Limitations of Coverage and/or Medical Necessity

Medicare considers vagus nerve stimulation to be medically necessary and reasonable for the following condition:

- For patients with medically refractory partial onset seizures, for whom surgery is not recommended or for whom surgery has failed.

  A partial onset seizure has a focal onset in one area of the brain and may or may not involve a loss of motor control or alteration of consciousness. Partial onset seizures may be simple, complex, or complex partial seizures, secondarily generalized.

Patients with medically refractory partial onset seizures have failed multiple drug therapies, which includes both conventional (ex: Phenytoin, Carbamazepine, Primidone, Valproate) and new anticonvulsant drugs (ex: Felbamate, Lamotrigine, Gabapentine, Vigabatrine, Topiramate, Tiagabine) in controlling seizures and do not qualify for surgery.

HCPCS Codes

61885 Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array

61886 with connection to two or more electrode arrays

64573 Incision for implantation of neurostimulator electrodes; cranial nerve

64585 Revision or removal of peripheral neurostimulator electrodes

64590 Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling

64595 Revision or removal of peripheral neurostimulator pulse generator or receiver

95970 Electronic analysis of implanted neurostimulator pulse generator system (eg., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie., cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming

95971 simple brain, spinal cord, or peripheral (ie., peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

95974 complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour

95975 complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (list separately in addition to code for primary procedure)

ICD-9-CM Codes That Support Medical Necessity

345.41 Partial epilepsy, with impairment of consciousness, with intractable epilepsy, so stated

345.51 Partial epilepsy, without mention of impairment of consciousness, with intractable epilepsy, so stated

HCPCS Section and Benefit Category

Surgery/Nervous System/Medicine

HCFA National Coverage Policy

Coverage Issues Manual 60-22

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.

Vagus nerve stimulation is not covered for patients with other types of seizure disorders which are medically refractory and for whom surgery is not recommended or for whom surgery has failed.

Noncovered ICD-9-CM Code(s)

When CPT codes 61885, 61886, 64573, 64585, 64590, 64595, 95970, 95971, 95974, and 95975 are performed for vagus nerve stimulation, any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy will be considered noncovered.

Sources of Information

Adams, R.D. & Victor, M. (1993). *Principles of Neurology* (5th ed.). (pp. 274-282). New York: McGraw-Hill.

Ben-Menachem, E. (1996) Vagus Nerve Stimulation. *Bailliere's Clinical Neurology.* Vol. 5, (No. 4) (pp. 841-848).

Ben-Menachem, E. Manon-Espaillat, R., Ristanovic, R., Wilder, B.J., Stefan, H., Mirza, W., Tarver, W.B., Wernicke, J.F., and First International Vagus Nerve Stimulation Study Group. (1994). Vagus Nerve Stimulation for Treatment of Partial Seizures: 1. A Controlled Study of Effect on Seizures. *Epilepsia,* 35 (3), 616-626.

Berkow, R., & Fletcher, A.J. (Eds.). (1992). *The Merck Manual* (16th ed.). N.J.: Merck & Co.

Clements, S.D. (1996). Vagus nerve stimulation: Adjunctive Treatment for Patients with Medically Refractory Partial Seizures. *Journal of Neuroscience Nursing,* 28, (6), 398.

George, R., Salinsky, M., Kuzniecky, R., Rosenfeld, W., Bergen, D., Tarver, W.B., Wernicke, J.F., and First International Vagus Nerve Stimulation Study Group. (1994). Vagus Nerve Stimulation for Treatment of Partial Seizures: 3. Long-term Follow-up on First 67 Patients Exiting a Controlled Study. *Epilepsia,* 35 (3), 637-643.

Murphy, J.V., Hornig, G., & Schallert, G. (1995). Left Vagal Nerve Stimulation in Children with Refractory Epilepsy: Preliminary Observations. *Archives of Neurology,* 52, 886-889.

Ramsay, R.E., Uthman, B.M., Augustinsson, L.E., Uton, R.M., Naritoku, D., Willis, J., Treig, T., Barolat, G., Wernicke, J.F., and First International Vagus Nerve Stimulation Study Group. (1994). Vagus Nerve Stimulation for Treatment of Partial Seizures: 2. Safety, Side Effects, and Tolerability. *Epilepsia,* 35 (3), 627-636.

Salinsky, M.C., Uthman, B.M., Ristanovic, R.K., Wernicke, J.F., Tarver, W.B., and the Vagus Nerve Stimulation Study Group. (1996). Vagus nerve stimulation for the treatment of medically intractable seizures: Results of a 1-year open-extension trial. *Archives of Neurology,* 53, 1176-1180.

Takaya, M., Terry, W.J., & Naritoku, D.K. (1996). Vagus Nerve Stimulation Induces a Sustained Anticonvulsant Effect. *Epilepsia,* 37 (11), 1111-1116.

The Vagus Nerve Stimulation Study Group. (1995). A Randomized Controlled Trial of Chronic Vagus Nerve Stimulation for Treatment of Medically Intractable Seizures. *Neurology,* 45, 224-230.

Tierney, L.M. Jr., McPhee, S.J., & Papadakis, M.A. (1997). *Current: Medical Diagnosis & Treatment* (36th ed.). (pp. 897-902). CT: Appleton & Lange.

Uthman, B.M., Wilder, B.J., Penry, J.K., Dean, C., Ramsay, R.E., Reid, S.A., Hammond E.J., Tarver, W.B., Wernicke, J.F. (1993). Treatment of Epilepsy by Stimulation of the Vagus Nerve. *Neurology,* 43,1338-1345.

Coding Guidelines

A physician, usually a neurologist, typically tests the device and leads and sets the initial programming parameters, both in the operating room and in the office setting during the days/weeks following the implant. The services are coded with the following procedure codes: 95970, 95971, 95974, and/or 95975. These analysis and programming codes may be billed periodically to test and reprogram the device.

When CPT codes 61885, 61886, 64573, 64585, 64590, 64595, 95970, 95971, 95974, and 95975 are performed for vagus nerve stimulation, the appropriate diagnosis code that supports medical necessity should be submitted.

The Peer Review Organization (PRO) has medical review jurisdiction for HCPCS codes 61885, 61886, 64590, and 64595 when performed by Type of Bill 13X; however, the fiscal intermediary (FI) has medical review jurisdiction for HCPCS codes 64573, 64585, 95970, 95971, 95974, and 95975. When HCPCS codes 61885, 61886, 64590, and 64595 are performed by other Types of Bill than 13X, the FI has medical review jurisdiction.

Documentation Requirements

Documentation maintained in the patient's file should include:

- History and physical (including a neurologic history, examination, and documentation of neurologic symptomatology);
- A history of medically refractory partial onset seizures;

- Documentation of medical regimes, which should include all conventional and newer anticonvulsant medications that failed;
- Current medication regimes; and
- A description of the surgical procedure.

This information can generally be found in the office/progress notes, history and physical, and/or operative note.

Other Comments

Terms Defined:

Epilepsy—a recurrent paroxysmal disorder of cerebral function characterized by sudden, brief attacks of altered consciousness, motor activity, sensory phenomena, or inappropriate behavior caused by abnormal excessive discharge of cerebral neurons.

The term epilepsy denotes any disorder characterized by recurrent seizures. A seizure is a transient disturbance of cerebral function due to an abnormal paroxysmal neuronal discharge in the brain.

Seizures are divided into two types: partial, in which a focal or localized onset can be discerned, and general, in which the seizures appear to begin bilaterally. Seizures that begin locally often evolve into generalized seizures of either the tonic-clonic or complex partial type, in which case they are called secondarily generalized seizures.

Partial seizures are classified as simple when consciousness is retained and are classified as complex when consciousness is impaired. Simple partial seizures are further classified according to their main clinical manifestations: motor, sensory, autonomic, or psychic.

CAC Notes

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

Start Date of Comment Period:	N/A	
Start Date of Notice Period:	**December 1999 Special *Bulletin***	
Original Effective Date:	01/21/99	
Revision Date/Number:	**01/01/2000** (2000 HCPCS)	4

Revision History:

Start Date of Comment Period:	N/A	
Start Date of Notice Period:	October/November 1999 *Bulletin*	
Original Effective Date:	01/21/99	
Revision Date/Number:	11/15/99	3

Revision due to clarification from HCFA

Start Date of Comment Period:	N/A	
Start Date of Notice Period:	June/July 1999 *Bulletin*	
Original Effective Date:	01/21/99	
Revision Date/Number:	07/01/99	2

Start Date of Comment Period:	N/A	
Start Date of Notice Period:	01/21/99	
Original Effective Date:	01/21/99	
Revision Date/Number:	01/01/99 (1999 HCPCS)	1

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HCPC change occurred prior to implementation

Start Date of Comment Period:	07/17/98
Start Date of Notice Period:	12/07/98
Original Effective Date:	01/21/99 ❖

77750: Clinical Brachytherapy

Revision Overview—Type of Bill 28x has been removed from the policy. Procedure code 76873 was added to the "Coding Guidelines" section of the policy. "Rational for Creating Policy" section has been removed to correspond with the current appointed policy format.

Description

Brachytherapy, or internal radiation therapy is the method by which a radioactive substance is placed in, on or around a tumor. This can be interstitial, intracavitary, or on the surface with the radioactive substance enclosed in tubes, needles, wires, or seeds. The insertion of the radionuclide may be temporary or permanent and may be used in conjunction with external beam, or radiation therapy.

Type of Bill

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

Revenue Code

333 Radiation Therapy

Indications and Limitations of Coverage and/or Medical Necessity

Medicare Part A will consider brachytherapy to be medically necessary in documented cases of neoplasm in a patient for whom the need for a course of treatment has been established.

- Brachytherapy is used to improve control of local disease, treat areas at high risk for recurrence of malignancy, preserve vital organ function and minimize normal surrounding tissue damage.
- Transperitoneal ultrasound guided implantation of radioactive seeds is indicated in organ confined prostate cancer, Stage A and B. In general neoplasms exhibiting endoscopic evidence of extension distally beyond the verumontanum or proximally into the bladder neck or trigone are considered unsuitable. This is a permanent implant.

HCPCS Codes

77750	Infusion or instillation of radioelement solution
77761	Intracavitary radioelement application; simple
77762	intermediate
77763	complex
77776	Interstitial radioelement application; simple
77777	intermediate
77778	complex
77781	Remote afterloading high intensity brachytherapy; 1-4 source positions or catheters
77782	5-8 source positions or catheters
77783	9-12 source positions or catheters
77784	over 12 source positions or catheters
77789	Surface application of radioelement
77790	Supervision, handling, loading of radioelement
77799	Unlisted procedure, clinical brachytherapy

ICD-9-CM Codes That Support Medical Necessity

N/A

HCPCS Section and Benefit Category

Radiology

HCFA National Coverage Policy

Hospital Manual 443
Intermediary Manual 3631

Reasons for Denial

N/A

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Noncovered ICD-9-CM Code(s)

N/A

Sources of Information

Florida Radiological Society
American College of Radiology Users Guide
Current Procedural Terminology (CPT-4).
Dorlands Illustrated Medical Dictionary, 28th edition.
Philadelphia. W.B. Saunders Co.
HCFA letter 12/01/94

Coding Guidelines

The interstitial radioelement application **(77776-77778)** for cancer, e.g., Palladium 103, Iodine 125, is normally performed by a radiation oncologist and a urologist in inpatient or outpatient hospital.

Separate reimbursement would be made for the ultrasound services associated with the procedure through the appropriate ultrasonic guidance procedure code. The most appropriate procedure code for **prostatic volume study** would be:

76873	Echography, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)

This study should not be billed as an unlisted procedure and changing the procedure code to **77262** (therapeutic radiology treatment planning; simple) is inappropriate.

For services on or after 1/1/96, the following code should be used to bill for **transperineal ultrasound guided seed implantation 77776** (simple), **77777** (intermediate), **77778** (complex)

Medical Documentation Required:

- Operative Report/Procedure Report
- History and Physical
- Pathology Report

Reimbursement for procedure codes **77781-77784** (remote after loading high intensity brachytherapy) includes the cost of the expendable source used during these procedures, specifically Iridium 192 **(79900)**. Separate reimbursement will not be made.

The code selected for billing should reflect the number of ribbons or sources used.

Multiple treatment sessions on the same day are payable as long as there has been a distinct break in therapy services and the individual sessions are of the character usually furnished on different days.

The following Type of Bill must also include HCPCS 77750, 77761, 77762, 77763, 77776, 77777, 77778, 77781, 77782, 77783, 77784, 77789, 77790, 77799:

Hospital - 13X

Skilled Nursing Facility - 23X.

HCPCS codes 77750-77790 are subject to the radiology payment limit as listed in MIM Part 3 Addendum I.

Documentation Requirements

Documentation maintained in the patient's medical record must include the following:

- medical necessity for administering more than one radiation treatment delivery on the same day

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 Radiology and Oncology Societies.

Start Date of Comment Period:	N/A
Start Date of Notice Period:	**December 1999 Special Issue *Bulletin***
Original Effective Date:	03/23/98
Revision Date/Number:	01/01/2000 1 (2000 HCPCS)

Revision History:

Start Date of Comment Period:	07/03/97
Start Date of Notice Period:	02/23/98
Original Effective Date:	03/23/98 ❖

78267: Breath Test for Helicobacter Pylori (H. Pylori)

Description

Helicobacter pylori is a gram-negative rod that is adapted to survive in the highly acid gastric environment. It plays a major role in the pathogenesis of peptic ulcer disease and to the development of chronic active gastritis. H. pylori infection is an independent risk factor for gastric cancer and primary gastric malignant lymphoma.

The breath test for H. pylori is a non-invasive diagnostic procedure utilizing analysis of breath samples to determine the presence of H. pylori. The test is positive when an active H. pylori infection is present, and is negative with eradication of the infection. The breath test can detect H. pylori colonization with reported 95 percent accuracy. There are several different types of breath tests available, depending on the use of C-13 or C-14 isotope.

The carbon-13 breath test (not radioactive) consists of analysis of breath samples before and after ingestion of 13C-urea. 13C-urea will decompose to form 13CO2 and NH4 in the presence of urease, which is produced by H. pylori in the stomach. The 13CO2 is absorbed in the blood, then exhaled in the breath. The exhaled breath sample is then analyzed and compared with the baseline breath sample which was obtained before the ingestion of the 13C-urea.

The 14C-urea breath test (radioactive) is performed by having the patient swallow a capsule containing C-14 urea. A breath sample is collected in a balloon or vial 10 minutes later. The sample is then mixed with scintillation fluid and analyzed by a scintillation counter.

There are other tests that can aid in the detection of peptic ulcer disease. These include EGD (Esophagogastroduodenoscopy) with tissue examination, serum antibody test, and radiological examination.

Type of Bill

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

Revenue Codes

301 Chemistry

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider the breath test for H. pylori to be medically reasonable and necessary for the following conditions:

A patient has uncomplicated symptoms of peptic ulcer disease (i.e., epigastric pain, dyspepsia, nausea, and anorexia) and antibiotic therapy is planned if the H. pylori breath test is positive, and no gastrointestinal endoscopy has been done within the preceding six weeks or is planned;

An upper gastrointestinal contrast series has been done which shows duodenal ulcer or significant gastritis and/or duodenitis, and no endoscopy has been done within the preceding six weeks or is planned; and/or

There are persistent or recurrent symptoms six weeks after appropriate antibiotic and H3 antagonist treatment for a documented H. Pylori infection and no endoscopy has been planned.

Medicare of Florida will consider the breath test for H. Pylori not medically necessary in the following situation:

Patients who are being screened for H. Pylori infection in the absence of documented upper gastrointestinal tract symptoms and/or pathology;

Patients who have had an upper gastrointestinal endoscopy within the preceding six weeks or for whom an upper gastrointestinal endoscopy is planned;

Patients who have new onset dyspepsia responsive to conservative treatment (withdrawal of nonsteroidal anti-inflammatory drugs and/or use of anti-secretory agents);

Patients who have non-specific dyspeptic symptoms with a negative H. pylori serum antibody test, and/or

Patients who are asymptomatic after treatment of an H. pylori infection (either proven or suspected). Therefore, repeating the breath test for mere confirmation of treatment success will not be covered.

HCPCS Codes

78267	Urea breath test, C-14; acquisition for analysis; (Note: use this code for C-14 breath test only)
78268	analysis; (Note: use this code for C- 14 breath test only)
83013	Helicobacter pylori, breath test analysis (mass spectrometry); (Note: use this code for C-13 breath test only)
83014	drug administration and sample collection; (Note: use this code for C-13 breath test only)

ICD-9-CM Codes That Support Medical Necessity

151.0-151.9	Malignant neoplasm of the stomach (MALT lymphoma)
531.30-531.31	Gastric ulcer, acute without mention of hemorrhage or perforation
531.70-531.71	Gastric ulcer, chronic without mention of hemorrhage or perforation
532.30-532.31	Duodenal ulcer, acute without mention of hemorrhage or perforation
532.70-532.71	Duodenal ulcer, chronic without mention of hemorrhage or perforation
534.30-534.31	Gastrojejunal ulcer, acute without mention of hemorrhage or perforation
534.70-534.71	Gastrojejunal ulcer, chronic without mention of hemorrhage or perforation
535.00	Acute gastritis without mention of hemorrhage
535.10	Atrophic gastritis without mention of hemorrhage
789.01	Abdominal pain, right upper quadrant
789.02	Abdominal pain, left upper quadrant
789.06	Abdominal pain, epigastric

HCPCS Section and Benefit Category

Pathology and Laboratory/Radiology

HCFA National Coverage Policy

N/A

Reasons for Denial

When performed for indications other than those listed under 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" in this policy.

Sources of Information

Cutler, A.F., Havstad, S., Ma, C.K., et al. Accuracy of Invasive and Noninvasive Tests to Diagnose Helicobacter pylori Infection. *Gastroenterology.* 1995; 109: 136-141.

Faigel, D.O., Childs, M., Furth, E.E., et al. New Noninvasive Tests for Helicobacter pylori Gastritis. *Digestive Diseases and Sciences.* 1996; 41: 740-748.

Fennerty, M.B. A Review of Tests for the Diagnosis of Helicobacter Pylori Infection. *Laboratory Medicine*. 1998: 29: 561-566.

Klein, P.D., Malaty, H.M., Martin, R.F., et al. Noninvasive Detection of Helicobactor pylori Infection in Clinical Practice: The 13C Urea Breath Test. *The American Journal of Gastroenterology.* 1996; 91: 690-694.

NIH Consensus Conference. Helicobacter pylori in Peptic Ulcer Disease. *The Journal of the American Medical Association.* 1994; 272: 65-69.

Soll, A.H. Medical Treatment of Peptic Ulcer Disease. *The Journal of the American Medical Association*. 1996; 275:6-13.

Coding Guidelines

Use code 78267 (C-14) or 83013 (C-13) for isotope administration and sample collection only.

Use code 78268 (C-14) or 83013 (C-13) for the actual analysis. If the physician performs drug administration, specimen collection and analysis, then both codes (78267 and 78268 or 83013 and 83014) should be reported.

Currently, the kit used by the practitioner performing the acquisition includes the isotope. Therefore, separate reporting for provision of the radiopharmaceutical (HCPCS A4641 or code 78990) is unnecessary. Also included is a "mailer," which precludes the reporting of code 99000.

Documentation Requirements

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

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

Other Comments

N/A

CAC Notes

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

Start Date of Comment Period:	N/A
Start Date of Notice Period:	**December 1999 Special Issue *Bulletin***
Original Effective Date:	**02/25/2000** 2000 HCPCS ❖

84436: Thyroid Function Tests

Revision Overview—The policy identifier number has been changed from 80091 to 84436. All references to "thyroid panels" have been removed from the policy, including the policy name descriptor. Descriptors for procedure codes 84479 and 84480 have been changed. Procedure codes 80091 and 80092 have been deleted from the policy. "Coding Guidelines" have been removed from the policy. "Rationale for Creating Policy" section has been removed to correspond with the current appointed policy format.

Description

Thyroid function tests are standard tests used for the diagnosis of thyroid dysfunction, for investigation of conditions in which thyroid disease is in the differential diagnosis, and for the monitoring of treatment of diseases of the thyroid. Thyroid function tests include the total thyroxine (TT4), T3 resin uptake (T3 uptake), free thyroxine (FT4), triiodothyronine (TT3), free triiodothyronine (FT3), and thyroid stimulating hormone (TSH).

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

Medicare Part A will consider thyroid function tests to be medically necessary under any of the following circumstances:

- A patient has signs and symptoms of hypothyroidism which can include the following:
  - ataxia
  - bradycardia and hypothermia
  - coarseness or loss of hair
  - constipation
  - decreased concentration
  - depression
  - dry skin and cold intolerance
  - fatigue
  - goiter
  - hoarseness
  - hyperlipidemia
  - irregular or heavy menses and infertility
  - memory and mental impairment
  - myalgias
  - myxedema, fluid infiltration of tissues
  - reflex delay, relaxation phase
  - weight gain
  - yellow skin
- A patient has signs and symptoms of hyperthyroidism which can include the following:
  - alterations in appetite
  - changes in vision, photophobia, eye irritation, diplopia, or exophthalmos (proptosis)
  - dependent lower extremity edema
  - exertional intolerance and dyspnea
  - fatigue and muscle weakness
  - frequent bowel movements
  - heat intolerance and increased sweating
  - impaired fertility
  - menstrual disturbance (decreased flow)
  - mental disturbances
  - nervousness and irritability
  - palpitations and tachycardia
  - pretibial myxedema (with Graves disease)
  - sleep disturbances
  - sudden paralysis
  - thyroid enlargement/tenderness
  - tremor
  - weight loss
- Once thyroid levels have stabilized, testing would normally not be performed more than once every 6 months.
- More frequent testing is medically necessary at the time of initial diagnosis of hyperthyroidism or hypothyroidism until desired thyroid levels are achieved.
- More frequent testing may also be medically necessary if there are acute changes in the patient s condition, or if it is necessary to adjust a patient s dosage.

Note: **Once thyroid testing is performed to rule out the cause of a condition and/or symptom (i.e., malaise, hyperlipidemia, etc.) it is not considered medically necessary to repeat the test(s) unless the results indicate a thyroid disorder or the patient exhibits new symptomology.**

HCPCS Codes

84436	Thyroxine; total
84437	requiring elution (e.g., neonatal)
84439	free
84443	Thyroid stimulating hormone (TSH)
84479	Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)
84480	Triiodothyronine (T-3); total (TT-3)
84481	free
84482	reverse

ICD-9-CM Codes That Support Medical Necessity

193	Malignant neoplasm of thyroid gland
226	Benign neoplasm of thyroid glands
237.4	Neoplasm of uncertain behavior of other and unspecified endocrine glands
239.7	Neoplasm of unspecified nature, thyroid gland
240.0-240.9	Goiter specified and unspecified
241.0-241.9	Nontoxic nodular goiter
242.00-242.91	Thyrotoxicosis with or without goiter
243	Congenital hypothyroidism
244.0-244.9	Acquired hypothyroidism
245.0-245.9	Thyroiditis

246.0-246.9	Other disorders of thyroid
253.2	Panhypopituitarism
253.3-253.4	Pituitary dwarfism and other anterior pituitary disorder
253.7	Iatrogenic pituitary disorders
255.4	Corticoadrenal insufficiency up to and including polyglandular dysfunction, unspecified
272.0	Pure hypercholesterolemia
272.1	Pure hyperglyceridemia
272.2	Mixed hyperlipidemia
275.40-275.49	Disorders of calcium metabolism
276.1	Hyperosmolality and/or hyponatremia
278.01	Morbid Obesity
290.10-290.3	Presenile; Senile dementia with delusional or depressive features; with delirium
293.1	Subacute delirium
300.00-300.02	Anxiety states, up to generalized anxiety disorder
310.1	Organic personality syndrome
311	Depressive disorder, not elsewhere classified
333.1	Essential and other specified forms of tremor
356.9	Idiopathic peripheral neuropathy, unspecified
358.0	Myasthenia gravis
359.5	Myopathy in endocrine diseases classified elsewhere
368.2	Diplopia
374.41	Lid retraction or lag
376.21	Thyrotoxic exophthalmos
376.30-376.31	Unspecified and Constant exophthalmos
376.33-376.34	Orbital edema or congestion, intermittent exophthalmos
427.0	Paroxysmal supraventricular tachycardia
427.1	Paroxysmal ventricular tachycardia
427.2	Paroxysmal tachycardia, unspecified
427.31	Atrial fibrillation
427.32	Atrial Flutter
427.81-427.9	Other specified cardiac dysrhythmia
560.1	Paralytic ileus
564.0	Constipation
564.7	Megacolon, other then Hirschsprung's
625.3	Menorrhagia/dysmenorrhea
626.0-626.2	Absence of menstruation, up to and including excessive or frequent menstruation
626.4	Irregular menstrual cycle
648.10-648.14	Other current conditions in the mother, classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium, thyroid dysfunction
701.1	Keratoderma, acquired (dry skin)
703.8	Other specified diseases of nail (brittle nails)
704.00	Alopecia, unspecified
729.1	Myalgia and myositis, unspecified
729.82	Cramp of limb (muscle cramp)
733.09	Osteoporosis, drug induced
759.2	Anomalies of other endocrine glands
775.3	Neonatal thyrotoxicosis
780.09	Alteration of consciousness, other
780.50	Sleep disturbance, unspecified
780.79	Other malaise and fatigue
780.8	Excessive sweating (Hyperhidrosis)
781.3	Lack of coordination, ataxia
782.3	Edema
783.1	Abnormal weight gain
783.2	Abnormal loss of weight
783.4	Lack of expected normal physiological development
784.1	Throat pain
784.49	Other voice disturbance (hoarseness)
785.0	Tachycardia, unspecified
785.1	Palpitations
786.03-786.09	Dyspnea and respiratory abnormalities
794.5	Thyroid, abnormal scan or uptake
799.2	Nervousness

HCPCS Section and Benefit Category

Pathology and Laboratory

HCFA National Coverage Policy

N/A

Reasons for Denial

Thyroid Function Tests **(84436-84439, 84443, and 84479-84482)** are not covered by Medicare Part A if performed on a routine or screening basis in the absence of thyroid disease or abnormal signs or symptoms.

Noncovered ICD-9-CM Code(s)

All other ICD-9-CM diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section.

Sources of Information

Current Procedural Terminology (CPT-4).

1999 Physician International Classification of Diseases 9th Revision Clinical Modification.

Other Medical Carriers.

Singer, P. A., Cooper, D. S., Levy, E. G., Ladenson, P. W., Braverman, L. E., Daniels, G., et. al. (1995). Treatment Guidelines for Patients with Hyperthyroidism and Hypothyroidism**.** *The Journal of the American Medical Association,* 273, 808-812.

AACE Clinical Practice Guidelines for the Evaluation and Treatment of Hyperthyroidism and Hypothyroidism.

Abstracts of Clinical Care Guidelines-April 1995.

Mosby's Diagnostic and Laboratory Reference-Second Edition.

Coding Guidelines

N/A

Documentation Requirements

Documentation supporting the medical necessity of this procedure, such as ICD-9-CM codes, must be submitted with each claim. Claims submitted without such evidence will be denied as being not medically necessary.

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing thyroid function tests. Additionally, a copy of the test results should be maintained in the medical records.

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

Other Comments

N/A

CAC Notes

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

Start Date of Comment Period: N/A
Start Date of Notice Period: **December 1999 Special Issue *Bulletin***
Original Effective Date: 02/24/97
Revised Effective Date: **01/01/2000** 4 (2000 HCPCS)

Revision History:
Start Date of Comment Period: N/A
Start Date of Notice Period:
Original Effective Date: 02/24/97
Revised Effective Date: 10/01/98 3 (1999 ICD-9-CM Update)

Start Date of Comment Period: N/A
Start Date of Notice Period: 05/29/98 (G-333 *Bulletin*)
Original Effective Date: 02/24/97
Revised Effective Date: 07/13/98 2
Start Date of Comment Period: 07/03/97
Start Date of Notice Period: 01/23/98 (G-317 *Bulletin*)
Original Effective Date: 02/24/97
Revised Effective Date: 02/26/98 1

Establish ICD-9-CM diagnosis list that supports medical necessity.

Start Date of Comment Period: N/A
Start Date of Notice Period: 01/22/97
Original Effective Date: 02/24/97 ❖

88141: Pap Smears

Revision Overview—Descriptors for procedure codes 88148, G0147, and G0148 have been changed.

Description

Pap smear (Papanicolaou smear/test) is a cytologic examination of a vaginal smear for early detection of cancer (especially of the cervix and uterus), employing exfoliated cells and a special staining technique which differentiates diseased tissue.

Type of Bill

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

Revenue Code

311 Cytology
923 Other diagnostic services; Pap smear

Indications and Limitations of Coverage and/or Medical Necessity

Diagnostic Pap smear:

Diagnostic Pap smears and related services are covered by Medicare of Florida when ordered by a physician under one of the following conditions:

- Previous cancer of the cervix, uterus or vagina that has been or is presently being treated;
- Previous abnormal Pap smear;
- Abnormal findings of the vagina, cervix, uterus, ovaries or adnexa;
- Significant complaint pertaining to the female reproductive system; and/or
- Any signs or symptoms that the physician judges to be reasonably related to a gynecologic disorder. The contractor's medical staff determines whether a previous malignancy at another site is an indication for a diagnostic Pap smear or whether the test must be considered a screening Pap smear.

HCPCS Codes

88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
88143	with manual screening and rescreening under physician supervision
88144	with manual screening and computer-assisted rescreening under physician supervision
88145	with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
88148	screening by automated system with manual rescreening under physician supervision
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
88152	with manual screening and computer-assisted rescreening under physician supervision
88153	with manual screening and rescreening under physician supervision
88154	with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88155	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (eg., maturation index, karyopyknotic index, estrogenic index) (list separately in addition to code(s) for other technical and interpretation services)
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88165	with manual screening and rescreening under physician supervision
88166	with manual screening and computer-assisted rescreening under physician supervision
88167	with manual screening and computer-assisted rescreening using cell selection and review under physician supervision

ICD-9-CM Codes That Support Medical Necessity

016.70-016.76	Tuberculosis of other female genital organs
054.10	Genital herpes, unspecified
054.11	Herpetic vulvovaginitis
054.12	Herpetic ulceration of vulva
078.0	Molluscum contagiosum
078.10-078.19	Viral warts
090.0-099.9	Syphilis and other venereal diseases
112.1	Candidiasis of vulva and vagina
112.2	Candidiasis of other urogenital sites
131.00-131.9	Trichomoniasis
170.6	Malignant neoplasm of pelvic bones, sacrum, and coccyx,
171.6	Malignant neoplasm of pelvis
179	Malignant neoplasm of uterus, part unspecified
180.0-180.9	Malignant neoplasm of cervix uteri
181	Malignant neoplasm of placenta
182.0-182.8	Malignant neoplasm of body of uterus
183.0-183.8	Malignant neoplasm of ovary and other uterine adnexa
184.0-184.9	Malignant neoplasm of other and unspecified female genital organs
198.6	Secondary malignant neoplasm of ovary
198.82	Secondary malignant neoplasm of genital organs
218.0-218.9	Uterine leiomyoma
219.0-219.9	Other benign neoplasm of uterus
220	Benign neoplasm of ovary
221.0-221.9	Benign neoplasm of other female genital organs
233.0-233.3	Carcinoma in situ of breast and genitourinary system
233.9	Carcinoma in situ of other and unspecified urinary organs
236.3	Neoplasm of uncertain behavior of genitourinary organs

239.5	Neoplasm of unspecified nature of other genitourinary organs
256.0-256.9	Ovarian dysfunction
616.0	Cervicitis and endocervicitis
616.10-616.11	Vaginitis and vulvovaginitis
616.2	Cyst of Bartholin's gland
616.50-616.51	Ulceration of vulva
616.8	Other specified inflammatory diseases of cervix, vagina, and vulva
616.9	Unspecified inflammatory disease of cervix, vagina, and vulva
617.0	Endometriosis of uterus
617.9	Endometriosis, site unspecified
620.0	Follicular cyst of ovary
620.1	Corpus luteum cyst or hematoma
620.2	Other and unspecified ovarian cyst
620.8	Other noninflammatory disorders of ovary, fallopian tube, and broad ligament
621.0	Polyp of corpus uteri
621.1	Chronic subinvolution of uterus
621.2	Hypertrophy of uterus
621.8	Other specified disorders of uterus, not elsewhere classified
622.0	Erosion and ectropion of cervix
622.1	Dysplasia of cervix (uteri)
622.7	Mucous polyp of cervix
622.8	Other specified noninflammatory disorders of cervix
623.0	Dysplasia of vagina
623.5	Leukorrhea, not specified as infective
623.7	Polyp of vagina
623.8	Other specified noninflammatory disorders of vagina
624.6	Polyp of labia and vulva
624.8	Other specified noninflammatory disorders of vulva and perineum
626.2	Excessive or frequent menstruation
626.6	Metrorrhagia
626.7	Postcoital bleeding
626.8	Other disorders of menstruation and other abnormal bleeding from female genital tract
626.9	Unspecified disorders of menstruation and other abnormal bleeding from female genital tract
627.1	Postmenopausal bleeding
627.2	Menopausal or female climacteric states
627.3	Postmenopausal atrophic vaginitis
627.8	Other specified menopausal and postmenopausal disorders
627.9	Unspecified menopausal and postmenopausal disorder
628.0-628.9	Infertility, female
654.10-654.14	Tumors of body of uterus
795.0	Nonspecific abnormal Papanicolaou smear of cervix

Screening Pap

Screening Pap smears are covered when ordered and collected by a doctor of medicine or osteopathy, or other authorized practitioners (e.g., a certified nurse midwife, physician assistant, clinical nurse specialist or nurse practitioner) under one of the following conditions:

- If there has been no prior test for the preceding 3 years (use ICD-9-CM code V76.2);
- There is evidence (on the basis of her medical history or other findings) that she is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years (use ICD-9-CM code V15.89) ; and/or
- There is evidence (on the basis of her medical history or other findings) that she is at high risk of developing cervical or vaginal cancer (use ICD-9-CM code V15.89).

Note: Payment is not made for a screening Pap smear for women at high risk or who qualify under the childbearing provision more frequently than once every year.

The high risk factors for cervical cancer include:

- Early onset of sexual activity (under 16 years of age);
- Multiple sexual partners (five or more in a lifetime);
- History of a sexually transmitted disease (including HIV infection); and/or
- Fewer than 3 negative Pap smears within the previous 7 years.

The high risk factor for vaginal cancer includes:

- DES (diethylstilbestrol) - exposed daughters of women who took DES during pregnancy.

HCPCS Codes

G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservation fluid, automated thin layer preparation, evaluation by cytotechnologist under physician supervision
G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual evaluation and reevaluation by cytotechnologist under physician supervision
G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual evaluation and computer-assisted reevaluation by cytotechnologist under physician supervision
G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual evaluation and computer-assisted reevaluation using cell selection and review under physician supervision

G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision. This code is used to report an automated primary evaluation rather than an automated quality control step.
G0148	Screening cytopathology smears, cervical or vaginal; performed by automated system with manual re-evaluation under physician supervision. This code is used to report an automated primary evaluation rather than an automated quality control step.
P3000	Screening Papanicolaou smear, cervical or vaginal, up to three smears by technician under physician supervision

ICD-9-CM Codes That Support Medical Necessity

V15.89	Other specified personal history presenting hazards to health
V76.2	Special screening for malignant neoplasms, cervix

HCPCS Section and Benefit Category

Pathology and Laboratory

HCFA National Coverage Policy

Coverage Issues Manual 50-20
Hospital Manual 437.1
Intermediary Manual 3628.1

Reasons for Denial

Payment will not be allowed for a diagnostic Pap smear (88142-88154; 88164-88167) and a screening Pap smear (G0123, G0143-G0148; P3000) on the same date of service.

A screening Pap smear performed more than once in 3 years and high risk factors are not present.

Pap smears performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical necessity" section of the policy.

Noncovered ICD-9-CM Code(s)

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

Sources of Information

Webster's Medical Dictionary
Interpretation of Diagnostic Tests

Coding Guidelines

Code 88142 is not an add-on code. It is not appropriate to report this code in addition to a code from the 88147-88148, 88150-88154 or 88164-88167 series if the only laboratory procedures performed was a Pap smear with thin layer preparation.

Code 88155 is listed separately in addition to code(s) for other technical and interpretation services (88142-88145; 88150-88154; 88164-88167).

The applicable bill types for Screening Pap smears are: 13x, 14x, 23x and 71x. These services must be billed under Revenue code 311.

The following HCPCS codes are physician services and are to be billed to the carrier: 88141, G0124, G0141, P3001, and Q0091.

Providers may choose to bill their diagnostic Pap smears with either Revenue code 923 or 311.

Documentation Requirements

Medical record documentation (e.g., history and physical, office/progress notes, and the pathology report) maintained by the ordering/referring physician must indicate the medical necessity for performing the test. This should be maintained in the patient's permanent record, to be made available in the event of a review request.

Other Comments

A woman of childbearing age is one who is premenopausal and has been determined by a physician or other qualified practitioner to be of childbearing age, based on her medical history or other findings.

CAC Notes

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

Start Date of Comment Period:	N/A
Start Date of Notice Period:	**December 1999 Special Issues *Bulletin***
Original Effective Date:	07/22/99
Revision Date/Number:	**12/06/1999** 2 (2000 HCPCS)

Revision History:

Start Date of Comment Period:	N/A
Start Date of Notice Period:	December/January 2000 *Bulletin*
Original Effective Date:	07/22/99
Revision Date/Number:	1/17/2000 1
Start Date of Comment Period:	08/05/98
Start Date of Notice Period:	June/July 1999 Bulletin
Original Effective Date:	07/22/99 ❖

94762: Noninvasive Ear or Pulse Oximetry for Oxygen Saturation

Revision Overview—The policy identifier number has been changed from 94760 to 94762. Type of Bill 71x and 75x have been removed. "Indications and Limitations of Coverage and or Medical Necessity" section has been revised to remove references to single and multiple determinations, including procedure codes 94760 and 94761 and ICD-9-CM codes that support the medical necessity of these codes. "Coding Guidelines" section has been revised to indicate that effective January 1, 2000, procedures codes 94760 and 94761 are considered bundled services under the Medicare program. "Documentation Requirements" section has been revised to reflect documentation required for procedure code 94762. "Rationale for Creating Policy" section has been removed to correspond with the current appointed policy format.

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

Revenue Code

460 Pulmonary Function, General Classification

Indications and Limitations of Coverage and/or Medical Necessity

Continuous Overnight Monitoring:

Medicare of Florida 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.

Sources of Information

N/A

Coding Guidelines

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

Note: Effective 1/1/2000, procedure codes 94760 and 94761 are considered bundled services and, therefore, are not separately reimbursable.

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 for oxygen saturation by continuous overnight monitoring (94762). 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:	**December 1999 Special Issue *Bulletin***
Original Effective Date:	01/21/99
Revision Date/Number:	**01/01/2000** 1 (2000 HCPCS)

Revision History:

Start Date of Comment Period:	08/05/98
Start Date of Notice Period:	12/07/98
Original Effective Date:	01/21/99 - G-354 Bulletin ❖

95900: Nerve Conduction Studies

Revision Overview—Descriptors for procedure codes 95900, 95903 and 95904 have been revised.

Description

Electrodiagnostic studies can be used to determine whether a disease process is limited to a particular peripheral nerve, nerve root, portion of the brachial or lumbosacral plexus, or muscle.

The purpose of these tests is to determine any changes in NCV in various disease states. These may consist of "single nerve" conditions or conditions involving "multiple nerves". Nerves may be predominantly sensory, motor, or mixed.

- Single Nerve Syndrome
  - mononeuropathy
- Multiple Nerve Syndrome
  - inflammatory and toxic neuropathy
  - postlaminectomy syndrome
  - brachial neuritis or radiculitis
  - thoracic or lumbosacral neuritis or radiculitis, unspecified
  - diabetes with neurological manifestations*
  - hereditary and idiopathic peripheral neuropathy*

* In diabetic polyneuropathy code first the underlying disease but add the specific neurological code.

Nerve Conduction Studies are standard procedures in the study of peripheral nerve disease. The measurement of nerve conduction is useful as an initial diagnostic tool because it can distinguish major categories of disease (axonal vs. demyelinating) and can localize entrapments and other mononeuropathies. A baseline measurement makes it possible to differentiate progression of the peripheral neuropathy from other clinical conditions at future points in time.

Nerve conduction measurements involve stimulating a nerve at one point and recording the response, either at the muscle (motor nerve) or at some distance along the nerve (sensory nerve). The results of nerve conduction studies usually include latency of response, conduction velocity, and amplitude of response. The latency of response refers to the time elapsed between the start of the stimulus and the muscle response (muscle fiber depolarization) or nerve response (sensory nerve action potential). The conduction velocity between two points along the nerve is expressed in meters per second.

Type of Bill

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

Revenue Codes

920 Other Diagnostic Services, General Classification
922 Other Diagnostic Services, Electromyelgram

Indications and Limitations of Coverage and/or Medical Necessity

Nerve Conduction Studies:

Nerve conduction tests are indicated for the diagnosis of suspected, or the follow-up of, known peripheral nerve disease affecting conductivity.

Nerve conduction studies are typically used to diagnose focal neuropathies or compressive lesions such as Carpal Tunnel Syndrome or Ulnar neuropathies. They are also useful for diagnosis or confirmation of suspected generalized neuropathies, such as diabetic, uremic or metabolic neuropathies. Traumatic nerve lesions may also require nerve conduction studies for diagnosis and prognosis.

The Carrier is cognizant of the fact that patients are not always referred with a definite diagnosis in mind. Often, pain or numbness in an extremity is the reason for a nerve conduction study. Therefore, symptom-based diagnoses such as "pain in limbs" (729.5), "disturbance in skin sensation" or "paresthesia" (782.0), or "weakness" (780.7) are acceptable provided the clinical history unequivocally supports the need for a study.

Only a limited number of nerves can be tested, in practicality, and the examination must be tailored to clinical impression. Commonly evaluated nerves include:

- upper extremity- median, ulnar, radial nerve
- lower extremity- peroneal, tibial, superficial peroneal, sural nerves

Less accessible nerves in the upper extremity include the bracheal plexus and shoulder girdle nerves. In the lower extremity the lumbosacral plexus, saphenous nerve, and lateral femoral cutaneous nerve are relatively difficult to test and are usually used for patients whose clinical symptoms lead you to these areas.

Generally, the following diagnoses may be established without exceeding the motor and sensory nerve conduction unit limits given below:

Conditions	Motor NCV 95900	Sensory NCV 95904
Carpal Tunnel (unilateral)	3	4
Carpal Tunnel (bilateral)	4	4
Radiculopathy (i.e., sciatica)	3	2
Mononeuropathy	3	3
Polyneuropathy	4	4
Myopathy-muscle disease	2	2
ALS- motor neuron disease	4	2
Plexopathy	4	6
Neuromuscular Junction disorder	2	2

Repeating nerve conduction studies should be based on clinical justification. There should be evidence-based documentation for any repeat study. However, you could see nerve conduction studies repeated after the initial diagnosis has been made for the following conditions:

- for a patient with worsening signs and symptoms;
- for new trauma or injury to the affected area; and/or
- for a patient who is being managed medically for a condition and who is not showing signs of improvement using current prescribed modalities.

Repeat testing should only be performed for conditions that require medical management.

Reimbursement for (NCV) studies **95900, 95903, 95904** is limited to certain diagnosis criteria for all specialties. See Covered ICD-9-CM Codes.

HCPCS Codes

95900	Nerve conduction, amplitude and latency/ velocity study, each nerve; motor, without F-wave study
95903	motor, with F-wave study
95904	sensory or mixed

ICD-9-CM Codes That Support Medical Necessity

250.61-250.63	Diabetes with neurological manifestations
335.0-335.9	Anterior horn cell disease
337.20-337.29	Reflex sympathetic dystrophy
354.0-354.9	Mononeuritis of upper limb and mononeuritis multiplex
355.0-355.6	Mononeuritis of lower limb
355.71-355.79	Other mononeuritis of lower limb
355.8-355.9	Mononeuritis of lower limb, unspecified and of unspecified site
356.0-356.9	Hereditary and idiopathic peripheral neuropathy
357.0-357.9	Inflammatory and toxic neuropathy
359.0-359.9	Muscular dystrophies and other myopathies
722.80-722.83	Postlaminectomy syndrome
723.1	Cervicalgia
723.4	Brachial neuritis or radiculitis NOS
724.4	Thoracic or lumbosacral neuritis or radiculitis, unspecified
729.5	Pain in limb
780.79	Other malaise and fatigue (weakness, generalized)
782.0	Disturbance of skin sensation

HCPCS Section and Benefit Category

Medicine and Neurology

HCFA National Coverage Policy

CIM 50-17

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.

Consistent excessive use of units of testing, repeated testing on the same patient, or testing every patient referred for pain, weakness or paresthesia may become evident on review. In these cases, denial may occur.

Noncovered ICD-9-CM Code(s)

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

Sources of Information

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Coding Guidelines

Claims for Nerve Conduction Studies should be billed using procedure codes **95900, 95903**, and **95904**.

Current Perception Threshold Testing (neurometer CPT) is considered part of an evaluation and management service and should not be billed separately. Any claim reporting CPT Testing as nerve conduction and/or latency studies would not be appropriate and will be denied.

Segmental testing of a single nerve will not be reimbursed on a multiple unit basis. For instance, testing the ulnar nerve at the wrist, forearm, below elbow, above elbow, axilla and supraclavicular regions will all be considered as a one unit test of 95900 or 95904. Different methods of measuring the conduction in the same nerve will not be reimbursed as separate services. For instance, even if two or more methods of testing are used (as orthodromic and antidromic testing) to obtain results from a single nerve, only one unit of change will be paid.

Documentation Requirements

The clinical history and examination, carried out before the study, must always describe and document clearly and comprehensibly the need for the planned test. Documentation should include patient history for sensory and/or motor nerve dysfunction.

The patient's medical records must clearly document the medical necessity of the test and the number of nerves to be tested. This information along with the nerve conduction study results is usually found in the office/ progress notes and/or history and physical.

The performing provider, in addition to the referring provider, is responsible for determination of the appropriateness of a study.

Other Comments

Terms Defined:

Mononeuropathy—indicates a disorder of a single nerve and is often due to local causes such as trauma or entrapment as in carpal tunnel syndrome. Patients with mononeuropathies exhibit motor and/or sensory symptoms and signs due to injury of a particular nerve.

Mononeuropathy—multiplex signifies focal involvement of two or more nerves, usually as a result of generalized disorder, such as diabetes mellitus or vasculities.

Myopathies—are a diverse group of disorders characterized by primary dysfunction of skeletal muscles and include polymyositis, muscular dystrophy, and congenital, toxic and metabolic myopathies.

Neuritis—is typically reserved for inflammatory disorders of nerves resulting from infection or autoimmunity.

Neuronopathies—occur in diverse forms, at varying ages, and with varied clinical presentations. They can be both acquired and inherited. The common feature is pathophysiology of either the motor neurons in the anterior horn of the spinal cord (motor neuronopathies) or, less commonly, of the dorsal root ganglia (sensory neuronopathies).

Plexopathies—Plexi are located between the roots and peripheral nerves, and their disorders often pose a clinical challenge. The manifestations of a plexopathy may be distant from the actual site of nerve injury.

Polyneuropathies—are diseases which affect peripheral nerve axons, their myelin sheaths, or both. They are manifested by sensory, motor and autonomic signs and symptoms.

Peripheral neuropathy and polyneuropathy—are terms that describe the syndromes resulting from diffuse lesions of peripheral nerves, usually manifest by weakness, sensory loss, and autonomic dysfunction.

Reflex sympathetic dystrophy—is an excessive or abnormal response of the sympathetic nervous system to injury of the shoulder and arm, rarely the leg. Burning or aching pain following trauma to an extremity of a severity greater than that expected from the initiating injury. Pain, usually burning or aching, in an injured extremity is the single most common findings. Manifestations of vasomotor instablility are generally present and include temperature, color, and texture alterations of the skin of the involved extremity.

Radiculitis—inflammation of spinal nerve roots, accompanied by pain and hyperesthesia.

Radiculopathy—any diseased condition of roots of spinal nerves.

CAC Notes

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

Start Date of Comment Period:	N/A	
Start Date of Notice Period:	**December 1999 Special Issue Bulletin**	
Original Effective Date:	07/13/98	
Revision Date/Number:	**01/01/2000** (2000 HCPCS	3

Revision History:

Start Date of Comment Period:	N/A	
Start Date of Notice Period:	11/02/98	
Original Effective Date:	07/13/98	
Revision Date/Number:	10/01/98 (1999 ICD-9-CM Update)	2
Start Date of Comment Period:	N/A	
Start Date of Notice Period:	09/18/98	
Original Effective Date:	07/13/98	
Revision Date/Number:	09/03/98	1

This policy has been revised to add diagnoses 335.0-335.9 (anterior horn cell disease) to the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

Start Date of Comment Period:	02/23/98
Start Date of Notice Period:	05/29/98
Original Effective Date:	07/13/98 ❖

99183: Hyperbaric Oxygen Therapy (HBO Therapy)

Overview of the changes: Procedure code G0167 has been added to "Reasons for Denial" section to report non reimbursed services when performed in the absence of a physician.

Description

Hyperbaric Oxygen Therapy is a medical treatment in which the patient is entirely enclosed in a pressure chamber breathing 100% oxygen (O_2) at greater than one atmosphere (atm) pressure. Either a monoplace chamber pressurized with pure O_2 or a larger multiplace chamber pressurized with compressed air where the patient receives pure O_2 by mask, head tent, or endotracheal tube may be used.

In order to receive Medicare reimbursement for HBO therapy, the physician must be personally in constant attendance in the hyperbaric department (unit) when the patient is receiving hyperbaric oxygen therapy. This is a professional activity that cannot be delegated in that it requires independent medical judgment by the physician. The physician must be present, carefully monitoring the patient during the hyperbaric oxygen session and be immediately available should a complication occur.

Type of Bill

Hospital-13X
Skilled Nursing Facility-21X

Revenue Code

413 Respiratory Services-Hyperbaric Oxygen Therapy

Indications and Limitations of Coverage/and or Medical Necessity

HBO therapy is covered by Medicare for the following conditions:

1. *Acute carbon monoxide intoxication* induces hypoxic stress. The cardiac and central nervous systems are the most susceptible to injury from carbon monoxide. The administration of supplemental oxygen is essential treatment. Hyperbaric oxygen causes a higher rate of dissociation of carbon monoxide from hemoglobin than can occur breathing pure air at sea level pressure. The chamber compressions should be between 2.5 and 3.0 atm abs. It is not uncommon in patients with persistent neurological dysfunction to require subsequent treatments within six to eight hours, continuing once or twice daily until there is no further improvement in cognitive functioning.

2. *Decompression illness* arises from the formation of gas bubbles in tissue or blood in volumes sufficient enough to interfere with the function of an organ or to cause alteration in sensation. The cause of this enucleated gas is rapid decompression during ascent. The clinical manifestations range from skin eruptions to shock and death. The circulating gas emboli may be heard with a doppler device. Treatment of choice for decompression illness is HBO with mixed gases. The result is immediate reduction in the volume of bubbles. The treatment prescription is highly variable and case specific. The depths could range between 60 to 165 feet of sea water for durations of 1.5 to over 14 hours. The patient may or may not require repeat dives.

3. *Gas embolism* occurs when gases enter the venous or arterial vasculature embolizing in a large enough volume to compromise the function of an organ or body part. This occlusive process results in ischemia to the affected areas. Air emboli may occur as a result of surgical procedures (e.g., cardiovascular surgery, intra-aortic balloons, arthroplasties, or endoscopies), use of monitoring devices (e.g., Swan-Ganz introducer, infusion pumps), in nonsurgical patients (e.g., diving, ruptured lung in respirator-dependent patient, injection of fluids into tissue space), or traumatic injuries (e.g., gunshot wounds, penetrating chest injuries). Hyperbaric oxygen therapy is the treatment of choice. It is most effective when initiated early. Therapy is directed toward reducing the volume of gas bubbles and increasing the diffusion gradient of the embolized gas. Treatment modalities range from high pressure to low pressure mixed gas dives.

4. *Gas gangrene* is an infection caused by the clostridium bacillus, the most common being clostridium perfringens. Clostridial myositis and myonecrosis (gas gangrene) is an acute, rapidly growing invasive infection of the muscle. It is characterized by profound toxemia, extensive edema, massive death of tissue and variable degree of gas production. The most prevalent toxin is the alpha-toxin which in itself is hemolytic, tissue-necrotizing and lethal. The diagnosis of gas gangrene is based on clinical data supported by a positive gram-stained smear obtained from tissue fluids. X-ray radiographs, if obtained, can visualize tissue gas. The onset of gangrene can occur one to six hours after injury and presents with severe and sudden pain at the infected area. The skin overlying the wound progresses from shiny and tense, to dusky, then bronze in color. The infection can progress as rapidly as six inches per hour. Hemorrhagic vesicles may be noted. A thin, sweet-odored exudate is present. Swelling and edema occur. The noncontractile muscles progress to dark red to black in color.
The acute problem in gas gangrene is to stop the rapidly advancing infection caused by alpha-toxin. Medical treatment is aimed at stopping the production of alpha-toxin and to continue treatment until the advancement of the disease process has been arrested. The goal of HBO therapy is to stop alpha-toxin production thereby inhibiting further bacterial growth at which point the body can use its own host defense mechanisms. HBO treatment starts as soon as the clinical picture presents **and** is supported by a positive gram-stained smear. A treatment approach utilizing HBO, is adjunct to antibiotic therapy and surgery. Initial surgery may be limited to opening the wound. Debridement of necrotic tissue can be performed between HBO treatments when clear demarcation between dead and viable tissue is

evident. The usual treatment consists of oxygen administered at 3.0 atm abs pressure for 90 minutes three times in the first 24 hours. Over the next four to five days, treatment sessions twice a day are usual. The sooner HBO treatment is initiated, the better the outcome in terms of life, limb and tissue saving.

5. *Crush injuries* and *suturing of severed limbs, acute traumatic peripheral ischemia* (ATI), *and acute peripheral arterial insufficiency*: Acute traumatic ischemia is the result of injury by external force or violence compromising circulation to an extremity. The extremity is then at risk for necrosis or amputation. Secondary complications are frequently seen: infection, non-healing wounds, and non-united fractures.
   The goal of HBO therapy is to enhance oxygen at the tissue level to support viability. When tissue oxygen tensions fall below 30mmHg., the body's ability to respond to infection and wound repair is compromised. Using HBO at 2-2.4 atm, the tissue oxygen tension is raised to a level such that the body's responses can become functional again. The benefits of HBO therapy for this indication are enhanced tissue oxygenation, edema reduction and increased oxygen delivery per unit of blood flow thereby reducing the complication rates for infection, nonunion and amputation.
   The usual treatment schedule is three 1.5 hour treatment periods daily for the first 48 hours. Additionally, two 1.5 hour treatment sessions daily for the next 48 hours may be required. On the fifth and sixth days of treatment, one 1.5 hour session would typically be utilized. At this point in treatment, outcomes of restored perfusion, edema reduction and either demarcation or recovery would be sufficient to guide discontinuing further treatments.
   For acute traumatic peripheral ischemia, crush injuries and suturing of severed limbs, Hyperbaric Oxygen Therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures, when loss of function, limb, or life is threatened. Arterial insufficiency ulcers may be treated by HBO therapy if they are persistent after reconstructive surgery has restored large vessel function.

6. The principal treatment for **progressive necrotizing infections** (necrotizing fasciitis, meleney ulcer) is surgical debridement and systemic antibiotics. HBO therapy is recommended as an adjunct only in those settings where mortality and morbidity are expected to be high despite aggressive standard treatment.
   One of the necrotizing infections, Meleney's ulcer, is a polymicrobial (mixed aerobic-anaerobic organisms) ulcer which slowly progresses affecting the total thickness of the skin. Also called a bacterial synergistic gangrene, the Meleney ulcer is associated with the formation of burrowing cutaneous fissures and sinus tracts that emerge at distant skin sites. This ulcer presents as a wide area of pale red cellulitis that subsequently ulcerates and gradually enlarges to form a large ulcerative plaque, typically with a central area of granulation tissue encircled by gangrenous or necrotic tissue.
   Another type of progression necrotizing infection is necrotizing fasciitis. This condition is a relatively rare infection. It is usually a result of a group A streptococcal infection beginning with severe or extensive cellulitis that spreads to involve the superficial and deep fascia, producing thrombosis of the subcutaneous vessels and gangrene of the underlying tissues. A cutaneous lesion usually serves as a portal of entry for the infection, but sometimes no such lesion is found.

7. *Preparation and preservation of compromised skin grafts* utilizes HBO therapy for graft or flap salvage in cases where hypoxia or decreased perfusion have compromised viability. HBO therapy enhances flap survival. Treatments are given at a pressure of 2.0 to 2.5 atm abs lasting from 90-120 minutes. It is not unusual to receive treatments twice a day. When the graft or flap appears stable, treatments are reduced to daily. Should a graft or flap fail, HBO therapy may be used to prepare the already compromised recipient site for a new graft or flap. It does not apply to the initial preparation of the body site for a graft. HBO therapy is not necessary for normal, uncompromised skin grafts or flaps.

8. *Chronic refractory osteomyelitis* persists or recurs following appropriate interventions. These interventions include the use of antibiotics, aspiration of the abscess, immobilization of the affected extremity, and surgery. The Undersea and Hyperbaric Medical Society have defined "chronic" as existing six months or more. HBO therapy is an adjunctive therapy used with the appropriate antibiotics. Antibiotics are chosen on the basis of bone culture and sensitivity studies. HBO therapy can elevate the oxygen tensions found in infected bone to normal or above normal levels. This mechanism enhances healing and the body's antimicrobial defenses. It is believed that HBO therapy augments the efficacy of certain antibiotics (gentamicin, tobramycin, and amikacin). Finally, the body's osteoclast function of removing necrotic bone is dependent on a proper oxygen tension environment. HBO therapy provides this environment. HBO treatments are delivered at a pressure of 2.0 to 2.5 atm abs for a duration of 90-120 minutes. It is not unusual to receive daily treatments following major debridement surgery. The number of treatments required vary on an individual basis. Medicare can cover the use of HBO therapy for chronic refractory osteomyelitis that has been demonstrated to be unresponsive to conventional medical **and** surgical management.

9. HBO's use in the treatment of *osteoradionecrosis* and *soft tissue radionecrosis* is one part of an overall plan of care. Also included in this plan of care are debridement or resection of nonviable tissues in conjunction with antibiotic therapy. Soft tissue flap reconstruction and bone grafting may also be indicated. HBO treatment can be indicated both preoperatively and postoperatively.
   The patients who suffer from soft tissue damage or bone necrosis present with disabling, progressive,

painful tissue breakdown. They may present with wound dehiscence, infection, tissue loss and graft or flap loss. The goal of HBO treatment is to increase the oxygen tension in both hypoxic bone and tissue to stimulate growth in functioning capillaries, fibroblastic proliferation and collagen synthesis. The recommended daily treatments last 90-120 minutes at 2.0 to 2.5 atm abs. The duration of HBO therapy is highly individualized.

10. *Cyanide poisoning* carries a high risk of mortality. Victims of smoke inhalation frequently suffer from both carbon monoxide and cyanide poisoning. The traditional antidote for cyanide poisoning is the infusion of sodium nitrite. This treatment can potentially impair the oxygen carrying capacity of hemoglobin. Using HBO therapy as an adjunct therapy adds the benefit of increased plasma dissolved oxygen. HBO's benefit for the pulmonary injury related to smoke inhalation remains experimental. The HBO treatment protocol is to administer oxygen at 2.5 to 3.0 atm abs for up to 120 minutes during the initial treatment. Most patients with combination cyanide and carbon monoxide poisoning will receive only one treatment.
11. *Actinomycosis* is a bacterial infection caused by Actinomyces israelii. Its symptoms include slow growing granulomas that later breakdown, discharging viscid pus containing minute yellowish granules. The treatment includes prolonged administration of antibiotics (penicillin and tetracycline). Surgical incision and draining of accessible lesions is also helpful. Only after the disease process has shown refractory to antibiotics and surgery, could HBO therapy be covered by Medicare.

Prior to the initiation of HBO therapy, it is expected in most cases that the diagnosis will be established by the referring or treating physician.

Indications of effective treatment outcomes for HBO include:

- Improvement or healing of wounds.
- Improvement of tissue perfusion.
- New epithelial tissue growth and granulation.
- Tissue O_2 of at least 30 mmHg of oxygen is necessary for oxidative function to occur.
- Mechanical reduction in the bubble size of air emboli alleviates decompression sickness and gas/air emboli.
- Tissue O_2 of 40 or greater defines resolved hypoxia. The body can now resume host functions of wound healing and anti-microbial defenses without the need of HBO therapy.

HBO therapy should not be a replacement for other standard successful therapeutic measures; however, it is the treatment of choice and standard of care for decompression sickness and arterial gas embolism. Traumatic or spontaneous pneumothorax constitute contraindications to adjunctive HBO therapy only if untreated. Pregnancy is considered a contraindication to HBO therapy except in the case of carbon monoxide poisoning where it is specifically indicated.

HCPCS Codes

99183	Physician attendance and supervision of hyperbaric oxygen therapy, per session

ICD-9-CM Codes That Support Medical Necessity

039.0-039.9	Actinomycotic infections
040.0	Gas gangrene
444.21-444.22	Arterial embolism and thrombosis of arteries of the extremities
444.81	Arterial embolism and thrombosis of iliac artery
526.89	Other specified diseases of the jaws
686.01	Pyoderma gangrenosum (Meleney's ulcer)
686.09	Other pyoderma (Meleney's ulcer)
728.86	Necrotizing fasciitis
730.10-730.19	Chronic osteomyelitis
733.41-733.49	Aseptic necrosis of bone
902.53	Injury to blood vessels of iliac artery
903.01	Injury to blood vessels of axillary artery
903.1	Injury to brachial blood vessels
904.0	Injury to blood vessels of common femoral artery
904.41	Injury to blood vessels of popliteal artery
909.2	Late effect of radiation
927.00-927.09	Crushing injury of shoulder and upper arm
927.10-927.11	Crushing injury of elbow and forearm
927.20-927.21	Crushing injury of wrist and hand(s) except finger(s) alone
927.8	Crushing injury of multiple sites of upper limb
927.9	Crushing injury of unspecified site of upper limb
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
928.3	Crushing injury of toe(s)
928.8-928.9	Crushing injury of multiple sites and unspecified site of lower limb
929.0-929.9	Crushing injury of multiple and unspecified sites
958.0	Early complication of trauma; air embolism
986	Toxic effect of carbon monoxide
987.7	Toxic effect of hydrocyanic acid gas
989.0	Toxic effect of hydrocyanic acid and cyanides
990	Effects of radiation, unspecified
993.2	Other and unspecified effects of high altitude
993.3	Caisson disease
993.9	Unspecified effect of air pressure
996.52	Mechanical complication due to graft of other tissue, not elsewhere classified
996.90-996.99	Complications of reattached extremity or body part
999.1	Complications of medical care; air embolis

HCPCS Section and Benefit Category

Medicine

HCFA National Coverage Policy

Coverage Issues Manual 35-10
HCFA letter July 13, 1998 DHPP:CJ

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.
- Topical application of oxygen (Topox) does not meet the definition of HBO therapy. Also, its clinical efficacy has not been established; therefore, no reimbursement may be made.
- HBO's benefit for the pulmonary injury related to smoke inhalation remains experimental.
- National coverage policy for HBO therapy requires that a physician be present during an HBO therapy session. Services performed in the absence of a physician will not be reimbursed (G0167).

No program payment may be made for HBO in the treatment of the following conditions (per CIM 35-10):

- Cutaneous, decubitus (707.0), and stasis ulcers (454.0, 454.2)
- Chronic peripheral vascular insufficiency (443.0-443.9)
- Anaerobic septicemia and infection other than clostridial
- Skin burns (thermal)
- Senility (797)
- Myocardial infarction (410.00-412)
- Cardiogenic shock (785.51)
- Sickle cell crisis (282.62)
- Acute thermal and chemical pulmonary damage, i.e., smoke inhalation with pulmonary insufficiency
- Acute or chronic cerebral vascular insufficiency
- Hepatic necrosis (570)
- Aerobic septicemia
- Nonvascular causes of chronic brain syndrome (Pick's disease [331.1], Alzheimer's disease [331.0], Korsakoff's disease [294.0])
- Tetanus (037)
- Systemic aerobic infection
- Organ transplantation (V42.0-V42.9)
- Organ storage
- Pulmonary emphysema (492.8)
- Exceptional blood loss anemia (280.0, 285.1)
- Multiple sclerosis (340)
- Arthritic diseases
- Acute cerebral edema (348.5)

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

American College of Hyperbaric Medicine
Dorlands Illustrated Medical Dictionary, 28th edition. Philadelphia. W.B. Saunders Co.
Undersea and Hyperbaric Medical Society. (1996). *Hyperbaric Oxygen Therapy: A Committee Report.*

Coding Guidelines

Evaluation and management services and/or procedures (e.g., wound debridement, transcutaneous O_2 determinations) provided in a hyperbaric oxygen treatment facility in conjunction with a hyperbaric oxygen therapy session may be reported separately.

All Types of Bill must submit the ICD-9-CM code which represents the Beneficiary's medical condition requiring the use of hyperbaric oxygen therapy. In addition, all Types of Bill must indicate units billed. This code reflects a per session descriptor, therefore, regardless of the time HBO therapy is performed (e.g., 1 hour, 2 hours) during each session, each unit billed equals one session. The following Types of Bill must also include HCPCS 99183: Hospital 13x.

For each of the fourteen covered conditions, the following diagnosis should be utilized:

1. Acute carbon monoxide intoxication - Diagnosis 986
2. Decompression illness - Diagnosis 993.2, or 993.3
3. Gas embolism - Diagnosis 958.0, 993.9, or 999.1
4. Gas gangrene - Diagnosis 040.0
5. Acute traumatic peripheral ischemia - Diagnosis 902.53, 903.01, 903.1, 904.0 or 904.41
6. Crush injuries and suturing of severed limbs - Diagnosis 927.00-927.09, 927.10-927.11, 927.20-927.21, 927.8, 927.9, 928.00-928.01, 928.10-928.11, 928.20-928.21, 928.3, 928.8-928.9, 929.0-929.9, or 996.90-996.99
7. Progressive necrotizing infections: Meleney's ulcer-Diagnoses 686.01or 686.09, (necrotizing fasciitis) - Diagnosis 728.86
8. Acute peripheral arterial insufficiency - Diagnosis 444.21, 444.22, 444.81, or 733.41-733.49
9. Preparation and preservation of compromised skin grafts - Diagnosis 996.52
10. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management - Diagnosis 730.10-730.19
11. Osteoradionecrosis as an adjunct to conventional treatment - Diagnosis 526.89 or 909.2
12. Soft tissue radionecrosis as an adjunct to conventional treatment - Diagnosis 990
13. Cyanide poisoning - Diagnosis 987.7 or 989.0
14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment. - Diagnosis 039.0-039.9

Documentation Requirements

There must be medical documentation to support the condition for which HBO therapy is being given. Documentation for all services should be maintained on file (e.g., progress notes and treatment record) to substantiate medical necessity for HBO treatment.

This medical documentation must include:

1. An initial assessment which will include a medical history detailing the condition requiring HBO therapy. The medical history should list prior treatments and their results including antibiotic therapy and surgical interventions. This assessment should also contain information about adjunctive treatment currently being rendered.

2. Physician progress notes.
3. Any communication between physicians detailing past or future (proposed) treatments.
4. Positive gram-stain smear is required to support the diagnosis of gas gangrene.
5. Culture reports are required to confirm the diagnosis of Meleney's ulcer.
6. Definitive radiographic evidence and bone culture with sensitivity studies are required to confirm the diagnosis of osteomyelitis.
7. HBO treatment records describing the physical findings, the treatment rendered and the effect of the treatment upon the established goals for therapy.

Other Comments

N/A

CAC Notes

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

Start Date of Comment Period: N/A
Start Date of Notice Period: **December 1999 Special Issue *Bulletin***
Original Effective Date: 01/19/95 (AI)
Revised Effective Date: **01/01/2000** 11 (2000 HCPCS)

Revision History:

Start Date of Comment Period: N/A
Start Date of Notice Period: August/September 1999 *Bulletin*
Original Effective Date: 01/19/95 (AI)
Revised Effective Date: 08/26/99 10

HCFA's delay of revisions to Coverage Issues Manual 35-10 until January 1, 2000.

Start Date of Comment Period: N/A
Start Date of Notice Period:
Original Effective Date: 01/19/95 (AI)
Revised Effective Date: 05/01/99 9

The HCFA revised Coverage Issues Manual 35-10 to define the medical conditions, restate the physician supervision requirement for constant attendance and add credentialing requirements that must be met to qualify for payment. This revision was communicated through transmittals 112 and AB-99-21.

Start Date of Comment Period:
Start Date of Notice Period: 02/08/99
Original Effective Date: 01/19/95 (AI)
Revised Effective Date: 02/08/99 8

Statement of physician location during HBO session updated as was American College of Hyperbaric Medicine's statement.

Start Date of Comment Period: N/A
Start Date of Notice Period: 08/26/98
Original Effective Date: 01/19/95 (AI)
Revised Effective Date: 10/10/98 7

HCFA central office provided clarification of National policy for HBO requiring physician presence during the session.

Start Date of Comment Period: N/A
Start Date of Notice Period: N//A
Original Effective Date: 01/19/95 (AI)
Revised Effective Date: 05/29/98 6

Start Date of Comment Period: N/A
Start Date of Notice Period: 02/23/98
Original Effective Date: 01/19/95 (AI)
Revised Effective Date: 03/23/98 5

Start Date of Comment Period: 10/31/97
Start Date of Notice Period: 02/23/98
Original Effective Date: 01/19/95 (AI)
Revised Effective Date: 03/23/98 4

Start Date of Comment Period: None Needed
Start Date of Notice Period: N/A
Original Effective Date: 01/19/95 (AI)
Revised Effective Date: 10/24/97 3

A revision is necessary to reflect 1998 ICD-9-CM coding changes.

Start Date of Comment Period: None Needed
Start Date of Notice Period: N/A
Original Effective Date: 01/19/95 (AI)
Revised Effective Date: 08/29/97 2

A revision is necessary to reflect the changes in the 7-97 CIM instructions, amend ICD-9-CM codes that support medical necessity as well as clarify and define the term necrotizing infections.

Start Date of Comment Period: None Needed
Start Date of Notice Period: N/A
Original Effective Date: 01/19/95 (AI)
Revised Effective Date: 02/25/97 1

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

J0585: Botulinum Toxin Type A (Botox)

Revision Overview—Descriptor for procedure code 95870 has been revised. Statement in the "Coding Guidelines" section, regarding the reimbursement for the unused portion of the drug, has been revised for clarification.

Description

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

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

Type of Bill

Hospital: 13x
Skilled Nursing Facility: 21x, 23x
Rural Health Clinic: 71x
Comprehensive Outpatient Rehabilitation Facility: 75x

Revenue Codes

250 General Classification-CORF Providers Only
636 Drug Requiring Detailed Coding

Indications and Limitations of Coverage and/or Medical Necessity

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

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

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

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

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

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

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

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

HCPCS Codes

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

J0585 Botulinum toxin type A, per unit

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

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

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

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

HCPCS Section and Benefit Category

Drugs and Biologicals

HCFA National Coverage Policy

Medicare Carrier Manual, section 2049

Reasons for Denial

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

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

Cosmetic for the removal of wrinkles.

Noncovered ICD-9-CM Code(s)

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

Sources of Information

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

Schneider, I., Pototschnig, C., Thumfart, W., and Hans, E. Treatment of Dysfunction of the Cricopharyngeal Muscle with Botulinum A Toxin: Introduction of a New, Noninvasive Method. *Annals of OtoRhinoLaryngology*. (1994). 103(1): 31-35.

Snow, B., Tsui, J., Bhatt, M., et al. Treatment of Spasticity with Botulinum Toxin: A Double-Blind Study. *Annals of Neurology*. (1990). 28: 512-515.

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

Coding Guidelines

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

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

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

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

Due to the short life of the botulinum toxin, Medicare will reimburse the unused portion of this drug. However, documentation must show in the patient's medical record the exact dosage of the drug given and the exact amount of the discarded portion of the drug.

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

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

Documentation Requirements

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

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

Other Comments

Terms Defined:

Achalasia—The inability of a muscle to relax.

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

Chemodenervation—Nerve destruction by a clinical neurolytic agent.

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

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

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

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

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

CAC Notes

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

Start Date of Comment Period:	N/A
Start Date of Notice Period:	**December 1999 Special Issue *Bulletin***
Original Effective Date:	03/23/98
Revision Date/Number:	**01/01/2000** 3 (2000 HCPCS)

Revision History:

Start Date of Comment Period:	N/A
Start Date of Notice Period:	October/November 1999 *Bulletin*
Original Effective Date:	03/23/98
Revision Date/Number:	11/15/99 2
Start Date of Comment Period:	N/A
Start Date of Notice Period:	October/November 1999 *Bulletin*
Original Effective Date:	03/23/98
Revision Date/Number:	11/15/99 1
Start Date of Comment Period:	11/01/97
Start Date of Notice Period:	02/23/98
Original Effective Date:	03/23/98
	Bulletin G-318 ❖

J9999: Antineoplastic Drugs

Revision Overview—Procedure codes Doxorubicin Liposomal (Doxil) J9001 and Traztuzumab (Herceptin®) J9355 have added to the policy. "Coding Guidelines" section has been revised to reflect the new procedure codes.

Description

According to Medicare guidelines, certain medical services which are deemed reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are covered services. FDA approval is often one of the main criteria of Medicare's coverage guidelines for drugs and biologicals. However, in the case of chemotherapeutic agents, FDA approval does not always keep pace with clinically indicated efficacy. Therefore, the need exists to address off-label chemotherapy drug uses which have been validated by clinical trials.

The purpose of this policy is to establish the FDA approved indications of antineoplastic drugs and to indicate the circumstances under which Medicare will consider off-label uses for chemotherapy drugs to be medically reasonable and necessary, and to specify those drugs and their FDA approved and off-label uses as they become available. This policy does not restrict what providers can provide nor what beneficiaries receive. It simply defines what can be covered by Medicare in order to avoid or reduce denials for unapproved treatment.

Type of Bill

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

Revenue Codes

636 Drugs Requiring Detailed Coding

Indications and Limitations of Coverage and/or Medical Necessity

For off-label use:

Effective January 1, 1994, unlabeled uses of FDA approved drugs and biologicals used singly or in an anti-cancer regimen for a medically accepted indication are evaluated under the conditions described in the following paragraphs. A regimen is a combination of anti-cancer agents which have been clinically recognized for the treatment of a specific type of cancer. An example of a drug regimen is: Cyclophosphamide + Vincristine + Prednisone (CPV) for non-Hodgkin's lymphoma. There may be different regimens or combinations which are used at different phases of the cancer's history (induction, prophylaxis of CNS involvement, post remission, and relapsed or refractory disease). A protocol may specify the combination of drugs, doses, and schedules for administration of the drugs. For purposes of this provision, a cancer treatment regimen includes drugs used to treat toxicities or side effects of the treatment regimen when the drugs are administered incident to a chemotherapy treatment.

To evaluate the off-label uses of chemotherapeutic agents for coverage, the uses must **not** be listed as "not indicated" by HCFA, the FDA, or the compendia. Justification for approval of off-label uses must be based upon data from clinical trials in which there was a defined combination and dosage schedule, an appropriate study design, an adequate number of trial subjects, and evidence of significant increase in survival rate or life expectancy or an objective and significant decrease in tumor size or reduction in tumor-related symptoms. (**Stabilization is not considered a response to therapy.**) The unlabeled uses of a chemotherapy drug must be supported by one of the following:

- The compendia. (If an unlabeled use does not appear in the compendia or is listed there as insufficient data or investigational, the compendia will be contacted to determine whether a report is forthcoming. If a report is forthcoming, the information in that report will be used as a basis for decision making. The compendium process for making decisions regarding unlabeled uses is very thorough and continually updated).
- Phase III clinical trials.
- Clinical research that appears in peer reviewed medical literature. This includes scientific, medical, and pharmaceutical publications in which original manuscripts are published, only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This does not include in-house publications of pharmaceutical manufacturing companies or abstracts (including meeting abstracts).

  Use peer-reviewed medical literature appearing in the following publications:
  - American Journal of Medicine
  - Annals of Internal Medicine
  - The Journal of the American Medical Association
  - Journal of Clinical Oncology
  - Blood
  - Journal of the National Cancer Institute
  - The New England Journal of Medicine
  - British Journal of Cancer
  - British Journal of Hematology
  - British Medical Journal
  - Cancer
  - Drugs
  - European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology)
  - Lancet, or
  - Leukemia.

The intermediary is not required to maintain copies of these publications.

Physicians seeking to establish Medicare coverage for specific off-label uses of chemotherapeutic drugs must submit documentation from any of the above publications supporting the efficacy of each of the off-label uses to the Medicare Medical Policy and Procedures Department.

Following are chemotherapy drugs and their FDA approved and off-label uses for which Medicare of Florida considers coverage to be medically reasonable and necessary.

Doxorubicin HCL 10mg (Adriamycin PFS; Adriamycin RDF; Rubex)

Doxorubicin is an anthracycline glycoside; it is classified as an antibiotic but is not used as an antimicrobial agent. It selectively kills malignant cells and produces tumor regression in a variety of human neoplasms.

A variety of dosage schedules of Doxorubicin, alone or in combination with other antitumor agents, are used. The prescriber may consult the medical literature, as well as the manufacturer's literature, in choosing a specific dose.

Doxorubicin may be administered intravenously, intra-arterially, and as a topical bladder installation.

Doxorubicin is FDA approved for treatment of the following medical conditions:

- Acute lymphocytic (lymphoblastic) leukemia, acute nonlymphocytic (myeloblastic) leukemia, bladder carcinoma, breast carcinoma, gastric carcinoma, small cell lung carcinoma, epithelial ovarian carcinoma, thyroid carcinoma, neuroblastoma, Wilm's tumor, Hodgkin's lymphoma, non-Hodgkin's lymphoma, soft tissue sarcoma, and osteosarcoma.

Clinical trials have also demonstrated the efficacy of Doxorubicin in the treatment of additional carcinomas. Medicare of Florida will cover Doxorubicin for its FDA approved uses, as well as for treatment of the following neoplasms:

- Cervical carcinoma
- Endometrial carcinoma
- Head and neck carcinoma
- Non-small cell lung carcinoma
- Pancreatic carcinoma
- Prostatic carcinoma
- Ovarian germ cell tumors
- Ewing's sarcoma
- Multiple myeloma
- Chronic lymphocytic leukemia
- Primary hepatocelular carcinoma
- Hepatoblastoma
- Thymoma
- Gestational trophoblastic tumors
- AIDS related Kaposi's sarcoma

HCPCS Codes

J9000 Doxorubicin HCl, 10 mg.

ICD-9-CM Codes That Support Medical Necessity

150-0-150.9	Malignant neoplasm of esophagus
151.0-151.9	Malignant neoplasm of stomach
155.0	Malignant neoplasm of liver, primary
157.0-157.9	Malignant neoplasm of pancreas
160.0-160.9	Malignant neoplasm of nasal cavities, middle ear, and accessory sinuses
162.2-162.9	Malignant neoplasm of lung (non-small cell lung carcinoma)
164.0	Malignant neoplasm of thymus
170.0-170.9	Malignant neoplasm of bone and articular cartilage
171.0-171.9	Malignant neoplasm of connective and other soft tissue
174.0-174.9	Malignant neoplasm of female breast
175.0-175.9	Malignant neoplasm of male breast
176.0-176.9	Kaposi's sarcoma
180.0-180.9	Malignant neoplasm of cervix uteri
182.0	Malignant neoplasm of corpus uteri, except isthmus
183.0	Malignant neoplasm of ovary
185	Malignant neoplasm of prostate
186.0-186.9	Malignant neoplasm of testis
188.0-188.9	Malignant neoplasm of bladder
189.0	Malignant neoplasm of kidney, except pelvis
193	Malignant neoplasm of thyroid gland
195.0	Malignant neoplasm of head, face, and neck
200.00-200.88	Lymphosarcoma and reticulosarcoma
201.00-201.98	Hodgkin's disease
202.00-202.98	Other malignant neoplasms of lymphoid and histiocytic tissue (non-Hodgkin's lymphoma)
203.00-203.01	Multiple myeloma
204.00-204.01	Acute lymphoid leukemia
204.10-204.11	Chronic lymphoid leukemia
205.00-205.91	Myeloid leukemia

Doxorubicin, Liposomal (Doxil)

Doxorubicin is an anthracycline cytostatic antibiotic. Liposomal Doxorubicin is Doxorubicin excapsulated in long-circulating liposomes. Liposomes are microscopic vesicles composed of a phospholipid bilayer that are capable of encapsulating active drugs. Once within the tumor, the active ingredient Doxorubicin is presumably available to be released locally as the liposomes degrade and become permeable in situ.

Liposomal Doxorubicin is FDA approved for treatment of patients with AIDS-related Kaposi's sarcoma disease that has progressed in spite of prior combination chemotherapy or patients who are intolerant of such therapy. Clinical trials have also demonstrated the efficacy of Liposomal Doxorubicin in the treatment of an additional carcinoma. Medicare of Florida will now cover Liposomal Doxorubicin for its FDA approved use, as well as for the treatment of the following neoplasm:

- Ovarian carcinoma

HCPCS Codes

J9001 Doxorubicin hydrochloride, all lipid formulations, 10mg

ICD-9-CM Codes That Support Medical Necessity

176.0-176.9	Kaposi's sarcoma
183.0	Malignant neoplasm of ovary

Docetaxel (Taxotere®)

Docetaxel, an antineoplastic agent belonging to the taxoid family, acts by disrupting cell replication. It is a derivative of 10-deacetylbaccatin 111, a compound extracted from the needles of the European yew tree. Docetaxel acts by disrupting the microtubular network in cells, an essential component of vital mitotic and interphase cellular functions.

Taxotere is supplied as either 20 mg or 80 mg Concentrate for Infusion. The recommended dose is 60-100 mg/m2 administered intravenously over one hour every three weeks.

Taxotere is FDA approved as a frontline agent in the treatment of metastatic breast cancer when anthracycline-based therapy and other agents have failed. It is also FDA approved as a second-line treatment of AIDS-related Kaposi's sarcoma. Clinical trials have demonstrated the efficacy of Taxotere in the treatment of several additional carcinomas, as well. Medicare of Florida will now cover Taxotere for its FDA approved uses, as well as for the treatment of the following neoplasms:

- Non-small cell and small cell carcinoma of the lung
- Squamous cell carcinoma of the head and neck
- Ovarian carcinoma
- Gastric carcinoma
- Melanoma

HCPCS Codes

J9170 Docetaxel, 20 mg.

ICD-9-CM Codes That Support Medical Necessity

151.0-151.9	Malignant neoplasm of stomach
162.2-162.9	Malignant neoplasm of lung (non-small/small cell lung carcinoma)
172.0-172.9	Malignant melanoma of skin
174.0-174.9	Malignant neoplasm of female breast
175.0-175.9	Malignant neoplasm of male breast
176.0-176.9	Kaposi's sarcoma
183.0	Malignant neoplasm of ovary
195.0	Malignant neoplasm of head and neck

Gemcitabine (Gemzar®)

Gemcitabine is a deoxycytidine analogue antimetabolite which is structurally related to cytarabine. In contrast to cytarabine, it has greater membrane permeability and enzyme affinity, as well as prolonged intracellular retention. The compound acts as an inhibitor of DNA synthesis, and its mechanism of action appears to be cell-cycle specific.

Gemzar is for intravenous use only. It is supplied as 200mg of powder to be reconstituted, and should be administered by intravenous infusion at a dose of 1000mg/m2 over 30 minutes once weekly for up to 7 weeks, (or until toxicity necessitates reducing or holding a dose), followed by a week of rest from treatment. Subsequent cycles should consist of infusions once weekly for 3 consecutive weeks out of every 4 weeks. Dosage adjustment is based upon the degree of hematologic toxicity experienced by the patient.

Gemzar is FDA approved for first-line treatment of patients with advanced or metastatic adenocarcinoma of the pancreas or non-small cell lung cancer. Clinical trials have also demonstrated the efficacy of Gemzar in the treatment of an additional carcinoma. Medicare of Florida will now cover Gemzar for its FDA approved use, as well as for treatment of the following neoplasm:

- Bladder carcinoma

HCPCS Codes

J9201 Gemcitabine HCl, 200 mg.

ICD-9-CM Codes That Support Medical Necessity

157.0-157.9	Malignant neoplasm of pancreas
162.2-162.9	Malignant neoplasm of lung (non-small cell lung carcinoma)
188.0-188.9	Malignant neoplasm of bladder

Topotecan Hydrochloride (Hycamtin®)

Topotecan Hydrochloride is a semi-synthetic derivative of camptothecin and is an anti-tumor drug with topoisomerase I-inhibitory activity. Hycamtin for injection is supplied in a single dose vial containing topotecan hydrochloride equivalent to 4mg. of topotecan as free base. The reconstituted solution is intended for administration by intravenous infusion.

The cytotoxicity of topotecan is thought to be due to double strand DNA damage produced during DNA synthesis when replication enzymes interact with the ternary complex formed by topotecan, topoisomerase I, and DNA. Mammalian cells cannot efficiently repair these double strand breaks.

Hycamtin is FDA approved for treatment of metastatic carcinoma of the ovary. Clinical trials have also demonstrated the efficacy of Hycamtin in the treatment of additional carcinomas. Medicare of Florida will now cover Hycamtin for its FDA approved use, as well as for treatment of the following neoplasms:

- Non-small cell and small cell carcinoma of the lung
- Myelodysplastic syndrome (MDS)
- Chronic myelomonocytic leukemia (CMML)

HCPCS Codes

J9350 Topotecan, 4 mg.

ICD-9-CM Codes That Support Medical Necessity

162.2-162.9	Malignant neoplasm of lung (non-small/small cell lung carcinoma)
183.0	Malignant neoplasm of ovary
205.10	Chronic myeloid leukemia without mention of remission (CML)
205.11	Chronic myeloid leukemia in remission (CML)
238.7	Neoplasm of uncertain behavior of other lymphatic and hematopoietic tissues (MDS)

Trastuzumab (Herceptin®)

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

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

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

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

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

HCPCS Codes

J9355 Trastuzumab, 10mg

ICD-9-CM Codes That Support Medical Necessity

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

Denileukin Diftitox (Ontak®)

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

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

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

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

HCPCS Codes

J9999 Not otherwise classified, antineoplastic drug

ICD-9-CM Codes That Support Medical Necessity

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

HCPCS Section and Benefit Category

Chemotherapy Drugs

HCFA National Coverage Policy

Medicare Hospital Manual 442.7

Medicare Intermediary Manual 3101.3, 3112.4, 3627.9, 3627.10

Reasons for Denial

The use of Adriamycin, Doxil, Taxotere, Gemzar, Hycamtin, Herceptin, or Ontak for any clinical indication other than those outlined 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 each of the "ICD-9-CM Codes That Support Medical Necessity" sections of this policy.

Sources of Information

United States Pharmacopoeia Drug Information

Abramowicz, M. (Ed.) (1996). On Drugs and Therapeutics. *The Medical Letter*, 39. 21-24.

DeVita, V.T., Hellman, S., Rosenberg, S.A. (Eds.) (1996). *Cancer Principles and Practice of Oncology* (5th ed.). Philadelphia: J.B. Lippincott Company.

Journal Articles Pertaining To Gemzar:

Abratt, R.P., Bezwoda, W.R., Goedhals, L. And Hacking, D.J. (1997). Weekly Gemcitabine With Monthly Cisplatin: Effective Chemotherapy for Advanced Non-Small Cell Lung Cancer. *Journal of Clinical Oncology,* 15 (2), 744-749.

Crino, L., Scagliotti, G., Marangola, M., Figola, F., Clerici, M., et al. (1997). Cisplatin-Gemcitabine Combination in Advanced Non-Small Cell Lung Cancer. *Journal of Clinical Oncology*, 15 (1), 297-303.

Kelly, K. (1997). Overview of the Randomized Phase III Trials in Non-Small Cell Lung Cancer in North America. *Seminars in Oncology*, 24 (3), S8.2-S8.5.

Journal Articles Pertaining To Taxotere:

Aamdal, S., Wolff, I., Kaplan, S., et al. (1994). Docetaxel (Taxotere) In Advanced Malignant Melanoma: a Phase II Study of the EORTC Early Clinical Trials Group. *European Journal of Cancer*, 30A, 1061-1064.

Bedikian, A., Weiss, G., Legha, S., et al. (1995). Phase II Trial of Docetaxel in Patients With Advanced Cutaneous Malignant Melanoma Previously Untreated with Chemotherapy. *Journal of Clinical Oncology*, 13, 2895-2899.

Dreyfuss, A., Clark, J., Norris, C., et al. (1996) Docetaxel: An Active Drug Against Squamous Cell Carcinoma of the Head and Neck. *Journal of Clinical Oncology*, 14, 1672-1678.

Fossella, F., Lee, J., Shin, D., et al. (1995). Phase II Study of Docetaxel for Platinum-Refractory Non-Small Cell Lung Cancer. *Journal of Clinical Oncology*, 13, 645-651.

Francis, P., Schneider, J., Hann, L., et al. (1994). Phase II Trial of Docetaxel in Patients With Platinum-Refractory Advanced Ovarian Cancer. *Journal of Clinical Oncology*, 12, 2301-2308.

Miller, V., Rigas, J., Francis, P., et al. (1995). Phase II Trial of a 75-mg/m2 Dose of Docetaxel with Prednisone Premedication For Patients With Advanced Non-Small Cell Lung Cancer. *Cancer*, 75, 968-972.

Piccart, M., Gore, M., Ten Bokkel Huinink, W., et al. (1995). Docetaxel: An Active New Drug For Treatment of Advanced Epithelial Ovarian Cancer. *Journal of the National Cancer Institute*, 87, 676-681.

Smyth, J., Smith, I., Sessa, C., et al. (1994). Activity of Docetaxel in Small Cell Lung Cancer. *European Journal of Cancer*. 30A, 1058-1060.

Sulkes, A., Smyth, J., Sessa, C., et al. (1994). Docetaxel (Taxotere®) in Advanced Gastric Cancer: Results of a Phase II Clinical Trial. *British Journal of Cancer*. 70, 380-383.

Journal Articles Pertaining To Hycamtin:

Ardizzoni, A., Hansen, H., Dombernowsky, P., et al. (1997). Topotecan, a New Active Drug in the Second-Line Treatment of Small-Cell Lung Cancer: A Phase II Study in Patients With Refractory and Sensitive Disease. *Journal of Clinical Oncology,* 15 (5), 2090-2096.

Masuda, N., Fukuoka, M., Kusunoki, Y., et al. (1992). CPT-II: A New Derivative of Camptothecin for the Treatment of Refractory or Relapsed Small Cell Lung Cancer. *Journal of Clinical Oncology,* 10 (8), 1225-1229.

Perez-Soler, R., Glisson, B.S., Lee, J.S., et al. (1996). Treatment of Patients With Small Cell Lung Cancer Refractory to Etoposide and Cisplatin With the Topoisomerase I Poison Topotecan. *Journal of Clinical Oncology*, 14 (10), 2785-2790.

Schiller, J.H., Kim, K., Hutson, P., et al. (1996). Phase II Study of Topotecan in Patients With Extensive-Stage Small Cell Carcinoma of the Lung: An Eastern Cooperative Oncology Group Trial. *Journal of Clinical Oncology,* 14 (8), 2345-2352.

Coding Guidelines

When billing for Doxorubicin HCL 10mg, use HCPCS code J9000 and the appropriate ICD-9-CM diagnosis code which indicates the medical condition being treated.

When billing for Liposomal Doxorubicin, use HCPCS code **J9001** and include the name of the drug and the appropriate ICD-9-CM diagnosis code which indicates the medical condition being treated.

When billing for either Doxetaxel 80mg or Doxetaxel 20mg, use HCPCS code J9170 and include both the drug strength and the appropriate ICD-9-CM diagnosis code which indicates the medical condition being treated.

When billing for Gemcitabine 200mg, use HCPCS code J9201 and the appropriate ICD-9-CM diagnosis code which indicates the medical condition being treated.

When billing for Topotecan 4mg, use HCPCS code J9350 and the appropriate ICD-9-CM diagnosis code which indicates the medical condition being treated.

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

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

Hospitals may also use the following alpha-numeric code (in addition to the drug code):

Q0084 - Chemotherapy administration by infusion technique only, per visit. (Revenue code 335-Chemotherapy/IV)

Hospitals should **not** use HCPCS 96400-96540 to report chemotherapy, as these are non-reportable HCPCS codes.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must substantiate the medical need for the use of these chemotherapy drugs by clearly indicating the condition for which these drugs are being used. This documentation is usually found in the history and physical or in the office/progress notes.

If the provider of the service is other than the ordering/referring physician, that provider must maintain copies of the ordering/referring physician's order for the chemotherapy drug. The physician must state the clinical indication/medical need for using the chemotherapy drug in his order.

Other Comments

N/A

CAC Notes

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

Start Date of Comment Period:	N/A	
Start Date of Notice Period:	**December 1999 Special Issue *Bulletin***	
Original Effective Date:	11/02/98	
Revision Date/Number:	01/01/2000 (2000 HCPCS)	4

Revision History:

Start Date of Comment Period:	N/A	
Start Date of Notice Period:	December/January 2000 *Bulletin*	
Original Effective Date:	11/02/98	
Revision Date/Number:	01/17/2000	3

Additional indication for J9000

Start Date of Comment Period:	N/A	
Start Date of Notice Period:	August/September 1999 *Bulletin*	
Original Effective Date:	11/02/98	
Revision Date/Number:	09/23/99	2

Additional indication for J9000

Start Date of Comment Period:	02/08/99	
Start Date of Notice Period:	June/July 1999 *Bulletin*	
Original Effective Date:	11/02/98	
Revision Date/Number:	07/22/99	1

Additional off-label indications approved

Start Date of Comment Period:	05/29/98	
Start Date of Notice Period:	09/18/98 *Bulletin*	G-348
Original Effective Date:	11/02/98 ❖	

Adult Liver Transplantation: Change in Coverage

Adult liver transplantation, when performed on beneficiaries with end stage liver disease other than hepatitis B or malignancies, is a covered service under Medicare (effective July 15, 1996), when performed in a facility approved by HCFA as meeting institutional coverage criteria.

Effective December 10, 1999, HCFA national coverage policy is revised to remove hepatitis B as a noncovered condition. The ICD-9-CM codes for hepatitis B are:

070.20	070.21	070.22	070.23
070.30	070.31	070.32	070.33

Because this change is being implemented off the regular quarterly update cycle, Medicare will reopen and reprocess all claims for liver transplants with dates of service on or after December 10, 1999, in accordance with the revised policy.

A list of approved liver transplant centers in Florida was published in the *Medicare A Bulletin* G-368 on March 15,1999. An additional approved facility was identified in the October/November *Medicare A Bulletin* (page 16). ❖

2000 OUTPATIENT SERVICES FEE SCHEDULES

Outpatient Fee Schedules for Clinical Laboratory, Orthotics/Prosthetics, Surgical Dressings, Radiology, and Other Diagnostic Services

The Medicare Part A outpatient fee schedules for clinical laboratory, orthotics/prosthetics, surgical dressings, radiology, and other diagnostic services are provided via this bulletin. The fee schedule reimbursement amounts are effective for services rendered on and after January 1, 2000. However, 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.* For this reason, the Locality 01 fee schedule reimbursement information for both Radiology and Other Diagnostics is not repeated for Locality 02.

NOTE: Although the attached fee schedule listings do not reflect reimbursement in Locality 02, the Direct Data Entry (DDE) system will reflect all four (4) localities; however, localities 01 and 02 are the same fee schedule rate(s).

Fee Schedule Listings

HCFA, in conjunction with the Medicare Part B carriers, developed the attached fee schedule amounts. HCPCS for radiology (70010-79999) and other diagnostic service (90000-99199) are reimbursed by provider locality in the state of Florida. Unlike radiology and other diagnostic services, clinical laboratory, surgical dressings and orthotics/prosthetics are not reimbursed by fee schedule *locality*. These services are reimbursed based on the standard fee schedule for the State of Florida. In other words, all providers are reimbursed at the same fee schedule allowances for these services, regardless of geographic location.

Appendices A through E provide fee schedule information, including three Florida localities and keys to comprehending the fee schedule(s) for:

- Clinical Laboratory — Appendix A
- Orthotics/Prosthetics — Appendix B
- Surgical Dressings — Appendix C
- Radiology (by locality) — Appendix D
- Other Diagnostic Services (by locality) — Appendix E

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

APPENDIX A: Clinical Laboratory Fee Schedule

CODE	60%	62%	CODE	60%	62%	CODE	60%	62%
ATP02	7.20	7.44	G0143	0.00	0.00	80061	18.51	19.13
ATP03	9.18	9.49	G0144	0.00	0.00	80061QW	18.51	19.13
ATP04	9.69	10.01	G0145	0.00	0.00	80069	12.00	12.40
ATP05	10.81	11.17	G0147	0.00	0.00	80072	35.67	36.86
ATP06	10.84	11.20	G0148	0.00	0.00	80074	65.82	68.01
ATP07	11.29	11.67	P2038	6.95	7.18	80076	11.29	11.67
ATP08	11.70	12.09	P3000	7.15	7.39	80090	79.56	82.21
ATP09	12.00	12.40	P9612	3.00	3.00	80091	18.45	19.07
ATP10	12.00	12.40	P9615	3.00	3.00	80092	41.66	43.05
ATP11	12.21	12.62	Q0111	5.90	6.10	80100	20.10	20.77
ATP12	12.48	12.90	Q0112	5.90	6.10	80101	19.03	19.66
ATP16	14.61	15.10	Q0113	7.47	7.72	80101QW	19.03	19.66
ATP18	14.71	15.20	Q0114	9.88	10.21	80102	18.31	18.92
ATP19	15.28	15.79	Q0115	13.68	14.14	80150	20.83	21.52
ATP20	15.78	16.31	78267	10.86	11.22	80152	24.74	25.56
ATP21	16.27	16.81	78268	93.09	96.19	80154	25.56	26.41
ATP22	16.77	17.33	80048	11.70	12.09	80156	20.12	20.79
G0001	3.00	3.00	80049	11.29	11.67	80158	24.05	24.85
G0026	5.90	6.10	80051	9.69	10.01	80160	23.79	24.58
G0027	8.99	9.29	80053	14.61	15.10	80162	18.35	18.96
G0103	25.42	26.27	80054	14.61	15.10	80164	18.72	19.34
G0107	3.50	3.62	80058	10.84	11.20	80166	21.42	22.13
G0123	0.00	0.00	80059	82.62	85.37	80168	22.58	23.33

APPENDIX A: Clinical Laboratory Fee Schedule (continued)

CODE	60%	62%
80170	22.65	23.41
80172	22.52	23.27
80174	23.79	24.58
80176	16.08	16.62
80178	9.13	9.43
80182	18.72	19.34
80184	15.83	16.36
80185	18.32	18.93
80186	19.03	19.66
80188	22.93	23.69
80190	23.15	23.92
80192	23.15	23.92
80194	20.17	20.84
80196	9.81	10.14
80197	18.97	19.60
80198	19.56	20.21
80200	22.27	23.01
80201	16.48	17.03
80202	18.72	19.34
80299	18.92	19.55
80400	45.06	46.56
80402	120.14	124.14
80406	108.14	111.74
80408	173.44	179.22
80410	111.03	114.73
80412	455.46	470.64
80414	71.36	73.74
80415	77.24	79.81
80416	182.40	188.48
80417	60.80	62.83
80418	800.92	827.62
80420	99.54	102.86
80422	63.69	65.81
80424	65.84	68.03
80426	205.16	212.00
80428	92.16	95.23
80430	108.42	112.03
80432	175.51	181.36
80434	139.75	144.41
80435	142.30	147.04
80436	125.98	130.18
80438	69.63	71.95
80439	92.84	95.93
80440	80.34	83.02
81000	4.37	4.52
81001	4.37	4.52
81002	3.54	3.66
81003	3.10	3.20
81003QW	3.10	3.20
81005	3.00	3.10
81007	3.55	3.67
81015	3.98	4.11
81020	5.09	5.26
81025	8.74	9.03
81050	4.14	4.28
82000	17.12	17.69
82003	27.96	28.89
82009	6.25	6.46
82010	9.88	10.21
82013	15.44	15.95
82016	19.16	19.80
82017	23.31	24.09
82024	53.38	55.16
82030	17.88	18.48
82040	5.67	5.86
82042	2.43	2.51
82043	2.43	2.51
82044	6.33	6.54
82044QW	6.33	6.54
82055	14.93	15.43
82075	16.66	17.22
82085	13.42	13.87
82088	56.32	58.20
82101	41.48	42.86
82103	18.56	19.18
82104	19.98	20.65
82105	23.18	23.95
82106	23.18	23.95
82108	35.22	36.39
82120	3.98	4.11
82120QW	3.98	4.11
82127	19.16	19.80
82128	19.16	19.80
82131	23.31	24.09
82135	22.75	23.51
82136	23.31	24.09
82139	23.31	24.09
82140	20.14	20.81
82143	9.50	9.82
82145	21.48	22.20
82150	8.96	9.26
82154	39.85	41.18
82157	40.46	41.81
82160	34.57	35.72
82163	28.37	29.32
82164	20.17	20.84
82172	19.58	20.23
82175	26.22	27.09
82180	13.66	14.12
82190	16.89	17.45
82205	15.83	16.36
82232	22.36	23.11
82239	23.67	24.46
82240	24.05	24.85
82247	6.94	7.17
82248	6.94	7.17
82252	2.70	2.79
82261	23.31	24.09
82270	3.50	3.62
82273	4.49	4.64
82273QW	4.49	4.64
82286	9.52	9.84
82300	13.11	13.55
82306	40.91	42.27
82307	44.53	46.01
82308	37.01	38.24
82310	7.12	7.36
82330	18.88	19.51
82331	7.15	7.39
82340	8.34	8.62
82355	15.99	16.52
82360	12.09	12.49
82365	17.11	17.68
82370	17.32	17.90
82374	6.76	6.99
82375	17.03	17.60
82376	7.85	8.11
82378	26.22	27.09
82379	23.31	24.09
82380	12.75	13.18
82382	23.76	24.55
82383	34.63	35.78
82384	32.92	34.02
82387	28.75	29.71
82390	14.84	15.33
82397	19.53	20.18
82415	17.51	18.09
82435	6.35	6.56
82436	4.50	4.65
82438	6.76	6.99
82441	8.30	8.58
82465	6.02	6.22
82465QW	6.02	6.22
82480	9.82	10.15
82482	8.22	8.49
82485	19.80	20.46
82486	24.09	24.89
82487	19.80	20.46
82489	19.80	20.46
82491	24.09	24.89
82492	24.09	24.89
82495	28.03	28.96
82507	38.43	39.71
82520	20.94	21.64
82523	25.83	26.69
82525	17.15	17.72
82528	31.11	32.15
82530	23.10	23.87
82533	22.53	23.28
82540	6.40	6.61
82541	24.09	24.89
82542	24.09	24.89
82543	24.09	24.89
82544	24.09	24.89
82550	9.01	9.31
82552	18.51	19.13
82553	12.86	13.29
82554	12.86	13.29
82565	7.07	7.31
82570	7.15	7.39
82575	13.06	13.50
82585	11.85	12.25
82595	8.95	9.25
82600	26.81	27.70
82607	20.83	21.52
82608	19.80	20.46
82615	11.29	11.67
82626	34.93	36.09
82627	30.72	31.74
82633	42.81	44.24
82634	40.46	41.81
82638	16.92	17.48
82646	27.51	28.43
82649	35.52	36.70
82651	35.68	36.87
82652	53.19	54.96
82654	18.90	19.53
82657	24.09	24.89
82658	24.09	24.89
82666	29.69	30.68
82668	25.97	26.84
82670	38.62	39.91
82671	44.64	46.13
82672	29.97	30.97
82677	33.43	34.54
82679	34.50	35.65
82690	21.75	22.48
82693	13.60	14.05
82705	7.04	7.27
82710	21.88	22.61
82715	23.79	24.58
82725	11.95	12.35
82726	24.09	24.89
82728	18.83	19.46

APPENDIX A: Clinical Laboratory Fee Schedule (continued)

CODE	60%	62%
82731	20.83	21.52
82735	12.48	12.90
82742	27.36	28.27
82746	20.32	21.00
82747	4.25	4.39
82757	16.71	17.27
82759	29.69	30.68
82760	15.47	15.99
82775	29.11	30.08
82776	11.59	11.98
82784	12.85	13.28
82785	22.76	23.52
82787	17.22	17.79
82800	4.83	4.99
82803	26.74	27.63
82805	39.21	40.52
82810	12.06	12.46
82820	13.82	14.28
82926	7.53	7.78
82928	7.24	7.48
82938	24.46	25.28
82941	24.38	25.19
82943	19.75	20.41
82946	20.83	21.52
82947	5.42	5.60
82947QW	5.42	5.60
82948	4.37	4.52
82950	6.56	6.78
82950QW	6.56	6.78
82951	17.80	18.39
82951QW	17.80	18.39
82952	5.42	5.60
82952QW	5.42	5.60
82953	6.56	6.78
82955	13.40	13.85
82960	8.03	8.30
82962	4.37	4.52
82963	29.69	30.68
82965	7.20	7.44
82975	21.88	22.61
82977	9.95	10.28
82978	19.70	20.36
82979	9.52	9.84
82980	24.05	24.85
82985	20.83	21.52
82985QW	20.83	21.52
83001	25.69	26.55
83002	25.60	26.45
83003	23.04	23.81
83008	23.20	23.97
83010	17.38	17.96
83012	23.76	24.55
83013	93.09	96.19
83014	10.86	11.22
83015	26.03	26.90
83018	30.35	31.36
83020	17.80	18.39
83021	24.09	24.89
83026	3.26	3.37
83030	11.43	11.81
83033	6.43	6.64
83036	13.42	13.87
83036QW	13.42	13.87
83045	4.83	4.99
83050	5.80	5.99
83051	10.10	10.44
83055	6.80	7.03
83065	5.93	6.13
83068	11.71	12.10
83070	6.56	6.78
83071	9.50	9.82
83080	23.31	24.09
83088	40.81	42.17
83150	17.11	17.68
83491	24.21	25.02
83498	37.54	38.79
83499	34.83	35.99
83505	33.59	34.71
83516	15.95	16.48
83519	18.67	19.29
83520	17.89	18.49
83525	15.81	16.34
83527	17.90	18.50
83528	21.98	22.71
83540	8.95	9.25
83550	12.08	12.48
83570	12.22	12.63
83582	19.59	20.24
83586	17.69	18.28
83593	36.35	37.56
83605	14.76	15.25
83615	8.35	8.63
83625	17.69	18.28
83633	7.61	7.86
83634	11.05	11.42
83661	27.26	28.17
83662	26.14	27.01
83670	12.66	13.08
83690	9.52	9.84
83715	15.56	16.08
83718	11.31	11.69
83718QW	11.31	11.69
83719	16.08	16.62
83721	13.18	13.62
83735	9.26	9.57
83775	10.19	10.53
83785	33.98	35.11
83788	24.09	24.89
83789	24.09	24.89
83805	24.36	25.17
83825	22.47	23.22
83840	22.56	23.31
83857	14.84	15.33
83858	18.52	19.14
83864	27.51	28.43
83866	13.62	14.07
83872	8.10	8.37
83874	17.84	18.43
83883	18.79	19.42
83885	7.85	8.11
83890	3.52	3.64
83891	3.52	3.64
83892	3.52	3.64
83893	3.52	3.64
83894	3.52	3.64
83896	3.52	3.64
83897	3.52	3.64
83898	23.17	23.94
83901	23.17	23.94
83902	15.00	15.50
83903	23.17	23.94
83904	23.17	23.94
83905	23.17	23.94
83906	23.17	23.94
83912	3.52	3.64
83916	27.12	28.02
83918	20.96	21.66
83919	20.96	21.66
83925	26.89	27.79
83930	9.13	9.43
83935	9.42	9.73
83937	28.42	29.37
83945	17.80	18.39
83970	57.04	58.94
83986	4.95	5.12
83986QW	4.95	5.12
83992	20.31	20.99
84022	21.53	22.25
84030	7.61	7.86
84035	5.05	5.22
84060	10.20	10.54
84066	13.35	13.80
84075	7.15	7.39
84078	10.09	10.43
84081	22.84	23.60
84085	9.32	9.63
84087	11.19	11.56
84100	6.56	6.78
84106	5.92	6.12
84110	11.68	12.07
84119	11.90	12.30
84120	20.33	21.01
84127	16.10	16.64
84132	6.35	6.56
84133	5.94	6.14
84135	26.44	27.32
84138	26.16	27.03
84140	23.27	24.05
84143	31.54	32.59
84146	26.78	27.67
84150	34.50	35.65
84153	25.42	26.27
84154	25.42	26.27
84155	5.06	5.23
84160	7.15	7.39
84165	14.84	15.33
84181	23.54	24.32
84182	24.87	25.70
84203	10.55	10.90
84206	18.52	19.14
84207	25.72	26.58
84210	15.01	15.51
84220	7.20	7.44
84228	7.85	8.11
84233	89.01	91.98
84235	72.31	74.72
84238	50.53	52.21
84244	30.40	31.41
84252	17.62	18.21
84260	20.96	21.66
84270	11.05	11.42
84275	10.17	10.51
84285	32.55	33.64
84295	6.65	6.87
84305	27.25	28.16
84307	21.37	22.08
84311	9.66	9.98
84315	3.46	3.58
84376	7.61	7.86
84377	7.61	7.86
84378	11.05	11.42

APPENDIX A: Clinical Laboratory Fee Schedule (continued)

CODE	60%	62%
84379	11.05	11.42
84402	35.19	36.36
84403	35.68	36.87
84425	12.09	12.49
84430	16.08	16.62
84432	22.20	22.94
84436	9.50	9.82
84437	7.85	8.11
84439	12.46	12.88
84442	20.44	21.12
84443	23.21	23.98
84445	24.05	24.85
84449	20.82	21.51
84450	7.14	7.38
84460	7.32	7.56
84466	17.65	18.24
84478	7.95	8.22
84478QW	7.95	8.22
84480	19.60	20.25
84481	21.73	22.45
84482	21.73	22.45
84485	9.90	10.23
84488	9.90	10.23
84490	9.90	10.23
84510	12.09	12.49
84512	7.50	7.75
84520	5.45	5.63
84540	6.56	6.78
84545	9.12	9.42
84550	6.25	6.46
84560	6.56	6.78
84577	17.24	17.81
84578	4.48	4.63
84580	9.81	10.14
84583	6.95	7.18
84585	21.42	22.13
84586	26.52	27.40
84588	46.91	48.47
84590	16.02	16.55
84597	9.66	9.98
84600	22.21	22.95
84620	16.37	16.92
84630	15.74	16.26
84681	26.52	27.40
84703	10.38	10.73
84703QW	10.38	10.73
84830	13.87	14.33
85002	6.22	6.43
85007	4.76	4.92
85009	5.14	5.31
85013	3.27	3.38
85014	3.27	3.38
85014QW	3.27	3.38
85018QW	3.27	3.38
85021	7.72	7.98
85022	7.59	7.84
85023	11.71	12.10
85024	11.70	12.09
85025	10.74	11.10
85027	8.95	9.25
85041	4.16	4.30
85044	5.94	6.14
85046	7.72	7.98
85048	3.52	3.64
85130	16.44	16.99
85170	5.00	5.17
85175	6.28	6.49
85210	8.03	8.30
85220	24.39	25.20
85230	24.75	25.58
85240	24.75	25.58
85244	28.22	29.16
85246	31.72	32.78
85247	31.72	32.78
85250	26.31	27.19
85260	24.75	25.58
85280	26.74	27.63
85290	22.58	23.33
85291	12.28	12.69
85292	7.20	7.44
85293	7.20	7.44
85300	8.03	8.30
85301	14.95	15.45
85302	16.61	17.16
85303	19.11	19.75
85305	16.02	16.55
85335	17.80	18.39
85337	14.41	14.89
85345	5.94	6.14
85348	5.14	5.31
85360	11.05	11.42
85362	9.52	9.84
85366	11.90	12.30
85370	14.67	15.16
85378	9.86	10.19
85379	14.06	14.53
85384	11.74	12.13
85385	11.74	12.13
85390	6.56	6.78
85400	12.22	12.63
85410	10.66	11.02
85415	13.11	13.55
85420	9.04	9.34
85421	14.07	14.54
85445	9.42	9.73
85460	10.69	11.05
85461	9.17	9.48
85475	12.26	12.67
85520	13.11	13.55
85525	13.11	13.55
85535	8.95	9.25
85540	11.88	12.28
85547	11.88	12.28
85549	25.92	26.78
85555	9.24	9.55
85557	18.46	19.08
85576	29.69	30.68
85585	3.98	4.11
85590	5.94	6.14
85595	6.18	6.39
85597	24.84	25.67
85610	5.43	5.61
85610QW	5.43	5.61
85611	5.45	5.63
85612	13.22	13.66
85635	13.61	14.06
85651	4.91	5.07
85652	3.73	3.85
85660	7.63	7.88
85670	7.98	8.25
85675	6.43	6.64
85705	11.05	11.42
85730	8.30	8.58
85732	8.95	9.25
85810	16.14	16.68
86000	9.65	9.97
86003	7.22	7.46
86005	11.02	11.39
86021	20.80	21.49
86022	25.38	26.23
86023	17.21	17.78
86038	16.70	17.26
86039	15.43	15.94
86060	10.09	10.43
86063	7.98	8.25
86140	7.15	7.39
86147	22.87	23.63
86148	22.20	22.94
86155	22.08	22.82
86156	9.26	9.57
86157	11.14	11.51
86160	16.59	17.14
86161	16.59	17.14
86171	13.85	14.31
86185	12.37	12.78
86215	18.32	18.93
86225	18.99	19.62
86235	24.78	25.61
86243	28.36	29.31
86255	16.66	17.22
86256	16.66	17.22
86277	21.75	22.48
86280	11.31	11.69
86308	7.15	7.39
86308QW	7.15	7.39
86309	8.95	9.25
86310	10.19	10.53
86316	28.19	29.13
86318	17.89	18.49
86318QW	17.89	18.49
86320	30.98	32.01
86325	30.90	31.93
86327	31.35	32.40
86329	19.40	20.05
86331	16.56	17.11
86332	33.68	34.80
86334	30.87	31.90
86337	29.59	30.58
86340	20.83	21.52
86341	27.34	28.25
86343	17.22	17.79
86344	11.04	11.41
86359	4.42	4.57
86360	9.66	9.98
86361	5.80	5.99
86376	20.11	20.78
86378	27.22	28.13
86382	23.36	24.14
86384	15.74	16.26
86406	14.70	15.19
86430	7.85	8.11
86431	7.85	8.11
86588QW	13.05	13.49

APPENDIX B: Orthotics/Prosthetics Fee Schedule

CODE	FEE	CODE	FEE	CODE	FEE	CODE	FEE
A4214	1.67	A4398	13.17	K0427	26.89	L0940	113.65
A4280	4.71	A4399	11.70	K0428	9.18	L0950	291.65
A4310	6.26	A4400	39.63	K0429	4.86	L0960	65.48
A4311	12.04	A4402	1.35	K0430	6.41	L0970	81.25
A4312	17.20	A4404	1.61	K0431	3.83	L0972	83.05
A4313	15.02	A4454	2.49	K0432	4.16	L0974	169.70
A4314	20.50	A4455	1.16	K0433	5.93	L0976	151.56
A4315	21.39	A4481	0.36	K0434	9.17	L0978	136.84
A4316	23.03	A4483	0.00	K0435	6.74	L0980	12.41
A4320	5.08	A4560	18.47	K0436	6.34	L0982	13.52
A4321	0.00	A4622	54.63	K0437	8.75	L0984	43.15
A4322	2.69	A4623	6.25	K0438	2.46	L1000	1443.28
A4323	7.68	A4625	6.61	K0439	0.05	L1010	58.12
A4326	10.29	A4626	2.59	L0100	432.50	L1020	79.41
A4327	40.32	A4629	4.42	L0110	127.60	L1025	90.25
A4328	9.40	A5051	2.08	L0120	21.39	L1030	60.30
A4329	24.30	A5052	1.59	L0130	154.64	L1040	72.58
A4330	6.82	A5053	1.60	L0140	53.37	L1050	62.85
A4338	11.70	A5054	1.60	L0150	88.99	L1060	70.88
A4340	30.28	A5055	1.37	L0160	126.69	L1070	72.47
A4344	15.28	A5061	2.58	L0170	536.13	L1080	50.21
A4346	18.69	A5062	2.00	L0172	108.71	L1085	139.50
A4347	16.50	A5063	2.07	L0174	195.29	L1090	65.17
A4351	1.73	A5071	3.53	L0180	265.60	L1100	115.03
A4352	5.20	A5072	2.86	L0190	399.80	L1110	194.84
A4353	6.66	A5073	2.61	L0200	367.11	L1120	31.04
A4354	9.56	A5081	3.14	L0210	38.10	L1200	1235.45
A4355	7.23	A5082	9.64	L0220	87.07	L1210	186.01
A4356	43.52	A5093	1.86	L0300	143.73	L1220	157.49
A4357	9.25	A5102	21.53	L0310	268.59	L1230	404.11
A4358	6.33	A5105	33.05	L0315	186.94	L1240	69.55
A4359	27.67	A5112	33.02	L0317	253.61	L1250	68.48
A4361	17.52	A5113	4.48	L0320	292.17	L1260	70.37
A4362	3.23	A5114	7.69	L0330	366.31	L1270	70.27
A4363	3.75	A5119	10.35	L0340	583.64	L1280	62.65
A4364	2.50	A5121	6.05	L0350	812.84	L1290	71.03
A4365	10.80	A5122	12.26	L0360	1199.38	L1300	1187.49
A4367	7.01	A5123	4.60	L0370	327.36	L1310	1221.94
A4368	0.25	A5126	1.07	L0380	459.42	L1500	1350.32
A4369	2.30	A5131	12.86	L0390	1012.27	L1510	854.27
A4370	3.27	A5200	10.77	L0400	1160.42	L1520	2029.03
A4371	3.48	E0751	5678.88	L0410	1353.03	L1600	91.61
A4372	3.98	E0753	1323.96	L0420	1340.34	L1610	31.21
A4373	5.99	K0112	227.46	L0430	1063.26	L1620	102.78
A4374	8.05	K0113	138.74	L0440	867.14	L1630	122.64
A4375	16.38	K0137	2.30	L0500	107.14	L1640	328.03
A4376	45.38	K0138	3.27	L0510	218.10	L1650	173.95
A4377	4.09	K0139	3.48	L0515	130.10	L1660	121.66
A4378	29.33	K0277	3.98	L0520	319.98	L1680	1000.22
A4379	14.33	K0278	5.99	L0530	294.51	L1685	1055.40
A4380	35.60	K0279	8.05	L0540	317.83	L1686	708.03
A4381	4.40	K0280	3.04	L0550	953.75	L1690	1478.17
A4382	23.48	K0281	0.12	L0560	1043.57	L1700	1229.74
A4383	26.89	K0400	4.71	L0565	1040.64	L1710	1445.49
A4384	9.18	K0407	2.10	L0600	68.15	L1720	1067.78
A4385	4.86	K0408	4.71	L0610	184.81	L1730	805.63
A4386	6.41	K0409	6.04	L0620	308.16	L1750	139.86
A4387	3.83	K0410	2.07	L0700	1645.77	L1755	1172.58
A4388	4.16	K0411	1.72	L0710	1796.47	L1800	63.05
A4389	5.93	K0419	16.38	L0810	1908.48	L1810	92.55
A4390	9.17	K0420	45.38	L0820	1543.88	L1815	84.81
A4391	6.74	K0421	4.09	L0830	2229.20	L1820	92.17
A4392	6.34	K0422	29.33	L0860	866.03	L1825	41.09
A4393	8.75	K0423	14.33	L0900	141.86	L1830	77.11
A4394	2.46	K0424	35.60	L0910	283.37	L1832	576.27
A4395	0.05	K0425	4.40	L0920	160.87	L1834	677.96
A4397	3.94	K0426	23.48	L0930	329.41	L1840	712.65

APPENDIX B: Orthotics/Prosthetics Fee Schedule (continued)

CODE	FEE	CODE	FEE	CODE	FEE	CODE	FEE
L1843	685.87	L2260	142.51	L3700	48.56	L4070	215.55
L1844	1188.46	L2265	83.72	L3710	100.86	L4080	75.98
L1845	715.99	L2270	38.18	L3720	503.20	L4090	67.26
L1846	897.37	L2275	92.89	L3730	662.42	L4100	75.86
L1847	439.66	L2280	345.10	L3740	744.44	L4110	60.29
L1850	204.62	L2300	194.80	L3800	139.10	L4130	414.92
L1855	875.60	L2310	87.46	L3805	222.56	L4350	74.75
L1858	962.30	L2320	146.26	L3807	0.00	L4360	209.13
L1860	793.65	L2330	279.14	L3810	45.08	L4370	134.20
L1870	815.64	L2335	164.21	L3815	41.85	L4380	82.29
L1880	503.17	L2340	387.50	L3820	71.89	L4392	17.99
L1885	790.99	L2350	633.44	L3825	51.04	L4394	13.13
L1900	215.00	L2360	36.78	L3830	58.89	L4396	128.29
L1902	58.39	L2370	182.49	L3835	63.85	L4398	59.04
L1904	334.30	L2375	80.32	L3840	43.73	L5000	400.81
L1906	97.69	L2380	87.52	L3845	56.47	L5010	968.04
L1910	190.11	L2385	95.22	L3850	80.67	L5020	1643.99
L1920	248.52	L2390	77.82	L3855	87.18	L5050	1818.55
L1930	168.17	L2395	118.81	L3860	118.53	L5060	2091.85
L1940	380.05	L2397	83.33	L3900	1086.76	L5100	1822.56
L1945	697.92	L2405	37.94	L3901	1218.54	L5105	2631.05
L1950	529.50	L2415	174.07	L3902	1875.21	L5150	2659.64
L1960	394.04	L2425	129.44	L3904	2480.63	L5160	2892.83
L1970	582.81	L2430	75.15	L3906	293.48	L5200	2770.29
L1980	260.90	L2435	129.23	L3907	394.95	L5210	1837.81
L1990	335.22	L2492	72.49	L3908	41.68	L5220	2089.00
L2000	721.05	L2500	224.27	L3910	307.92	L5230	2881.15
L2010	657.30	L2510	600.45	L3912	66.88	L5250	3929.63
L2020	830.07	L2520	327.49	L3914	67.34	L5270	3912.20
L2030	720.16	L2525	1123.57	L3916	88.35	L5280	3882.23
L2035	132.42	L2526	605.60	L3918	59.74	L5300	2489.26
L2036	1318.93	L2530	167.03	L3920	71.23	L5310	3693.16
L2037	1215.49	L2540	300.55	L3922	81.71	L5320	3745.15
L2038	1016.38	L2550	204.17	L3924	87.33	L5330	4785.26
L2039	1698.79	L2570	451.47	L3926	71.81	L5340	4943.05
L2040	129.82	L2580	427.97	L3928	42.41	L5400	1031.41
L2050	345.75	L2600	146.00	L3930	43.80	L5410	316.44
L2060	443.75	L2610	172.64	L3932	37.98	L5420	1263.96
L2070	127.47	L2620	190.08	L3934	33.52	L5430	381.12
L2080	271.83	L2622	218.00	L3936	61.97	L5450	310.05
L2090	335.08	L2624	296.37	L3938	65.18	L5460	413.08
L2102	330.71	L2627	1221.00	L3940	74.78	L5500	972.71
L2104	350.88	L2628	1434.31	L3942	51.72	L5505	1345.28
L2106	483.35	L2630	176.03	L3944	85.18	L5510	1102.63
L2108	759.56	L2640	238.90	L3946	69.90	L5520	1089.13
L2112	360.65	L2650	85.31	L3948	46.80	L5530	1308.15
L2114	412.63	L2660	132.49	L3950	110.20	L5535	1284.35
L2116	543.65	L2670	121.26	L3952	122.13	L5540	1370.81
L2122	583.04	L2680	111.25	L3954	76.82	L5560	1472.00
L2124	723.81	L2750	59.42	L3956	0.00	L5570	1530.37
L2126	967.28	L2755	99.89	L3960	573.42	L5580	1786.59
L2128	1218.99	L2760	43.19	L3962	597.07	L5585	2198.70
L2132	573.46	L2770	43.89	L3963	1510.43	L5590	1820.66
L2134	687.56	L2780	51.09	L3980	215.06	L5595	3216.45
L2136	840.70	L2785	30.04	L3982	265.70	L5600	3457.53
L2180	83.25	L2795	60.40	L3984	283.62	L5610	1568.04
L2182	65.16	L2800	75.83	L3985	420.91	L5611	1220.25
L2184	117.42	L2810	55.52	L3986	486.79	L5613	1907.81
L2186	130.11	L2820	61.73	L3995	23.81	L5614	1292.41
L2188	283.88	L2830	69.42	L4000	927.39	L5616	1030.97
L2190	73.73	L2840	38.74	L4010	521.88	L5617	428.52
L2192	253.48	L2850	44.02	L4020	651.87	L5618	226.70
L2200	33.80	L3224	41.80	L4030	358.92	L5620	210.56
L2210	54.85	L3225	48.09	L4040	290.18	L5622	274.57
L2220	62.97	L3650	41.64	L4045	233.19	L5624	275.35
L2230	54.55	L3660	71.50	L4050	293.49	L5626	361.10
L2240	59.45	L3670	99.66	L4055	190.04	L5628	386.11
L2250	252.60	L3675	122.08	L4060	225.92	L5629	240.69

APPENDIX B: Orthotics/Prosthetics Fee Schedule (continued)

CODE	FEE	CODE	FEE	CODE	FEE	CODE	FEE
L5630	339.90	L5722	728.89	L6380	925.08	L6780	354.84
L5631	332.77	L5724	1143.18	L6382	1391.76	L6790	342.23
L5632	185.72	L5726	1317.49	L6384	1925.33	L6795	955.34
L5634	230.38	L5728	1802.15	L6386	304.15	L6800	767.37
L5636	192.98	L5780	867.11	L6388	332.95	L6805	257.68
L5637	218.80	L5785	487.43	L6400	1757.39	L6806	1238.69
L5638	381.14	L5790	544.57	L6450	2347.83	L6807	998.02
L5639	849.14	L5795	1084.24	L6500	2456.32	L6808	852.20
L5640	484.29	L5810	368.73	L6550	2952.53	L6809	299.11
L5642	469.24	L5811	552.36	L6570	3314.89	L6810	146.07
L5643	1178.80	L5812	428.13	L6580	1265.56	L6825	860.44
L5644	447.33	L5814	2844.44	L6582	1146.25	L6830	1025.61
L5645	604.29	L5816	647.97	L6584	1797.62	L6835	893.41
L5646	414.97	L5818	727.32	L6586	1682.28	L6840	651.84
L5647	602.45	L5822	1289.72	L6588	2210.48	L6845	619.54
L5648	498.63	L5824	1161.47	L6590	2099.63	L6850	562.07
L5649	1806.81	L5826	2391.80	L6600	142.06	L6855	663.71
L5650	369.73	L5828	2138.75	L6605	140.27	L6860	505.18
L5651	909.53	L5830	1437.13	L6610	134.71	L6865	275.99
L5652	330.20	L5840	2657.25	L6615	145.15	L6867	737.85
L5653	440.78	L5845	1372.76	L6616	53.78	L6868	181.58
L5654	251.17	L5846	4151.65	L6620	232.23	L6870	180.01
L5655	212.85	L5850	96.89	L6623	647.76	L6872	713.30
L5656	285.55	L5855	260.35	L6625	460.26	L6873	354.29
L5658	275.38	L5910	274.30	L6628	362.81	L6875	588.67
L5660	460.92	L5920	401.85	L6629	110.81	L6880	381.90
L5661	460.89	L5925	339.31	L6630	163.23	L6890	128.82
L5662	428.44	L5930	2577.91	L6632	56.69	L6895	473.89
L5663	521.89	L5940	379.90	L6635	133.40	L6900	1352.35
L5664	502.81	L5950	594.01	L6637	284.53	L6905	1344.67
L5665	387.79	L5960	730.13	L6640	252.77	L6910	1149.84
L5666	53.02	L5962	480.50	L6641	121.50	L6915	579.72
L5667	1268.02	L5964	709.29	L6642	164.69	L6920	5054.46
L5668	85.51	L5966	903.81	L6645	303.99	L6925	6804.17
L5669	845.55	L5968	2783.20	L6650	315.61	L6930	5085.80
L5670	205.51	L5970	153.82	L6655	62.04	L6935	6909.76
L5672	225.84	L5972	287.31	L6660	69.52	L6940	6644.93
L5674	50.02	L5974	176.49	L6665	34.88	L6945	8119.32
L5675	72.55	L5975	355.07	L6670	38.56	L6950	7552.89
L5676	274.45	L5976	424.14	L6672	153.05	L6955	9045.62
L5677	373.42	L5978	221.02	L6675	90.95	L6960	246.43
L5678	30.07	L5979	1728.13	L6676	105.14	L6965	928.19
L5680	251.02	L5980	2808.09	L6680	175.72	L6970	1387.37
L5682	473.65	L5981	2268.55	L6682	194.27	L6975	2454.12
L5684	36.45	L5982	437.84	L6684	264.00	L7010	2766.17
L5686	38.69	L5984	431.45	L6686	596.16	L7015	4395.65
L5688	46.26	L5985	216.27	L6687	436.86	L7020	2577.25
L5690	74.11	L5986	479.93	L6688	434.23	L7025	2600.83
L5692	100.64	L5987	5509.64	L6689	520.25	L7030	3977.07
L5694	137.40	L5988	1530.01	L6690	566.92	L7035	2663.55
L5695	126.84	L6000	1006.30	L6691	262.41	L7040	2135.15
L5696	140.13	L6010	1119.85	L6692	423.54	L7045	1224.16
L5697	60.80	L6020	1044.08	L6693	2174.36	L7170	5636.45
L5698	99.42	L6050	1438.71	L6700	392.87	L7180	4740.96
L5699	179.10	L6055	2005.19	L6705	230.65	L7185	5566.08
L5700	2170.00	L6100	1457.63	L6710	261.39	L7186	6699.32
L5701	2606.01	L6110	1546.07	L6715	259.64	L7190	5846.28
L5702	3296.99	L6120	1801.72	L6720	646.12	L7191	7000.39
L5704	405.95	L6130	1960.61	L6725	312.81	L7260	1490.51
L5705	725.36	L6200	2066.16	L6730	515.32	L7261	2713.31
L5706	711.06	L6205	2758.00	L6735	225.67	L7266	999.80
L5707	937.43	L6250	2164.86	L6740	320.68	L7272	1731.37
L5710	283.24	L6300	2821.66	L6745	281.52	L7274	4350.00
L5711	395.86	L6310	2436.37	L6750	282.36	L7360	180.72
L5712	331.71	L6320	1330.95	L6755	283.08	L7362	189.75
L5714	340.71	L6350	2966.55	L6765	299.10	L7364	301.80
L5716	552.00	L6360	2667.94	L6770	283.75	L7366	406.53
L5718	689.94	L6370	1596.42	L6775	317.14	L7900	414.50

APPENDIX B: Orthotics/Prosthetics Fee Schedule (continued)

CODE	FEE	CODE	FEE	CODE	FEE	CODE	FEE
L8000	33.32	L8642	227.32	V2212	62.95	V2503	110.51
L8010	47.37	L8658	237.58	V2213	64.56	V2510	84.04
L8015	45.90	L8670	421.58	V2214	69.20	V2511	120.74
L8020	172.67	V2020	61.05	V2215	74.88	V2512	142.67
L8030	249.76	V2100	29.66	V2216	77.66	V2513	119.78
L8035	2805.94	V2101	31.26	V2217	71.43	V2520	78.99
L8300	73.76	V2102	44.34	V2218	76.60	V2521	137.52
L8310	113.41	V2103	25.76	V2219	33.72	V2522	133.83
L8320	49.55	V2104	28.53	V2220	27.35	V2523	114.05
L8330	49.10	V2105	34.93	V2300	50.42	V2530	168.91
L8400	14.35	V2106	35.44	V2301	58.48	V2531	414.69
L8410	16.33	V2107	37.25	V2302	64.07	V2623	679.84
L8415	16.24	V2108	36.13	V2303	53.07	V2624	46.10
L8417	57.59	V2109	41.53	V2304	55.54	V2625	298.63
L8420	18.98	V2110	48.48	V2305	68.11	V2626	189.47
L8430	20.87	V2111	42.74	V2306	63.52	V2627	1084.74
L8435	18.74	V2112	42.16	V2307	62.97	V2628	248.01
L8440	39.71	V2113	58.26	V2308	67.20	V2700	33.18
L8460	55.26	V2114	51.53	V2309	78.60	V2710	48.56
L8465	49.26	V2115	56.03	V2310	86.47	V2715	8.81
L8470	5.06	V2116	50.22	V2311	82.35	V2718	21.63
L8480	6.97	V2117	57.90	V2312	72.59	V2730	15.97
L8485	8.42	V2118	55.54	V2313	99.08	V2740	10.59
L8490	100.63	V2200	38.83	V2314	108.53	V2741	7.69
L8500	499.83	V2201	42.32	V2315	120.49	V2742	8.72
L8501	111.01	V2202	49.80	V2316	112.96	V2743	9.70
L8600	472.94	V2203	39.17	V2317	121.58	V2744	16.57
L8603	332.15	V2204	42.48	V2318	111.10	V2750	19.28
L8610	485.11	V2205	46.61	V2319	37.61	V2755	13.93
L8612	511.65	V2206	56.74	V2320	39.68	V2760	12.13
L8613	229.07	V2207	47.36	V2410	67.91	V2770	15.67
L8614	4499.58	V2208	47.94	V2430	88.41	V2780	12.65
L8619	6219.78	V2209	52.73	V2500	61.56		
L8630	255.16	V2210	67.85	V2501	93.77		
L8641	276.93	V2211	57.85	V2502	115.51		

APPENDIX C: Surgical Dressings Fee Schedule

CODE	FEE	CODE	FEE
A4460	0.97	A6238	21.74
A4462	3.13	A6240	11.68
A6154	13.29	A6241	2.45
A6196	7.01	A6242	5.79
A6197	15.68	A6243	11.75
A6199	5.04	A6244	37.46
A6200	9.06	A6245	6.93
A6201	19.84	A6246	9.46
A6202	33.27	A6247	22.68
A6204	5.94	A6248	15.49
A6207	7.00	A6251	1.90
A6209	7.14	A6252	3.10
A6210	19.00	A6253	6.05
A6211	28.01	A6254	1.16
A6212	9.25	A6255	2.89
A6214	9.82	A6257	1.46
A6216	0.05	A6258	4.10
A6219	0.91	A6259	10.43
A6220	2.46	A6263	0.28
A6222	2.03	A6264	0.46
A6223	2.30	A6265	0.12
A6224	3.44	A6266	1.83
A6229	3.44	A6402	0.12
A6234	6.24	A6403	0.41
A6235	16.05	A6405	0.32
A6236	25.99	A6406	0.76
A6237	7.54		

APPENDIX D: Radiology Fee Schedule

CODE	LOC 01/02	LOC 03	LOC 04
G0120	135.30	146.20	154.98
G0125	2102.59	2298.49	2447.15
G0126	2122.88	2319.78	2469.25
G0163	1880.67	2032.16	2131.50
G0164	1898.74	2050.91	2150.77
G0165	1880.67	2032.16	2131.50
Q0092	19.26	21.05	22.37
70010	222.83	241.63	256.52
70015	111.83	119.98	126.71
70030	24.88	26.94	28.62
70100	29.06	31.44	33.32
70110	36.21	39.15	41.52
70120	33.01	35.85	38.13
70130	46.85	50.60	53.61
70134	45.11	48.72	51.64
70140	33.37	36.21	38.50
70150	42.95	46.55	49.45
70160	28.35	30.70	32.56
70170	51.46	55.80	59.29
70190	34.43	37.32	39.64
70200	44.01	47.66	50.59
70210	32.31	35.11	37.36
70220	42.59	46.19	49.08
70240	25.94	28.05	29.75
70250	35.85	38.79	41.15
70260	51.15	55.38	58.81
70300	16.13	17.63	18.92
70310	24.52	26.58	28.24
70320	41.17	44.72	47.57
70328	28.36	30.69	32.54
70330	44.32	48.08	51.08
70332	107.02	116.18	123.45
70336	492.05	536.43	571.25
70350	23.49	25.44	27.04
70355	31.99	34.70	36.90
70360	24.88	26.94	28.62
70370	65.50	71.09	75.49
70371	121.69	131.53	139.41
70373	90.12	97.98	104.29
70380	34.04	36.98	39.33
70390	86.94	94.67	100.88
70450	220.55	240.03	255.39
70460	270.60	294.35	313.15
70470	330.23	359.35	382.27
70480	242.77	263.40	279.79
70481	282.65	306.85	325.99
70482	339.57	369.19	392.58
70486	235.69	256.04	272.23
70487	278.75	302.81	321.84
70488	338.16	367.72	391.07
70490	242.77	263.40	279.79
70491	282.65	306.85	325.99
70492	339.23	368.82	392.19
70540	496.56	541.32	576.38
70541	510.21	555.51	591.08
70551	496.56	541.32	576.38
70552	595.57	649.22	691.24
70553	1055.56	1152.66	1228.51
71010	27.32	29.56	31.35
71015	30.47	32.91	34.83
71020	34.79	37.68	40.01
71021	41.57	45.04	47.85
71022	43.69	47.25	50.13
71023	48.97	52.81	55.89
71030	45.43	49.13	52.10
71034	78.41	85.01	90.30
71035	28.71	31.06	32.93
71036	87.31	94.59	100.44
71040	84.78	91.64	97.12
71060	121.38	131.54	139.71
71090	93.00	100.88	107.22
71100	33.05	35.80	38.04
71101	39.00	42.13	44.63
71110	43.65	47.30	50.22
71111	50.44	54.65	58.06
71120	34.77	37.70	40.05
71130	37.91	41.06	43.56
71250	281.53	306.24	325.77
71260	328.81	357.88	380.76
71270	401.77	437.43	465.33
71550	502.23	547.20	582.42
71555	511.60	557.01	592.66
72010	62.16	67.19	71.25
72020	23.82	25.84	27.48
72040	34.09	36.93	39.22
72050	49.73	53.91	57.30
72052	60.89	65.88	69.80
72069	30.14	32.52	34.42
72070	35.83	38.81	41.19
72072	39.44	42.84	45.60
72074	46.17	50.26	53.56
72080	36.52	39.56	41.98
72090	39.36	42.50	45.00
72100	36.52	39.56	41.98
72110	50.43	54.67	58.09
72114	63.46	68.79	73.03
72120	45.48	49.51	52.77
72125	281.53	306.24	325.77
72126	327.75	356.77	379.63
72127	396.46	431.91	459.67
72128	281.53	306.24	325.77
72129	327.75	356.77	379.63
72130	396.46	431.91	459.67
72131	281.53	306.24	325.77
72132	327.75	356.77	379.63
72133	396.81	432.29	460.06
72141	502.23	547.20	582.42
72142	602.79	656.86	699.27
72146	548.40	597.79	636.40
72147	602.79	656.86	699.27
72148	542.72	591.91	630.37
72149	595.57	649.22	691.24
72156	1065.97	1163.60	1239.93
72157	1065.97	1163.60	1239.93
72158	1055.56	1152.66	1228.51
72170	28.35	30.70	32.56
72190	36.17	39.19	41.61
72192	277.50	301.91	321.13
72193	316.45	344.54	366.68
72194	380.51	414.51	441.11
72196	502.23	547.20	582.42
72200	28.35	30.70	32.56
72202	33.37	36.21	38.50
72220	30.57	33.23	35.39
72240	224.91	244.75	260.45
72255	208.88	227.01	241.31
72265	195.61	212.83	226.51
72270	297.25	323.14	343.67
72285	371.29	404.53	430.52
72295	337.92	368.75	392.81
73000	27.65	29.96	31.79
73010	28.35	30.70	32.56
73020	25.90	28.09	29.84
73030	30.93	33.59	35.76

APPENDIX D: Radiology Fee Schedule (continued)

CODE	LOC 01/02	LOC 03	LOC 04
73040	106.68	115.81	123.06
73050	35.46	38.45	40.84
73060	30.57	33.23	35.39
73070	27.29	29.59	31.42
73080	30.57	33.23	35.39
73085	107.02	116.18	123.45
73090	27.65	29.96	31.79
73092	26.95	29.21	31.00
73100	27.30	29.58	31.40
73110	28.70	31.07	32.95
73115	87.65	94.97	100.83
73120	27.30	29.58	31.40
73130	28.70	31.07	32.95
73140	23.11	25.11	26.73
73200	241.41	262.21	278.58
73201	281.53	306.24	325.77
73202	340.73	370.95	394.68
73220	496.56	541.32	576.38
73221	492.05	536.43	571.25
73500	26.96	29.19	30.98
73510	32.70	35.44	37.67
73520	38.30	41.39	43.86
73525	106.68	115.81	123.06
73530	34.02	36.58	38.60
73540	32.34	35.07	37.29
73550	30.57	33.23	35.39
73560	28.35	30.70	32.56
73562	31.28	33.97	36.16
73564	34.79	37.68	40.01
73565	27.66	29.95	31.77
73580	126.04	137.02	145.68
73590	28.35	30.70	32.56
73592	27.30	29.58	31.40
73600	27.30	29.58	31.40
73610	28.70	31.07	32.95
73615	107.02	116.18	123.45
73620	27.30	29.58	31.40
73630	28.70	31.07	32.95
73650	26.61	28.83	30.61
73660	23.11	25.11	26.73
73700	241.41	262.21	278.58
73701	281.53	306.24	325.77
73702	340.73	370.95	394.68
73720	496.56	541.32	576.38
73721	492.05	536.43	571.25
73725	510.57	555.87	591.45
74000	28.71	31.06	32.93
74010	33.41	36.17	38.41
74020	37.27	40.26	42.66
74022	44.40	47.99	50.90
74150	273.44	297.29	316.17
74160	321.76	350.05	372.34
74170	389.85	424.35	451.42
74181	502.23	547.20	582.42
74185	510.90	556.27	591.89
74190	72.05	77.95	82.69
74210	62.97	68.13	72.17
74220	68.42	73.94	78.32
74230	76.26	82.40	87.31
74235	159.04	171.70	181.88
74240	90.58	97.81	103.65
74241	91.62	98.93	104.83
74245	136.27	147.41	156.35
74246	97.66	105.60	112.00
74247	99.53	107.75	114.44
74249	143.35	155.20	164.70
74250	73.08	79.09	83.89
74251	82.46	88.89	94.11
74260	81.92	88.72	94.15
74270	100.23	108.50	115.23
74280	134.96	145.82	154.59
74283	199.15	213.69	225.56
74290	44.40	47.99	50.90
74291	26.30	28.41	30.12
74305	51.23	55.30	58.63
74320	146.11	158.99	169.09
74327	102.67	111.12	117.97
74328	154.39	167.73	178.26
74329	154.39	167.73	178.26
74330	163.05	176.80	187.74
74340	126.04	137.02	145.68
74350	157.57	171.04	181.67
74355	137.51	149.08	158.27
74360	146.80	159.74	169.88
74363	274.66	299.41	318.92
74400	89.13	96.80	102.99
74410	98.50	106.94	113.64
74415	104.89	113.98	121.20
74420	117.19	127.83	136.23
74425	67.28	72.92	77.37
74430	56.34	61.04	64.77
74440	62.44	67.64	71.80
74445	101.58	108.86	114.92
74450	71.90	78.11	83.03
74455	76.55	83.27	88.62
74470	74.53	80.51	85.31
74475	180.81	197.19	210.06
74480	180.81	197.19	210.06
74485	146.11	158.99	169.09
74710	57.05	61.77	65.51
74740	68.82	74.68	79.37
74742	148.95	161.92	172.09
74775	87.39	94.50	100.26
75552	502.58	547.57	582.81
75553	519.22	564.97	600.97
75554	513.36	558.87	594.59
75555	510.70	556.06	591.56
75600	499.33	546.72	583.50
75605	531.84	580.74	618.84
75625	531.63	580.64	618.92
75630	581.21	633.53	674.58
75650	549.12	598.94	637.91
75658	541.51	590.97	629.57
75660	540.13	589.47	627.99
75662	559.01	609.27	648.56
75665	540.61	590.12	628.85
75671	558.10	608.42	647.85
75676	540.61	590.12	628.85
75680	558.10	608.42	647.85
75685	539.78	589.10	627.60
75705	584.58	636.21	676.78
75710	531.97	581.02	619.31
75716	539.78	589.10	627.60
75722	531.84	580.74	618.84
75724	551.06	600.92	639.81
75726	531.28	580.27	618.52
75731	531.28	580.27	618.52
75733	540.13	589.47	627.99
75736	531.28	580.27	618.52
75741	539.78	589.10	627.60
75743	557.76	608.05	647.45
75746	530.79	579.61	617.66
75756	533.57	582.62	620.82
75774	491.43	538.32	574.66
75790	145.52	155.40	163.70
75801	245.71	267.85	285.34

APPENDIX D: Radiology Fee Schedule (continued)

CODE	LOC 01/02	LOC 03	LOC 04
75803	263.21	286.14	304.31
75805	270.98	295.46	314.67
75807	288.97	314.40	334.50
75809	53.36	57.50	60.88
75810	531.28	580.27	618.52
75820	71.92	77.33	81.79
75822	109.48	117.59	124.17
75825	531.28	580.27	618.52
75827	531.28	580.27	618.52
75831	531.28	580.27	618.52
75833	549.12	598.94	637.91
75840	531.28	580.27	618.52
75842	549.12	598.94	637.91
75860	531.63	580.64	618.92
75870	531.28	580.27	618.52
75872	531.28	580.27	618.52
75880	71.92	77.33	81.79
75885	546.29	595.99	634.87
75887	546.29	595.99	634.87
75889	531.28	580.27	618.52
75891	531.28	580.27	618.52
75893	500.77	548.16	584.97
75894	973.23	1064.81	1136.07
75896	855.70	935.84	998.24
75898	124.43	132.62	139.47
75900	813.66	891.86	952.63
75940	500.77	548.16	584.97
75945	194.63	212.82	227.16
75946	108.76	118.49	126.21
75960	601.98	658.62	702.70
75961	610.65	659.67	698.75
75962	619.47	678.54	724.45
75964	333.78	365.41	390.00
75966	659.53	720.60	768.27
75968	333.64	365.13	389.54
75970	476.69	521.09	555.70
75978	623.64	683.05	729.18
75980	276.81	300.40	319.15
75982	302.56	328.65	349.34
75984	110.32	119.36	126.60
75989	179.10	193.67	205.29
75992	619.82	678.92	724.85
75993	333.98	365.51	389.93
75994	660.01	721.25	769.13
75995	658.35	719.20	766.62
75996	333.64	365.13	389.54
76000	58.06	63.36	67.55
76001	133.25	144.67	153.74
76003	76.62	82.77	87.68
76010	28.71	31.06	32.93
76020	29.41	31.80	33.70
76040	43.65	47.30	50.22
76061	60.77	65.68	69.67
76062	81.96	88.68	94.06
76065	42.28	45.78	48.62
76066	58.06	62.93	66.76
76075	131.50	143.57	153.00
76076	40.13	43.59	46.39
76078	39.42	42.86	45.65
76080	67.45	72.72	76.96
76086	116.70	127.17	135.37
76088	160.53	175.04	186.39
76090	66.80	71.93	76.08
76091	82.11	88.51	93.72
76093	744.26	812.62	865.91
76094	980.35	1071.70	1142.77
76095	351.44	381.99	406.21
76096	77.68	83.87	88.82
76098	24.52	26.58	28.24
76100	76.66	82.72	87.59
76101	83.39	90.14	95.55
76102	95.47	103.46	109.89
76120	60.01	65.01	69.04
76125	43.65	47.30	50.22
76150	25.65	28.16	30.13
76355	371.34	404.47	430.41
76360	368.51	401.52	427.37
76365	368.51	401.52	427.37
76370	154.05	166.91	177.06
76375	140.87	154.15	164.43
76380	181.32	196.53	208.53
76390	493.01	537.65	572.62
76400	502.23	547.20	582.42
76506	86.70	93.74	99.45
76511	94.16	101.01	106.56
76512	93.67	101.22	107.27
76513	93.33	100.84	106.87
76516	76.62	82.77	87.68
76519	76.62	82.77	87.68
76529	83.03	89.77	95.17
76536	82.33	89.03	94.41
76604	77.32	83.51	88.44
76645	67.45	72.72	76.96
76700	115.27	124.52	131.91
76705	83.75	90.50	95.92
76770	112.08	121.22	128.52
76775	83.39	90.14	95.55
76778	112.08	121.22	128.52
76800	111.77	120.04	126.85
76805	130.31	140.66	149.00
76810	258.59	278.90	295.11
76815	87.28	94.19	99.72
76816	71.65	77.20	81.62
76818	101.21	109.27	115.76
76825	154.03	164.98	173.95
76826	76.07	81.42	85.77
76827	103.24	112.00	119.03
76828	72.96	78.89	83.76
76830	93.15	100.71	106.88
76831	94.91	102.56	108.78
76856	93.15	100.71	106.88
76857	59.66	64.63	68.65
76870	90.67	98.14	104.23
76872	93.50	101.09	107.27
76880	83.75	90.50	95.92
76885	95.28	102.91	109.13
76886	84.82	91.60	97.03
76930	92.99	100.46	106.45
76932	93.34	100.83	106.85
76934	92.09	99.61	105.74
76936	347.33	376.67	400.17
76938	92.09	99.61	105.74
76941	128.29	137.47	144.90
76942	92.43	99.98	106.13
76945	97.85	105.72	111.97
76946	77.29	83.97	89.30
76948	77.43	84.25	89.76
76950	79.57	86.00	91.21
76960	79.57	86.00	91.21
76965	295.94	321.45	341.53
76970	60.72	65.74	69.78
76975	99.17	106.97	113.31
76977	33.72	37.02	39.68
76986	160.92	173.84	184.30

APPENDIX D: Radiology Fee Schedule (continued)

CODE	LOC 01/02	LOC 03	LOC 04	CODE	LOC 01/02	LOC 03	LOC 04
77280	166.67	181.15	192.53	78111	108.23	118.31	126.22
77285	263.79	287.03	305.37	78120	77.98	85.16	90.89
77290	325.87	353.87	376.02	78121	125.34	136.61	145.32
77295	1286.55	1400.78	1490.53	78122	196.28	214.37	228.55
77300	82.25	88.69	93.81	78130	137.91	149.72	158.93
77305	106.83	115.63	122.70	78135	215.69	235.10	250.27
77310	141.96	153.27	162.34	78140	179.01	194.96	207.47
77315	180.71	194.48	205.56	78160	154.37	168.51	179.50
77321	201.14	218.43	232.08	78162	143.80	156.56	166.46
77326	137.33	148.52	157.49	78170	220.60	241.17	257.25
77327	202.13	218.42	231.40	78185	109.80	119.62	127.39
77328	293.97	317.44	336.14	78190	271.81	295.62	314.35
77331	63.68	67.67	70.94	78191	306.25	334.45	356.35
77332	78.35	84.64	89.65	78195	210.69	228.47	242.69
77333	114.61	123.74	131.05	78201	111.57	121.45	129.27
77334	185.74	200.75	212.67	78202	134.00	145.69	154.82
77336	180.37	197.89	211.39	78205	258.94	282.52	301.02
77370	211.05	231.50	247.24	78206	256.13	276.78	291.74
77401	108.39	119.15	127.61	78215	135.02	146.84	156.05
77402	108.39	119.15	127.61	78216	159.46	173.51	184.47
77403	108.39	119.15	127.61	78220	164.73	179.51	191.03
77404	108.39	119.15	127.61	78223	180.14	195.55	207.66
77406	108.39	119.15	127.61	78230	106.03	115.43	122.94
77407	127.08	139.58	149.35	78231	146.09	159.01	169.14
77408	127.08	139.58	149.35	78232	156.94	170.99	181.94
77409	127.08	139.58	149.35	78258	145.82	158.12	167.78
77411	127.08	139.58	149.35	78261	190.13	207.07	220.44
77412	141.85	155.79	166.65	78262	194.49	211.68	225.13
77413	141.85	155.79	166.65	78264	195.42	212.60	226.15
77414	141.85	155.79	166.65	78270	69.48	75.90	81.03
77416	141.85	155.79	166.65	78271	72.95	79.66	84.97
77417	35.94	39.52	42.32	78272	101.55	110.84	118.15
77470	526.94	573.13	609.45	78278	234.02	254.43	270.52
77600	194.39	209.41	221.41	78290	149.37	162.21	172.32
77605	262.11	282.70	299.32	78291	159.63	172.89	183.30
77610	194.39	209.41	221.41	78300	125.43	136.18	144.71
77615	260.58	280.92	297.28	78305	179.78	195.19	207.29
77620	196.47	211.67	223.77	78306	204.18	221.91	235.83
77750	300.09	317.19	331.67	78315	231.62	251.77	267.69
77761	287.41	306.35	322.23	78320	275.37	299.71	318.88
77762	429.46	457.47	480.83	78350	40.13	43.59	46.39
77763	607.91	646.33	678.51	78428	126.63	137.13	145.53
77776	317.48	337.43	354.43	78445	95.73	103.94	110.48
77777	544.00	578.89	608.07	78455	187.25	203.74	216.73
77778	764.88	812.06	851.66	78457	139.25	150.94	160.21
77781	847.93	926.54	987.91	78458	196.79	213.70	226.99
77782	890.47	971.16	1034.34	78460	132.95	143.81	152.45
77783	952.99	1036.65	1102.40	78461	240.85	261.30	277.47
77784	1048.84	1137.20	1207.08	78464	321.59	350.25	372.75
77789	74.48	78.94	82.67	78465	518.68	565.56	602.20
77790	73.03	77.52	81.25	78466	134.31	145.77	154.88
78000	46.84	51.04	54.42	78468	178.36	193.72	205.78
78001	62.32	67.77	72.07	78469	243.81	265.30	282.19
78003	53.57	58.02	61.59	78472	258.51	281.47	299.62
78006	114.75	124.78	132.71	78473	385.13	418.84	445.20
78007	122.53	133.31	141.83	78478	91.20	98.63	104.60
78010	89.03	96.91	103.22	78480	91.20	98.63	104.60
78011	114.01	124.07	132.01	78481	247.34	268.99	286.00
78015	131.52	142.79	151.77	78483	372.50	405.04	430.54
78016	172.69	187.41	198.96	78494	316.34	343.60	364.60
78018	248.75	270.90	288.31	78496	92.20	102.25	111.68
78070	107.99	116.62	123.61	78580	166.71	181.11	192.44
78075	242.38	264.27	281.49	78584	170.78	184.97	196.21
78102	105.30	114.29	121.46	78585	267.30	290.74	309.23
78103	157.91	171.43	182.09	78586	118.27	128.91	137.32
78104	194.40	211.45	224.92	78587	130.16	141.58	150.53
78110	46.14	50.29	53.63	78588	255.36	276.42	292.27

APPENDIX D: Radiology Fee Schedule (continued)

CODE	LOC 01/02	LOC 03	LOC 04	CODE	LOC 01/02	LOC 03	LOC 04
78591	127.64	139.05	147.97	78710	256.46	279.94	298.37
78593	154.53	168.34	179.13	78715	75.48	82.18	87.51
78594	214.20	233.72	248.95	78725	86.80	94.39	100.41
78596	330.58	359.72	382.67	78730	74.15	80.61	85.79
78600	130.80	142.39	151.43	78740	108.79	118.03	125.36
78601	153.85	167.56	178.30	78760	134.63	146.18	155.34
78605	155.26	169.04	179.83	78761	156.83	170.35	181.00
78606	177.86	193.52	205.75	78800	161.77	175.94	187.10
78607	309.78	337.05	358.56	78801	199.25	216.72	230.47
78610	75.13	81.80	87.11	78802	252.36	274.94	292.72
78615	166.88	182.11	194.03	78803	302.56	329.41	350.52
78630	224.69	245.00	260.97	78805	165.31	179.62	190.88
78635	128.54	139.57	148.28	78806	285.88	311.73	332.05
78645	157.73	171.63	182.50	78807	302.22	329.04	350.13
78647	268.15	292.07	310.84	79000	190.46	204.64	216.13
78650	205.46	223.96	238.44	79001	102.74	110.18	116.24
78660	107.01	116.19	123.48	79020	190.82	205.01	216.50
78700	137.20	149.42	158.97	79030	205.82	220.74	232.87
78701	158.34	172.47	183.47	79035	227.55	243.47	256.44
78704	186.57	202.98	215.92	79100	166.11	179.07	189.47
78707	217.05	235.87	250.73	79200	200.37	214.95	226.74
78708	227.50	246.77	262.07	79400	198.25	212.73	224.44
78709	235.68	255.19	270.68	79440	200.85	215.60	227.60

APPENDIX E: Other Diagnostic Services Fee Schedule

CODE	LOC 01/02	LOC 03	LOC 04	CODE	LOC 01/02	LOC 03	LOC 04
G0005	112.24	123.57	132.64	92250	58.33	62.43	65.39
G0006	549.40	605.79	651.33	92265	64.67	68.87	72.26
G0015	549.40	605.79	651.33	92270	62.93	66.99	70.29
G0106	135.30	146.20	154.98	92275	68.47	72.68	76.22
G0128	4.38	4.70	5.02	92283	25.78	27.79	29.33
G0130	41.52	45.10	47.97	92284	33.49	35.98	37.85
G0131	126.10	137.72	146.73	92285	48.37	52.18	54.90
G0132	41.52	45.10	47.97	92286	87.29	93.55	98.16
Q0035	24.88	26.94	28.62	92541	36.22	38.71	40.71
51736	38.44	40.91	43.14	92542	32.33	34.65	36.53
51741	66.59	70.74	74.56	92543	11.48	12.47	13.32
51792	115.91	125.22	133.19	92544	25.66	27.59	29.20
51795	115.29	123.62	131.03	92545	23.21	25.00	26.51
51797	100.02	106.56	112.52	92546	28.47	30.57	32.29
54240	88.97	95.23	100.95	92547	52.88	58.76	63.76
54250	120.55	127.56	134.05	92548	89.42	97.34	103.90
59020	66.67	72.37	77.51	92552	41.48	45.81	49.33
59025	41.41	44.56	47.41	92553	61.14	67.69	73.14
91000	45.91	48.49	50.61	92555	35.69	39.55	42.76
91010	111.82	119.45	125.57	92556	53.71	59.64	64.69
91011	135.11	144.25	151.50	92557	112.38	124.67	135.02
91012	138.13	147.85	155.67	92561	66.12	73.07	78.79
91020	122.00	130.32	137.11	92562	38.19	42.24	45.57
91030	55.05	58.24	60.99	92563	35.69	39.55	42.76
91032	104.84	111.98	117.78	92564	45.12	50.05	54.19
91033	135.47	145.58	153.81	92565	37.36	41.33	44.64
91052	57.01	60.62	63.63	92567	49.60	55.17	60.00
91055	61.95	65.90	69.35	92568	35.69	39.55	42.76
91060	38.14	40.81	43.04	92569	38.19	42.24	45.57
91065	26.99	29.16	30.91	92571	36.52	40.43	43.69
91122	127.81	136.78	144.75	92572	8.60	9.60	10.50
92060	55.25	58.68	61.35	92573	33.21	36.86	39.95
92065	34.31	36.59	38.34	92575	27.93	30.83	33.21
92081	45.76	48.99	51.38	92576	42.64	47.36	51.38
92082	52.08	55.67	58.29	92577	67.26	74.62	80.83
92083	56.45	60.39	63.36	92579	66.93	73.95	79.71
92135	67.61	72.67	76.24	92582	66.93	73.95	79.71
92235	100.14	107.64	113.49	92583	83.31	92.26	99.79
92240	126.46	135.49	142.40	92584	229.90	254.26	274.40

APPENDIX E: Other Diagnostic Services Fee Schedule (continued)

CODE	LOC 01/02	LOC 03	LOC 04
92585	122.19	132.93	141.43
92587	58.79	64.61	69.43
92588	79.08	86.33	92.32
92589	50.40	56.07	60.95
92596	55.38	61.43	66.57
93005	41.17	45.14	48.21
93012	216.52	238.88	257.00
93017	152.55	167.83	179.93
93024	119.66	128.36	135.36
93041	13.55	14.98	16.14
93225	112.24	123.57	132.64
93226	198.17	218.12	233.95
93231	138.50	152.62	163.95
93232	196.19	215.67	230.98
93236	234.55	257.45	275.26
93278	61.68	67.49	72.31
93303	221.90	240.39	255.09
93304	119.86	129.75	137.64
93307	206.46	224.37	238.53
93308	108.54	117.97	125.52
93312	269.65	291.38	309.36
93314	213.87	232.43	247.67
93315	294.79	317.59	336.58
93317	240.19	260.05	276.54
93320	90.41	98.42	104.82
93321	52.98	58.03	62.14
93325	115.86	127.65	137.25
93350	118.51	128.22	135.99
93501	846.70	925.95	990.84
93505	348.65	376.72	402.82
93508	724.76	789.60	843.71
93510	1664.08	1823.99	1954.49
93511	1653.18	1811.19	1940.96
93514	1788.88	1957.22	2096.90
93524	2202.59	2412.55	2585.14
93526	2217.88	2430.17	2603.30
93527	2264.97	2479.61	2655.51
93528	2301.52	2518.74	2699.21
93529	2058.22	2256.27	2417.01
93530	911.48	995.72	1065.89
93531	2334.13	2555.06	2737.54
93532	2398.17	2623.58	2811.48
93533	2149.58	2355.09	2524.22
93539	44.62	47.55	49.64
93540	46.03	49.02	51.15
93541	19.17	20.24	21.10
93542	19.17	20.24	21.10
93543	30.28	32.27	33.72
93544	28.50	30.43	31.84
93545	36.63	38.91	40.57
93555	275.63	300.62	320.26
93556	413.66	451.73	481.32
93561	53.53	57.74	61.28
93562	23.27	25.35	27.13
93571	260.99	281.99	298.72
93572	237.45	255.77	269.50
93600	213.20	228.43	240.57
93602	171.48	182.90	192.25
93603	201.05	215.28	226.77
93607	244.32	259.76	272.36
93609	623.76	659.09	688.66
93610	230.54	245.37	257.53
93612	241.58	257.57	270.68
93615	62.83	66.87	70.49
93616	101.44	107.82	113.27
93618	428.08	458.26	482.06
93619	769.74	825.07	868.76
93620	1093.22	1168.07	1227.02
93624	346.09	367.44	384.88
93631	698.23	751.26	796.76
93640	501.15	540.71	571.89
93641	658.26	706.42	744.37
93642	589.00	633.20	667.97
93721	65.29	72.17	77.83
93731	45.57	48.98	51.78
93732	68.38	72.78	76.42
93733	39.53	43.17	46.18
93734	36.20	38.73	40.76
93735	58.84	62.83	66.18
93736	35.00	38.31	41.10
93737	44.04	47.20	49.74
93738	68.04	72.40	76.03
93875	57.84	63.39	68.04
93880	180.60	198.47	213.62
93882	120.07	131.88	141.84
93886	215.50	236.02	253.36
93888	144.24	158.19	170.09
93922	63.14	69.44	74.89
93923	116.79	128.34	138.25
93924	128.50	141.42	152.62
93925	180.58	198.49	213.67
93926	120.90	132.92	143.12
93930	184.07	202.66	218.35
93931	122.21	134.51	144.88
93965	66.57	72.81	78.14
93970	200.81	220.81	237.85
93971	133.52	146.83	158.18
93975	271.05	295.42	316.33
93976	181.27	197.62	211.70
93978	188.70	207.51	223.58
93979	125.60	138.02	148.60
93980	208.73	227.89	244.30
93981	154.54	170.12	183.33
93990	113.19	124.63	134.22
94010	28.70	31.07	32.95
94014	41.54	44.21	46.35
94015	35.86	39.12	41.48
94060	55.29	59.92	63.61
94070	88.41	95.65	101.49
94200	17.19	18.74	20.08
94240	41.91	45.43	48.27
94250	12.53	13.58	14.48
94260	29.15	31.77	33.90
94350	35.87	38.76	41.10
94360	51.77	56.22	59.78
94370	24.62	26.47	28.02
94375	35.43	38.06	40.13
94400	40.24	43.57	46.52
94450	36.56	39.08	41.11
94620	95.18	103.02	109.35
94621	127.19	135.97	143.07
94680	37.19	40.45	43.22
94681	66.63	73.08	78.41
94690	24.57	26.95	28.91
94720	47.95	52.09	55.44
94725	81.27	88.79	94.84
94750	36.53	39.55	41.96
94762	62.98	70.57	77.40
94770	22.29	24.69	26.98
95004	9.43	10.50	11.43
95024	13.55	14.98	16.14
95027	13.55	14.98	16.14
95028	21.00	23.02	24.57
95044	18.50	20.33	21.76

APPENDIX E: Other Diagnostic Services Fee Schedule (continued)

CODE	LOC 01/02	LOC 03	LOC 04	CODE	LOC 01/02	LOC 03	LOC 04
95052	22.64	24.81	26.45	95870	31.33	33.48	35.26
95056	16.02	17.64	18.95	95872	103.18	109.69	115.22
95060	32.07	35.31	37.90	95875	81.16	86.20	90.74
95065	18.50	20.33	21.76	95900	36.72	39.34	41.53
95070	194.88	211.50	222.86	95903	43.49	46.28	48.61
95071	248.60	269.64	283.88	95904	30.60	32.76	34.54
95078	23.81	26.36	28.50	95920	171.82	183.28	192.66
95805	344.09	372.77	395.33	95921	59.90	63.51	66.53
95807	350.96	381.44	405.73	95922	63.91	67.85	71.20
95808	436.84	472.75	501.17	95923	100.30	107.36	112.74
95810	590.01	636.87	672.82	95925	70.92	76.48	80.90
95812	132.34	142.54	150.69	95926	70.92	76.48	80.90
95813	183.38	196.75	207.40	95927	71.62	77.23	81.69
95816	128.38	138.13	145.89	95930	42.97	46.00	48.25
95819	110.68	118.97	125.78	95933	65.42	70.41	74.48
95822	124.63	134.45	142.56	95934	38.20	40.74	42.90
95824	53.84	57.30	60.19	95936	39.63	42.20	44.39
95827	150.80	162.90	172.60	95937	50.62	54.02	56.85
95829	360.32	379.80	396.29	95950	275.56	300.54	321.50
95858	97.55	103.34	108.31	95951	800.16	860.98	908.11
95860	71.55	76.12	79.88	95953	402.41	435.07	461.83
95861	121.76	129.83	136.49	95954	200.27	213.34	223.83
95863	146.17	155.67	163.42	95956	697.10	754.00	796.62
95864	190.86	204.53	215.63	95957	165.86	177.49	187.26
95867	68.60	73.30	77.11	95958	315.82	336.02	352.71
95868	103.42	110.51	116.27	95961	209.74	222.71	233.44
95869	31.33	33.48	35.26	95962	220.32	233.90	245.26

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