Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins issued after October 1, 1997, are available at no-cost from our website at *www.floridamedicare.com.*

Features

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

Routing Suggestions:

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

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

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

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

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

A PHYSICIAN'S FOCUS

Adult Immunization

There is good evidence that adult immunization saves lives, reduces hospitalization rates, and is cost effective. Despite the benefits, adult immunization rates in the United States remain sub-optimal. A 1994 National Vaccine Advisory Committee report highlighted some reasons for low vaccination rates in adults. The report included five reasons:

- Misunderstandings of the importance of vaccine-preventable diseases in adults;
- Concerns about the safety and efficacy of adult vaccines;
- Complexity in approach to target groups for the different vaccines;
- A paucity of programs delivering adult vaccines, and
- Issues regarding payment for adult immunization.

In recent years, there have been improvements such as Medicare's expansion of coverage for routine influenza and pneumococcal vaccines so there is no 'out of pocket' expense for the patient or provider. Some adults may have more limited coverage or no coverage at all for immunizations they require, and some vaccines such as hepatitis B are relatively expensive. Guidelines are available that outline adult immunization recommendations with indications by age and with indications by personal risk status (health, occupation, lifestyle, and environment).

Opportunities exist in inpatient and outpatient settings for enhanced programs delivering adult immunizations. These programs combine continued education of providers and patient recipients, public information, plans for identifying high risk individuals in need of particular immunizations, and strategies for removing administrative and financial barriers.

Please use this and every flu season as a reminder to update your adult immunization program at your organization. Explore the data in your program to find areas needing improvement. Information on current adult immunization guidelines is available at *www.immunize.org* and *www.cdc.gov*. Medicare coverage issues may be researched *at www.floridamedicare.com.*

James J. Corcoran, M.D., M.P.H.
Medicare Medical Director

About *The Medicare A Bulletin*

The *Medicare A Bulletin* is a comprehensive magazine for all Florida Part A providers. Beginning in November 2000, the *Medicare A Bulletin* will become a quarterly publication. In accordance with the Health Care Financing Administration's 45-day notification parameters, the approximate delivery dates for the coming year are:

Effective Date of Changes	Publication Date
Changes effective January 1 2001	Mid-November 2000
Changes effective April 2001	Mid-February 2001
Changes effective July 2001	Mid-May 2001
Changes effective October 2001	Mid August, 2001

Important notifications that require communication in between these dates will be published via additional unscheduled special issues and posted to the First Coast Service Option, Inc. (FCSO) website (**www.florida.medicare.com**). In some cases, notifications posted on the fiscal intermediary website, will also be provided in hard copy format.

Who Receives the *Bulletin*?

If you were previously receiving individually distributed Part A bulletins, you now receive the comprehensive *Medicare A Bulletin*. Please remember that Medicare Part A (First Coast Service Options, Inc.) uses the same mailing address for all correspondence. No issue of the *Bulletin* may be sent to a specific person/department within an office. To ensure continued receipt of all Medicare correspondence, providers must keep their mailing addresses current.

What Is in the *Bulletin*?

The *Bulletin* is divided into several sections addressing general and facility-specific information and coverage guidelines.

The publication always starts with a column by the Intermediary Medical Director. Following an administrative section are usually general information and coverage sections with informational and billing issues, processing guidelines, and medical coverage applicable to all Medicare Part A providers and facilities. Coverage guidelines and billing issues targeting specific facilities or Part A providers are usually included in individual sections named under the applicable facility type. These facility-specific sections are in the *Bulletin* only when an article in that category is published (for example, if no CORF/ORF information is in the issue, that section is omitted.) Also, as needed, the *Bulletin* contains Electronic Data Interchange (EDI) and Fraud and Abuse sections.

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

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

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

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

GENERAL INFORMATION

Overpayment Interest Rate

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

Based on the notice of the PCR published in the **Federal Register** on **October 24, 2000,** the interest rate of **13.875** percent remains in effect until a new rate change is published.

Period	**Interest Rate**
August 1, 2000	13.875%
May 3, 2000 – July 31, 2000	13.750%
February 2, 2000 – May 2, 2000	13.50%
October 28, 1999 - February 1, 2000	13.375%
August 4, 1999 - October 27, 1999	13.25%
May 5, 1999 - August 3, 1999	13.375%
February 1, 1999 - May 4, 1999	13.75%
October 23, 1998 - January 31, 1999	13.50%
July 31, 1998 - October 22, 1998	13.75%
May 13, 1998 - July 30, 1998	14.00 %
January 28, 1998 - May 12, 1998	14.50%
October 24, 1997 - January 27, 1998	13.875%
July 25, 1997 - October 23, 1997	13.75%
April 24, 1997 - July 24, 1997	13.50%
January 23, 1997 - April 23, 1997	13.625%
October 24, 1996 - January 22, 1997	13.375% ❖

Timely Filing Guidelines for All Medicare A Providers

This article was printed in the August/September 2000 Medicare A Bulletin (page 49). The last filing date for services furnished October1, 1998 – September 30, 1999 was indicated as January 2, 2000. The correct date is January 2, 2001.

All Medicare claims must be submitted to the contractor within the established timeliness parameters. For timeliness purposes, services furnished in the last quarter of the calendar year are considered furnished in the following calendar year. The time parameters are:

Dates of Service	***Last Filing Date***
October 1, 1998 – September 30, 1999	by January 2, 2001*****
October 1, 1999 – September 30, 2000	by December 31, 2001
October 1, 2000 – September 30, 2001	by December 31, 2002
October 1, 2001 – September 30, 2002	by December 31, 2003

*****If the December 31 date falls on a federal nonworking day, the last filing date is extended to the next succeeding workday. A federal nonworking day is considered a Saturday, Sunday, legal holiday, or a day declared by statute or executive order as a nonworking day for federal employees.

Claims must be submitted complete and free of errors. Any claim filed with invalid or incomplete information, and returned to provider (RTP) for correction, is not protected from the timely filing guidelines. ❖

Mammography Screening Payment Limit for Calendar Year 2001

The mammography screening payment limit has been increased for the year 2001 to reflect the overall payment limit (global component) for mammography screening from $67.81 in calendar year 2000 to $69.23 in calendar year 2001. The apportionment between the professional and technical components remain the same (32 percent for the professional component, or $22.15 and 68 percent for the technical component, or $47.08). ❖

Medicare Deductible Amounts for Calendar Year 2001

Health insurance (HI) beneficiaries who use covered services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the HI program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible, for 61-90 days spent in the hospital. After 90 days in a spell of illness, the beneficiary has 60 lifetime reserve days of coverage. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each 21-100 days of skilled nursing facility services furnished during a spell of illness.

Year 2001 HI Deductible

Part A Hospital (Inpatient)	**Calculation per Benefit Period**	**CY 2001 Benefit Period**
Deductible - 1 through 60 days	Current year inpatient deductible	$792.00 per benefit period
Coinsurance - 61 through 90 days	Rate is ¼ of current year inpatient deductible amount	$198.00 per day
Lifetime Reserve - 91 through 150 days (non-renewable days)	Rate is 1/2 of current year inpatient deductible amount	$396.00 per day
Skilled Nursing Facility (SNF)	**Calculation Per Benefit Period**	**CY 2001 Benefit Period**
SNF - 1 through 20 days	No deductible or coinsurance (full days)	$0 per benefit period
SNF - 21 through 100 days	Rate is 1/8 of current year inpatient deductible amount	$99 per day
Blood Deductible	**Annual Requirement**	**CY 2001**
Part A/Part B	Satisfied via Part A and or Part B services	3 pints annually
Part B - Outpatient	**Annual Requirement**	**CY 2001**
Annual Deductible	Satisfied via Part B outpatient and or Physician/Supplier Services (Part B)	$100.00

GENERAL COVERAGE

Urokinase (Abbokinase®) Shortage

Abbokinase® is a thrombolytic agent indicated for the restoration of patency to intravenous (IV) catheters, including central venous catheters, obstructed by clotted blood or fibrin. This drug has been used to open centralvenous catheter occlusions for end-stage renal disease (ESRD) patients who are on dialysis, playing an integral role in restoring and securing vascular access for Medicare's dialysis patients.

On January 25, 1999, the Food and Drug Administration (FDA) issued a letter to inform healthcare providers of the agency's safety concerns regarding the manufacturing of Abbokinase® by Abbott Laboratories. Because of these concerns, the FDA has recommended that Abbokinase® be reserved for "only those situations where a physician has considered the alternatives and has determined that the use of Abbokinase® is critical to the care of a specific patient in a specific situation" (FDA "Letter to Healthcare Providers", January 25, 1999).

Since the FDA has recommended a restriction on its use to patients with critical care needs, Abbokinase® is no longer available in the U.S. for regular use in ESRD patients, resulting in a shortage of the drug. Dialysis facilities must find alternative medications to treat clotted central venous catheters. The following is a list of other thrombolytic products currently available in the U.S.: Streptokinase (Streptase® and Kabikinase®), Alteplase (Activase®), Anistreplase (Eminase®), and Reteplase (Retavase®). These medications could serve as possible alternatives to treat thrombotic dialysis catheters until Abbokinase® becomes available again. Updates on the FDA's deliberations on Abbokinase® can be monitored at the agency's website *www.fda.gov/medwatch/safety.htm.*

Use of these five drugs for the restoration of patency to obstructed IV central venous catheters is not listed as an indication on their FDA-approved labels. Florida Medicare has completed an evaluation of the appropriateness of using these five thrombolytic products for treatment of clotted central venous catheters. Florida Medicare will consider these alternative products for restoration of patency of obstructed IV central venous catheters to be medically reasonable and necessary until Abbokinase® becomes available again.

As described in section 3168(B) in the Medicare Intermediary Manual (MIM), thrombolytic agents used to treat clotted central venous catheters are not covered under the composite rate and therefore are separately billable. Thrombolytic agents used to treat clotted ESRD shunts, peripheral lines, or arteriovenous (AV) fistulas are covered under the composite and cannot be separately billed, according to section 3169.1 of the MIM and section 2710.4 of the Provider Reimbursement Manual. ❖

Extracorporeal Immunoadsorption (ECI) Using Protein A Columns

Section 35-90 of the Medicare Coverage Issues Manual has been revised to provide coverage of this treatment for patients with severe active rheumatoid arthritis.

Extracorporeal immunoadsorption (ECI), using Protein A columns, has been developed for the purpose of selectively removing circulating immune complexes (CIC) and immunoglobulins (IgG) from patients in whom these substances are associated with their diseases. The technique involves pumping the patient's anticoagulated venous blood through a cell separator from which 1-3 liters of plasma are collected and perfused over adsorbent columns, after which the plasma rejoins the separated, unprocessed cells and is retransfused to the patient.

For claims with dates of service on or after January 1, 2001, Medicare covers the use of Protein A columns for the treatment of ITP. In addition, Medicare will cover Protein A columns for the treatment of rheumatoid arthritis (RA) under the following conditions:

1. Patient has severe RA. Patient disease is active, having > 5 swollen joints, > 20 tender joints, and morning stiffness > 60 minutes.
2. Patient has failed an adequate course of a minimum of 3 Disease Modifying Anti-Rheumatic Drugs (DMARDs). Failure does not include intolerance.

This service must be reported using the recently issued national CPT code:

36521	Therapeutic apheresis; plasma and/or cell exchange with extracorporeal affinity column adsorption and plasma reinfusion.

The corresponding ICD-9-CM codes are:

287.3	Primary thrombocytopenia
714.0	Rheumatoid arthritis
714.1	Felty's syndrome
714.2	Other rheumatoid arthritis with visceral or systemic involvement
714.30-714.33	Types of juvenile rheumatoid arthritis

Other uses of these columns are currently considered to be investigational and, therefore, not reasonable and necessary under the Medicare law. (See section 1862(a)(1)(A) of the Act.). ❖

HCFA Promotes Eye Exams for People with Diabetes

The following article is reprinted from a recent press release.

The Health Care Financing Administration, the American Academy of Ophthalmology, and the American Optometric Association have launched a cooperative effort to increase the dilated eye exam rate among Medicare beneficiaries with diabetes.

The joint initiative seeks to raise public awareness of the connection between diabetes and blindness, and attack barriers—such as payment and transportation issues—that prevent people with diabetes from getting dilated eye exams.

"This shows what teamwork between Medicare and the private sector can do to bring better health care to millions of beneficiaries," said HCFA Administrator Nancy-Ann DeParle.

"Obtaining necessary preventive services like dilated eye exams is vitally important for diabetics," said Jeffrey Kang, MD, MPH, director of HCFA's Office of Clinical Standards and Quality and the agency's chief clinical officer. "This collaborate effort moves us a big step closer to ensuring that all Medicare beneficiaries with diabetes get the care they need and deserve."

People with diabetes are at an increased risk for eye problems, including blindness, and may need treatment even if their vision is normal. About 10 percent of the Medicare population has diabetes.

HCFA, the federal Medicare agency, has identified diabetes as a clinical priority area in which there is a significant opportunity to improve the quality of care provided to Medicare beneficiaries in all states across the nation.

Through its national network of Medicare Peer Review Organizations, who are committed to ensuring quality health care for Medicare beneficiaries, and in partnership with the AAO and AOA, HCFA hopes to positively influence the quality of care received by all Medicare beneficiaries with diabetes.

Medicare has provided a series of new or expanded preventive health care benefits since 1998, including mammograms, pap smears, colorectal cancer screening, bone mass measurement for beneficiaries at risk for osteoporosis and other bone abnormalities, flu and pneumonia vaccinations, glucose monitoring for diabetics and education and training programs for diabetics.

By law, regular fee-for-service Medicare may not cover refractive services — eye exams for eyeglasses — although some Medicare+Choice managed care plans may offer them. Medicare does cover medical exams, however, and this new program makes it easier for diabetics to get regular medical eye checkups.

This campaign will provide information about the Foundation of the American Academy of Ophthalmology's EyeCare America – National Eye Care Project (NECP), a program that provides eye care for Medicare beneficiaries age 65 and older who have diabetes and who have not had a medical eye exam in the last three years.

NECP matches qualifying persons with a volunteer ophthalmologist in their area who has agreed to provide a comprehensive medical eye exam and up to one year of follow-up care by that physician for any condition diagnosed at the initial exam, with no out-of-pocket expense to the patient, based on guidelines in an Office of Inspector General advisory opinion (OIG AO 99-7).

Medicare diabetes patients may also qualify for help in receiving an eye examination by calling AOA's Diabetes Hot Line. This program matches patients with a participating optometrist in their area who has agreed to perform a dilated eye examination and provide or arrange for subsequent care.

In cases of financial need, the optometrist may be able to waive the deductible and co-payment a Medicare patient usually pays.

Another barrier preventing Medicare patients with diabetes from receiving eye exams is lack of transportation. HCFA will address this barrier through its PROs. In some cases, PROs may be able to identify state or local community organizations that can provide transportation to eye appointments for Medicare beneficiaries.

PROs will inform Medicare beneficiaries of AAO's and AOA's programs through a series of postcards and brochures sent to qualifying beneficiaries. The project also features a national media campaign including radio and television public service announcements.

For more information about NECP, they may call 1-800-222-EYES (1-800-222-3937) 24 hours a day, seven days a week. AOA's Diabetes Hot Line is 1-800- 262-3947. Operators are available from 6:00 a.m. – 6:00 p.m. Eastern Standard Time Monday through Friday. To learn more about the joint AAO/AOA/HCFA Diabetes Initiative, call 1-888-691-9167. ❖

Additional Coverage for Autologous Stem Cell Transplantation

An article addressing additional coverage for autologous stem cell transplantation was published in the October/November 2000 *Medicare A Bulletin* (page 7). Since then, the following condition has been added to the national coverage under the noncovered conditions:

- Multiple rounds of autologous stem cell transplantation (known as tandem transplantation) for patients with multiple myeloma will remain noncovered. ❖

OUTPATIENT HOSPITAL SERVICES

Proper Billing of Outpatient Pathology Services under the Outpatient Prospective Payment System

The following article was printed in the October/November 2000 Medicare A Bulletin (page 11). During the formatting process, the left column indicating the HCPCS code was cut off inadvertently, therefore, the article is being reprinted.

The Health Care Financing Administration has delayed until January 1, 2001, the implementation of the hospital outpatient rebundling requirements for independent laboratories that furnish pathology services to hospital outpatients.

Under the hospital outpatient rebundling provisions set forth in section 410.42(a), independent laboratories cannot bill for the technical component of a pathology service under the outpatient prospective payment system (OPPS). Hospitals must provide directly or under arrangements all services furnished to hospital outpatients. Therefore, if a specimen (e.g. tissue, blood, urine) is taken from a hospital outpatient, the facility or technical component of the diagnostic test must be billed by the hospital. Only in cases where the patient leaves the hospital and obtains the service elsewhere is the hospital not required to bill for the service.

In the Medicare physician fee schedule final rule published in the ***Federal Register*** on November 2, 1999, HCFA required hospitals to bill for the technical component of pathology services furnished to its inpatient Medicare beneficiaries. Based on public comments received, it was decided to delay implementation of that rebundling requirement until January 1, 2001 to allow independent laboratories and hospitals sufficient time to negotiate arrangements. To be consistent with the inpatient requirement, the same delay will be allowed for rebundling of the technical component of pathology services furnished to hospital outpatients. Therefore, the following pathology services furnished by independent laboratories to hospital outpatients **on or after August 1, 2000, and before January 1, 2001,** may continue to be paid by the carrier under the Medicare physician fee schedule:

HCPCS Code	Short Descriptor
85060	Blood smear interpretation
88160	Cytopath smear, other source
88199	Cytopathology procedure
88300	Surgical path, gross
88302	Tissue exam by pathologist
88311	Decalcify tissue
88313	Special stains
88319	Enzyme histochemistry
88321	Microslide consultation
88399	Surgical pathology procedure
80500	Lab pathology consultation
80502	Lab pathology consultation
86077	Physician blood bank service
88104	Cytopathology, fluids
88106	Cytopathology, fluids
88107	Cytopathology, fluids
88108	Cytopath, concentrate tech
88125	Forensic cytopathology
88161	Cytopath smear, other source
88162	Cytopath smear, other source
88172	Evaluation of smear
88173	Interpretation of smear
88304	Tissue exam by pathologist
88305	Tissue exam by pathologist
88312	Special stains
88314	Histochemical stain

HCPCS Code	Short Descriptor
88318	Chemical histochemistry
88323	Microslide consultation
88325	Comprehensive review of data
88329	Pathology consult in surgery
88331	Pathology consult in surgery
88332	Pathology consult in surgery
88346	Immunofluorescent study
88362	Nerve teasing preparations
89399	Pathology lab procedure
85097	Bone marrow interpretation
86078	Physician blood bank service
86079	Physician blood bank service
88180	Cell marker study
88182	Cell marker study
88307	Tissue exam by pathologist
88309	Tissue exam by pathologist
88342	Immunocytochemistry
88347	Immunofluorescent study
88348	Electron microscopy
88349	Scanning electron microscopy
88355	Analysis, skeletal muscle
88356	Analysis, nerve
88358	Analysis, tumor
88365	Tissue hybridization
89350	Sputum specimen collection
89360	Collect sweat for test

INPATIENT HOSPITAL SERVICES

Corrections to Calculation of Inpatient Payment Amounts

Further testing of the Inpatient PPS PRICER has identified minor problems with the software that have affected some payments calculated using the capital hospital specific rate and/or wage indexes for certain areas for inpatient bills with dates of discharge after September 30, 2000.

Users of the Fiscal Intermediary Shared System (FISS) will continue to pay inpatient hospital claims with discharge dates after September 30, 2000 and dates of receipt before October 14, 2000. These claims will be adjusted as soon as possible after installation of the new PRICER software, which it is expected to occur by October 30, 2000. Claims with discharge dates after September 30, 2000 and dates of receipt after October 13, 2000, will be held until the new software is installed and then released for processing.

After the new PRICER software is installed, FISS users must adjust previously processed bills with discharge dates after September 30, 2000, for providers classified as fully prospective for capital (type C) that have a cost report start date other than October 1, 2000. The corrected update factor is coded in the new PRICER software as 1.0147. ❖

ESRD

Clarification of Fiscal Intermediary and Durable Medical Equipment Regional Carrier Responsibilities Concerning Home Dialysis Method Election and Claim Processing

The Health Care Financing Administration (HCFA) has provided clarification concerning the responsibilities surrounding home dialysis method election and claim processing jurisdiction between the fiscal intermediary (FI) and the durable medical equipment regional carrier (DMERC).

Introduction

When a beneficiary with end stage renal disease (ESRD) begins a course of home dialysis, he or she fills out Form HCFA-382, "ESRD Beneficiary Selection," to choose whether he or she wants to use Method I or Method II to obtain home dialysis equipment and supplies. Method I dialysis beneficiaries receive their dialysis equipment and supplies directly from a dialysis facility. Claims for Method I dialysis are processed by the FIs. Method II dialysis beneficiaries choose to deal directly with a home dialysis supplier. Claims for Method II dialysis are processed by the DMERCs.

Proper Completion of Section D of Form HCFA-2728-U3

Under most circumstances, Medicare entitlement for individuals with ESRD undergoing dialysis treatment begins the third month after the month in which a regular course of dialysis begins. This 3-month waiting period is waived, however, if a beneficiary begins a self-dialysis training program in a Medicare approved training facility and is expected to self-dialyze after completion of the training. Form HCFA-2728-U3, "End Stage Renal Disease Medical Evidence Report Medicare Entitlement and/or Patient Registration," is completed by the patient's physician and sent to the Social Security Administration (SSA), which establishes the beneficiary's entitlement record. Section D, "Complete for All ESRD Self-Dialysis Training Patients (Medicare Applicants Only)," must be completed in order for the SSA to know that the waiting period should be waived. Dialysis facilities are encouraged to make certain that this section is completed for those Medicare beneficiaries participating in self-dialysis training programs to ensure the proper and timely establishment of entitlement.

Initial Selection

If an ESRD beneficiary chooses to participate in a self-dialysis training course and his or her physician certifies that it is reasonable to expect the individual to complete the training program and self-dialyze on a regular basis, the beneficiary must fill out Form HCFA-382 to choose either Method I or Method II dialysis. Dialysis facilities are responsible for obtaining the completed form from the beneficiary and sending it to the appropriate FI. When an FI receives the correctly completed HCFA-382, it must enter the beneficiary's choice in the Common Working File (CWF).

Changes in Method Selection

If a beneficiary decides to change his or her method selection, he or she must fill out a new Form HCFA-382 indicating the change. The beneficiary may fill out a new method election form at any time, but the change will not be effective until January 1 of the following calendar year in most circumstances. See Medicare Intermediary Manual (MIM) section 3644.4. As with initial choices of method selection, the dialysis facility must submit the new form to the appropriate FI, which in turn must enter the change into CWF with the correct effective date.

Exceptions to the January 1 Effective Date for Changes in Method Selection

There are situations in which a beneficiary may be allowed to make a change in method selection on a date other than January 1st. Some examples include:

- Failure of a kidney transplant within the past 6 months
- Patient is confined to a nursing home or hospice
- Home patient enters a facility as an infacility patient and then elects to go on home dialysis again after at least 6 full months in the center
- Patient changes place of residence and his or her new facility does not recognize the present method of payment, and another facility is not available
- Patient is in a life-threatening situation

To request an exception to the January 1 implementation date, a beneficiary or his or her authorized representative must submit a written request to the appropriate FI. The FI has discretion on whether or not to grant an exception.

FI Responsibility to Enter Method Selection in a Timely Manner

Proper payment of home dialysis claims depends upon the proper establishment of a beneficiary's method selection choice in CWF. FIs are responsible for entering method selection information into CWF, regardless of whether the beneficiary chooses Method I or Method II. HCFA-382 forms for initial method selection must be entered by the FI within 30 days of receipt. If a provider enters HCFA-382 information electronically, the FI is similarly responsible to ensure that it is processed to completion. If the beneficiary's entitlement record is not yet entered in the enrollment database, FIs must follow up every 30 days until entitlement is established and the initial method selection has been correctly entered.

Clarification of FI and DMERC Responsibilities Concerning Home Dialysis Method Election ... (continued)

Changes in method selection are not effective until January 1 of the year after a beneficiary filled out a new Form HCFA-382, unless the beneficiary requests and the FI decides to grant an exception. For example, if a beneficiary filled out a new method election form, changing from Method II to Method I on October 12th, 2000, the change in method selection would not be effective until January 1, 2001. In this example, the DMERCs would continue to process claims for October, November, and December 2000, even though Form HCFA-382 was dated in October. Because CWF only maintains three iterations of method selection, changes in method selection for the coming year must be entered between December 1st and December 31st of the year before the change becomes effective. All changes must be entered by December 31st to assure proper claims processing for the new calendar year, except in cases where Form HCFA-382 was not filed on time (see below). In instances where a beneficiary requests, and an FI decides to grant, an exception to the January 1 effective date, changes in method selection must be entered within thirty days of receipt.

Late-Filed Changes in Method Selection

If a beneficiary decides to change method selection late in the year, the FI may not receive the new form noting the change until after December 31st. In these situations, if the FI determines that the beneficiary or his or her authorized representative signed and completed the form prior to December 31st, the FI must enter the method election choice within one week of receipt. If the beneficiary did not fill out Form HCFA-382 form until after December 31st, the change in method selection will not be effective until the following January, unless the beneficiary requests and the FI grants an exception. **Renal facilities are encouraged to submit method selection changes that are filed late in the year as quickly as possible.** ❖

ESRD Claims Processed under Outpatient Prospective System

End Stage Renal Disease (ESRD) claims are receiving error #28 from the OPPS outpatient code editor (OCE) for several covered drugs codes.

Medicare contractors were instructed by HCFA to bypass the edit causing error 28 for claims submitted by ESRD providers on an interim basis. This process will be in place until such time as the OPPS OCE edit is corrected. ❖

SKILLED NURSING FACILITY SERVICES

Correction to the Health Insurance Prospective Payment System Assessment Indicators

An article addressing the Health Insurance Prospective Payment System (HIPPS) coding changes was published in the October/November 2000 *Medicare A Bulletin* (pages 14-15). The assessment indicators to report 30-day Medicare-required assessment and 90-day Medicare-required assessment were inadvertently omitted. The correct coding is:

Assessment Indicator	Descriptor
01	5-day Medicare-required assessment/not an initial admission assessment
02	30-day Medicare-required assessment
03	60-day Medicare-required assessment
04	90-day Medicare-required assessment

ELECTRONIC DATA INTERCHANGE

The Health Insurance Portability and Accountability Act

The following article was provided by the Health Care Financing Administration (HCFA) endorsing the Health Insurance Portability and Accountability Act (HIPAA) initiative.

THE HYPE ABOUT HIPAA

If you haven't heard of HIPAA, you have a lot of catching up to do!

In 1996 Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. The Administrative Simplification provisions of HIPAA direct the federal government to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans, and providers. This will enable the **entire** health care industry to communicate electronic data using a **single set** of standards thus eliminating all nonstandard formats currently in use. Once these standards are in place, a health care provider will be able to submit a standard transaction for eligibility, authorization, referrals, claims, or attachments containing the same standard data content to **any** health plan. This will "simplify" many clinical, billing, and other financial applications and reduce costs.

The Transaction Final Rule is the first of the Administrative Simplification requirements to be published in the ***Federal Register***. It was published on August 17, 2000 and requires providers to use the applicable standards for electronic transactions such as: submitting claims; receiving remittance advice statements; querying patient eligibility; checking claim status; requesting prior authorization where required for certain items of durable medical equipment; or requesting payment for the limited number of drugs covered by Medicare. These standards will be fully implemented October 16, 2002 (October 16, 2003 for small health plans). When fully implemented, Medicare contractors and other health care payers will be prohibited from accepting or issuing transactions that do not meet the new standards.

Health care providers and suppliers who conduct business electronically are urged to begin considering what steps they may need to take to upgrade their software to conform to the new standards. This can be done either independently or through commercial vendors. Health providers can also consider arranging for the services of a commercial clearinghouse or billing service knowledgeable about the new requirements to translate data on their behalf.

A copy of the Transaction and Code Set Final Rule, as well as more information on the full range of Administrative Simplification requirements (including identifiers, security and privacy of health information proposed rules) can be obtained from the following web site: http://aspe.hhs.gov/admnsimp/.

Look for further important HIPAA information in upcoming issues of this publication. ❖

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Technical Corrections to Coding Information for Hospital Outpatient Prospective Payment System (OPPS)

The following article was previously published on October 10, 2000, via the First Coast Service Options, Inc. Medicare provider website, www.floridamedicare.com.

Introduction

The Health Care Financing Administration (HCFA) has issued a list of long descriptor corrections to include the trade/brand names and/or model numbers to the specific assigned C-code for devices eligible for transitional pass-through payments under the OPPS. **The long descriptors in this publication supersede any previously published long descriptors for each C-code listed below**. Unless otherwise indicated, the effective date for the items in this publication applies to the date of service furnished **on or after October 1, 2000.**

The Outpatient Code Editor and PRICER software currently contain the codes included in this document. The long descriptors for some of the codes listed below may change with the upcoming 2001 HCPCS annual update effective January 1, 2001.

All of the C-codes included in this article are used exclusively for services paid under the outpatient PPS and may **not** be used to bill services paid under other Medicare payment systems. The listing of HCPCS codes contained in this instruction does not assure coverage of the specific item or service in a given case. To be eligible for pass-through and new device technology payments, the items contained in this document must be considered reasonable and necessary.

HCPCS Codes	Long Descriptors for Pass-Through Devices
C1000	Closure, arterial vascular device, Perclose Closer Arterial Vascular Closure Device, Prostar Arterial Vascular Closure Device, Vascular Solutions Duett Sealing Device (Model 1000)
C1036	Port/reservoir, venous access device, Vaxcel Implantable Vascular Access System, R Port Premier Vascular Access System
C1040	Stent, self-expandable for creation of intrahepatic shunts, Wallstent Transjugular Intrahepatic Portosystemic Shunt (TIPS) with Unistep Plus Delivery System (40/42/60/68 mm in length), Wallstent **RP** TIPS Endoprosthesis with Unistep Plus Delivery System (42/68 mm in length)

NOTE: Only the Wallstent RP TIPS Endoprosthesis with Unistep Plus Delivery System **is effective October 1, 2000.** The Wallstent TIPS Endoprosthesis with Unistep Plus Delivery System was effective August 1, 2000.

HCPCS Code	Long Descriptors for Pass-Through Devices
C1100	Guide wire, percutaneous transluminal coronary angioplasty, Medtronic AVE GT1 Guide Wire, Medtronic AVE GT 2 Fusion Guide Wire
C1371	Stent, biliary, Symphony Nitinol Stent Transhepatic Biliary System, Symphony Nitinol Biliary Stent with Radiopaque Markers
C1803	Brachytherapy seed, Best Industries Iodine 125, Nycomed Amersham I-125 (OncoSeed, Rapid Strand)
C1859	DuraDerm Acellular Allograft, per 21, 24 or 28 square centimeters, Dermagraft, per 37.5 square centimeters
C1937	Catheter, Synergy Balloon Dilatation Catheter, Explorer ST 6F
C2002	Catheter, Irvine Inquiry Steerable Electrophysiology 5F Catheter, Cardiac Pathways RV Reference Catheter, Cardiac Pathways 7F Radii Catheter
C2004	Catheter, electrophysiology, EP Deflectable Tip Catheter, (Octapolar Small Anatomy Models only)
C2005	Catheter, electrophysiology, EP Deflectable Tip Catheter (Hexapolar Small Anatomy Models only)
C2006	Catheter, electrophysiology, EP Deflectable Tip Catheter (Decapolar Small Anatomy Models only)
C2008	Catheter, electrophysiology, Irvine Luma-Cath 7F Steerable Electrophysiology Catheter Model 81910, Model 81915, Model 81912, Cardiac Pathways CS Reference Catheter
C2009	Catheter, electrophysiology, Irvine Luma-Cath 7F Steerable Electrophysiology Catheter Model 81920, Cardiac Pathways 7F Radii Catheter with Tracking
C2010	Catheter, electrophysiology, Cordis Fixed Curve Catheter (Decapolar Small Anatomy Models only, Hexapolar Small Anatomy Models only, Octapolar Small Anatomy Models only, Quadrapolar Small Anatomy Models only), Bard Viking Fixed Curve Catheter (Bipolar, Quadrapolar, ASP Models only)

Technical Corrections to Coding Information for Hospital Outpatient PPS (continued)

HCPCS Code	Long Descriptors for Pass-Through Devices
C2011	Catheter, electrophysiology, Cordis Deflectable Tip Catheter (Quadrapolar Small Anatomy Models only)
C2012	Catheter, ablation, Biosense Webster Celsius Braided Tip Ablation Catheter, Biosense Webster Celsius 5mm Temperature Ablation Catheter, Biosense Webster Celsius Temperature Sensing Diagnostic/Ablation Tip Catheter (formerly listed as Biosense Webster Celsius II Temperature Sensing Diagnostic/Ablation Tip Catheter)
C2014	Catheter, ablation, Biosense Webster Celsius II Asymmetrical Ablation Catheter, Cardiac Pathways Chilli Cooled Ablation Catheter Standard Curve (Model 3005) or Large Curve (Model 3006)
C2017	Catheter, ablation, Navi-Star Diagnostic/ Ablation Deflectable Tip Catheter, Cardiac Pathways Chilli Cooled Ablation Catheter 41422, 41442, 45422, 45442, 43422, 43442
C2020	Catheter, ablation, Blazer II XP, Blazer II 6F, Blazer II High Torque
C2609	Catheter, Flexima Biliary Drainage Catheter with Locking Pigtail, Flexima Biliary Drainage Catheter with Twist Loc Hub, Flexima Biliary Drainage Catheters with Temp Tip
C5280	Stent, ureteral, Bard Inlay Double Pigtail Ureteral Stent, Boston Scientific Contour Soft Percuflex Stent with Hydroplus Coating (Braided), Contour Soft Percuflex Stent with Hydroplus Coating, Contour VL Variable Length Percuflex Stent with Hydroplus Coating, Percuflex Plus Stent with Hydroplus Coating, Percuflex Stent (Braided)
C5283	Stent, self-expandable for creation of intrahepatic shunts, Wallstent Transjugular Intrahepatic Portosystemic Shunt (TIPS) with Unistep Plus Delivery System (90/94 mm in length), Wallstent **RP** TIPS Endoprosthesis with Unistep Plus Delivery System (94 mm in length) **NOTE:** Only the Wallstent RP TIPS Endoprosthesis with Unistep Plus Delivery System is **effective October 1, 2000**. The Wallstent TIPS with Unistep Plus Delivery System was effective August 1, 2000.

HCPCS C-code	Long Descriptors for New Device Technology Ambulatory Payment Classifications (APC)s	APC
C8522	Stent, biliary, PALMAZ Balloon Expandable Stent , Spiral Z Biliary Metal Expandable Stent, Za Biliary Metal Expandable Stent	990
C8529	Ismus Cath Deflectable 20-Pole Catheter/Crista Cath II Deflectable 20-Pole Catheter	990
C8532	Stent, esophageal, UltraFlex Esophageal Stent System, Esophageal Z Metal Expandable Stent with Dua Anti-Reflux Valve, Esophageal Z Metal Expandable Stent with Uncoated Flanges	991

NOTE: The HCPCS code assigned to the device(s) listed in this PM may be used only for that specific device. An already- assigned HCPCS C-code may not be substituted for a different brand/trade name device not listed in this PM, even if it is the same type of device. ❖

Correct Coding Initiative – Two New Versions

With the implementation of the prospective payment system for hospital outpatient services, the fiscal intermediary outpatient code editor (OCE) was modified to include, among other functions, a number of correct coding initiative (CCI) edits and unit edits.

Version 6.3 of the Correct Coding Initiative (CCI) was implemented on October 30, 2000, effective for services furnished **on or after October 1, 2000.** Version 6.3 includes all previous versions and updates from January 1996 to the present. Version 7.0 (which also includes all previous versions and updates) is effective for services furnished **on or January 1, 2001.**

The U.S. Department of Commerce, National Technical Information Service (NTIS) develops and maintains a national correct coding policy manual to assist providers in correctly coding services for reimbursement. Medicare contractors are prohibited from publishing specific correct coding edits (CCE). Concerns about correct coding edit pairs must be submitted in writing to:

The Correct Coding Initiative
AdminaStar Federal
P. O Box 50469
Indianapolis, IN 46250-0469

If a provider frequently receives error messages indicating HCPCS codes that have failed CCI edits or unit edits, it may be useful to obtain a current set of CCI edits. Generally, it is best to bill only for the highest value procedure code and omit the lesser value code(s). Medicare may then process the claim for the service rendered.

How to Obtain the CCI Edits

Although Medicare contractors are prohibited from publishing specific CCI edits, this information may be obtained by ordering the *National Correct Coding Policy Manual* from the National Technical Information Service (NTIS).

- To request a single issue of the *National Correct Coding Policy Manual*, call (703) 605-6000.
- For a subscription to the *National Correct Coding Policy Manual*, call (703) 605-6060 or (800) 363-2068.
- To receive information from NTIS by mail, call (800) 553-6847.
- Ordering and product information is also available on the World Wide Web at *www.ntis.gov/cci*.

As a reminder, Florida Medicare is not liable for information provided by AdminaStar Federal and/or NTIS. ❖

MEDICAL POLICIES

The Health Care Financing Administration (HCFA) instructions regarding development of local medical review policies (LMRPs) are addressed in the Medicare Intermediary Manual (HCFA publication 13-3, section 3911), indicating, "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 is covered. LMRPs are also developed to clarify or to provide specific details 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 containing information the provider must know to ensure compliance.

Effective Dates

In accordance with HCFA guidelines, a minimum 30-day advance notice is required when initially implementing a final LMRP.

Medical Policy Table of Contents

The LMRPs published in this section, are effective approximately 30 days from the date of this publication. Therefore, the policies contained in this section are effective for claims processed **January 1, 2001**, and after, unless otherwise noted.

Medicare Part A Medical Policy Procedures

Medical policies may be applied to Medicare claims on a pre-payment or post-payment basis. Medicare providers are accountable for compliyng with Medicare coverage/policy information published via national HCFA transmittals, or fiscal intermediary publication of LMRP.

Maintaining Local Medical Review Policies For Reference

Providers are encouraged to maintain all published medical policies on file (e.g., the policies published in this document); perhaps placing them in a manual/binder where they may be accessed/referenced by facility staff. In response to reader comments, the Medical Policy section may be removed separately, without disturbing the rest of the articles in the publication. ❖

*Final LMRPs are available on the Florida Medicare provider website (**www.floridamedicare.com**).*

Q0136: Non–ESRD Epoetin (Procrit)—Revision to Policy

The local medical review policy (LMRP) for Non–ESRD Epoetin (Procrit) – Q0136 was published in the October/November 2000 *Medicare A Bulletin* (pages 50-52. In that policy, the type of bill code for rural health clinic was inadvertently printed as 72x. The correct type of bill codes to report services furnished for Non–ESRD Epoetin are:

Type of Bill Code

Hospital – 13x
Skilled Nursing Facility – 21x
Rural Health Clinic – 71x. ❖

71010: Chest X-Ray—Addition to Policy

The local medical review policy for Chest X-ray – 71010 was published in the August/September 2000 *Medicare A Bulletin* (pages 23-31). In addition, changes to the policy based on the 2001 ICD-9-CM coding update was published in the October/November 2000 *Medicare A Bulletin* (page 53). Since that time the diagnosis range for malignant neoplasm of brain (191.0-191.9) has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy. This addition was effective for claims processed **on or after November 3, 2000.** ❖

99183, C1300: Hyperbaric Oxygen Therapy

The Health Care Financing Administration has revised the national coverage policy for hyperbaric oxygen (HBO) therapy. The local medical review policy will be revised to reflect national coverage and will be published on a later date.

For purposes of coverage under Medicare, hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.

Covered Conditions

Program reimbursement for HBO therapy will be limited to that which is administered in a chamber (including the one-man unit) and is limited to the following conditions:

- Acute carbon monoxide intoxication, (ICD-9-CM diagnosis 986)
- Decompression illness, (ICD-9-CM diagnosis 993.2, 993.3)
- Gas embolism, (ICD-9-CM diagnosis 958.0, 999.1)
- Gas gangrene, (ICD-9-CM diagnosis 040.0)
- Acute traumatic peripheral ischemia. HBO 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. (ICD-9-CM diagnosis 902.53, 903.01, 903.1, 904.0, 904.41)
- Crush injuries and suturing of severed limbs. As in the previous conditions, HBO therapy would be an adjunctive treatment when loss of function, limb, or life is threatened. (ICD-9-CM diagnosis 927.00-927.03, 927.09-927.11, 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, 996.90- 996.99)
- Progressive necrotizing infections (necrotizing fasciitis), (ICD-9-CM diagnosis 728.86)
- Acute peripheral arterial insufficiency, (ICD-9-CM diagnosis 444.21, 444.22, 444.81)
- Preparation and preservation of compromised skin grafts (not for primary management of wounds), (ICD-9-CM diagnosis 996.52; excludes artificial skin graft)*****

  ***NOTE:** The covered indication of "preparation and preservation of compromised skin grafts" requires that a compromised skin graft be present. This indication is not for primary management of wounds.
- Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management, (ICD-9-CM diagnosis 730.10-730.19)
- Osteoradionecrosis as an adjunct to conventional treatment, (ICD-9-CM diagnosis 526.89)
- Soft tissue radionecrosis as an adjunct to conventional treatment, (ICD-9-CM diagnosis 990)
- Cyanide poisoning, (ICD-9-CM diagnosis 987.7, 989.0)
- Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment, (ICD-9-CM diagnosis 039.0-039.4, 039.8, 039.9)

Noncovered Conditions

All other indications not specified under the "Covered Conditions" section are not covered under the Medicare program. No program payment may be made for any conditions other than those listed in "Covered Conditions" section.

No program payment may be made for HBO in the treatment of the following conditions:

- Cutaneous, decubitus, and stasis ulcers
- Chronic peripheral vascular insufficiency
- Anaerobic septicemia and infection other than clostridial
- Skin burns (thermal)
- Senility
- Myocardial infarction
- Cardiogenic shock
- Sickle cell anemia
- Acute thermal and chemical pulmonary damage, i.e., smoke inhalation with pulmonary insufficiency
- Acute or chronic cerebral vascular insufficiency
- Hepatic necrosis
- Aerobic septicemia
- Nonvascular causes of chronic brain syndrome (Pick's disease, Alzheimer's disease, Korsakoff's disease)
- Tetanus
- Systemic aerobic infection
- Organ transplantation
- Organ storage
- Pulmonary emphysema
- Exceptional blood loss anemia
- Multiple Sclerosis
- Arthritic Diseases
- Acute cerebral edema

Reasonable Utilization Parameters

Florida Medicare will issue payment when HBO therapy is clinically practical. HBO therapy should not be a replacement for other standard successful therapeutic measures. Depending on the response of the individual patient and the severity of the original problem, treatment may range from less than 1 week to several months duration, the average being 2 to 4 weeks. Medical necessity for use of hyperbaric oxygen for more than 2 months will be reviewed and must be documented, regardless of the condition of the patient, before further reimbursement is made.

Topical Application of Oxygen

This method of administering oxygen does not meet the definition of HBO therapy as stated above. Also, its clinical efficacy has not been established. Therefore, no Medicare reimbursement may be made for the topical application of oxygen. ❖

66821: YAG Laser Capsulotomy

Policy Number
66821

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
YAG Laser Capsulotomy

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Section 35-52

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
07/30/1998

Revision Effective Date
08/01/2000

Revision Ending Effective Date
07/31/2000

Policy Ending Date
N/A

LMRP Description
The neodymium:YAG (Nd:YAG) laser is used to treat posterior capsulotomies for posterior capsule opacification. Posterior capsule opacification generally occurs following cataract surgery. Desired outcomes of use of the Nd:YAG laser are an increase in visual acuity and/or improvement in glare and contrast sensitivity.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider the Nd:YAG laser capsulotomy medically necessary and reasonable if the following criteria are met:

- The patient complains of symptoms such as blurred vision, visual distortion and/or glare resulting in reduced ability or inability to carry out activities of daily living due to decreased visual acuity or an increase in glare, particularly under bright light conditions, and/or conditions of night driving.
- The eye examination confirms the diagnosis of posterior capsular opacification and excludes other ocular causes of functional impairment by one of the following methods.
  - The eye examination should demonstrate decreased light transmission (visual acuity 20/30 or 20/25 if the procedure is performed to assist in the diagnosis and treatment of retinal detachment) after other causes of loss of acuity have been ruled out, or
  - Additional testing must demonstrate 1) contrast sensitivity testing resulting in a decreased visual acuity by two lines or 2) a decrease of two lines of visual acuity in the glare tester, and
- This procedure should not be routinely scheduled after cataract surgery and rarely would it be expected to see this procedure performed within four months following cataract surgery.
- Occasionally, a YAG laser capsulotomy may also be performed to assist in the diagnosis and treatment of retinal detachment; to assist in the diagnosis and treatment of macular disease; to assist in the diagnosis and treatment of diabetic retinopathy; to evaluate the optic nerve head; or to diagnose posterior pole tumors.
- Generally, the YAG laser capsulotomy is expected to be performed only once per eye per lifetime of a beneficiary.

HCPCS Section & Benefit Category
Eye and Ocular Adnexa/Surgery

Type of Bill Code
Hospital – 13x
Skilled Nursing Facility – 21x, 23x
Rural Health Clinic – 71x

Revenue Code
361 Minor Surgery

HCPCS Codes
66821 Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (one or more stages)

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
366.50 After-cataract, unspecified
366.51 Soemmering's ring
366.53 After-cataract, obscuring vision

Diagnosis that Support Medical Necessity
N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity
N/A

66821 YAG Laser Capsulotomy (continued)

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

- When a series of procedures is planned for the removal of a posterior dense fibrotic capsule, it will be covered as a single procedure.
- If the procedure is performed on the same patient, on the same eye and is not part of a series of posterior capsule removal, documentation must be submitted to determine the medical necessity of the subsequent procedure(s).

Documentation Requirements

Medical record documentation maintained by the performing physician must clearly indicate the medical necessity of the service 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 procedure report. The documentation should include the results of a visual acuity test and/or a glare test.

Documentation may be requested if procedure code 66821 is billed within four months of cataract surgery.

Documentation should support the criteria for coverage as set forth in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

Claesson, M., Klaren, L., Beckman, C. & Sjostrand, J. (1994). Glare and contrast sensitivity before and after Nd:YAG laser capsulotomy. *Acta Ophtalmologica, 72,* 27-32.

Magno, B., Datiles, M., Maria, S., Fajardo, M., Caruso, R., & Kaiser-Kupfer, M. (1997). Evaluation of visual function following neodymium: YAG laser posterior capsulotomy. *Ophthalmology,* 104(8), 1288-1293.

Roger, J, McPherson, B., & Govan J. (1995). Posterior capsule reopacification after neodymium: YAG laser capsulotomy. *Journal of Cataract Refractory Surgery,* 21, 351-352.

Advisory Committee Notes

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

Start Date of Comment Period

N/A

Start Date of Notice Period

02/25/2000

Revision History

Revision Number:	2	
Start Date of Comment Period:	N/A	
Start Date of Notice Period:	02/25/2000 *Special Issue 2000 Bulletin*	
Revised Effective Date:	08/01/2000	
Explanation of Revision:	Outpatient PPS implementation	
Start Date of Comment Period:	N/A	
Start Date of Notice Period:	N/A	
Original Effective Date:	07/30/98	
Revision Date/Number:	07/30/98	1
Start Date of Comment Period:	02/23/98	
Start Date of Notice Period:	05/29/98	
Original Effective Date:	07/30/98 ❖	

82378: Carcinoembryonic Antigen (CEA)

Policy Number
82378

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Carcinoembryonic Antigen (CEA)

AMA CPT Copyright Statement

HCFA National Coverage Policy
N/A

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
01/01/2001

Revision Effective Date
N/A

Revision Ending Effective Date
N/A

Policy Ending Date
N/A

LMRP Description
Carcinoembryonic antigen (CEA) is a glycoprotein that circulates at a high level during fetal life and is detectable in only tiny amounts in the bloodstream of adults. CEA is elevated in certain types of malignancies, and thus is useful as a tumor marker.

In the early 1960's, CEA was thought to be a specific indicator for the presence of colorectal cancer. However, this protein has been found in patients who have other types of carcinomas, sarcomas, and even many benign diseases (e.g., ulcerative colitis, diverticulitis, cirrhosis, rectal polyps, peptic ulcer disease, pancreatitis). Another condition which causes elevated CEA levels is heavy cigarette smoking.

Because the CEA level can be elevated in both benign and malignant diseases, it is not considered to be a specific test for colorectal cancer. As a result, CEA is not a reliable screening test for the detection of colorectal cancer. CEA is useful in determining the prognosis and monitoring the patient's response to antineoplastic therapy. The degree of increase in the CEA level on the initial test can be an indicator of tumor burden and prognosis. A drastic reduction to normal CEA levels is expected with a complete eradication of the tumor. Therefore, this test is used to determine the adequacy of treatment.

CEA is useful for the follow-up of certain types of known cancer. If the CEA level begins to rise after treatment, this can be an indication of tumor recurrence. This makes CEA testing valuable in the follow-up of patients who have had potentially curative therapy.

CEA is helpful but not conclusive, and thus of little value, in a diagnostic work-up for cancer because (1) many patients with advanced breast or gastrointestinal tumors may not have elevated CEA levels and (2) many conditions other than cancer may cause elevated CEA levels.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider a CEA test medically reasonable and necessary when performed for the following indications:

- To determine the adequacy of antineoplastic therapy.
- As a serum tumor marker to monitor the status of various kinds of malignant tumors.

CEA is **not** indicated as a screening test for cancer.

HCPCS Section & Benefit Category
Pathology and Laboratory/Chemistry

Type of Bill Code
Hospital – 12x, 13x, 14x
Skilled Nursing Facility – 21x, 22x, 23x
Rural Health Clinic – 71x
End Stage Renal Disease – 72x

Revenue Code
301 Chemistry

HCPCS Codes
82378 Carcinoembryonic antigen (CEA)

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

151.0-151.9	Malignant neoplasm of stomach
152.0-152.9	Malignant neoplasm of small intestine, including duodenum
153.0-153.9	Malignant neoplasm of colon
154.0-154.8	Malignant neoplasm of rectum, rectosigmoid junction, and anus
159.0	Malignant neoplasm of other and ill-defined sites within the intestinal tract, part unspecified
162.0-162.9	Malignant neoplasm of trachea, bronchus, and lung
174.0-174.9	Malignant neoplasm of female breast
175.0-175.9	Malignant neoplasm of male breast
197.4	Secondary malignant neoplasm of small intestine, including duodenum

82378: **Carcinoembryonic Antigen (CEA)** ***(continued)***

197.5	Secondary malignant neoplasm of large intestine and rectum
235.2	Neoplasm of uncertain behavior of stomach, intestines, and rectum
V10.03	Personal history of malignant neoplasm, esophagus
V10.04	Personal history of malignant neoplasm, stomach
V10.05	Personal history of malignant neoplasm, large intestine
V10.06	Personal history of malignant neoplasm, rectum, rectosigmoid junction, and anus
V10.11	Personal history of malignant neoplasm, bronchus and lung
V10.3	Personal history of malignant neoplasm, breast

Diagnosis that Support Medical Necessity

N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

N/A

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the test. In addition, the documentation must support that the procedure was performed. This information is usually found in the history and physical, office/progress notes, or lab reports.

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

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

American Society of Clinical Oncology (1996). Clinical practice guidelines for the use of tumor markers in breast and colorectal cancer. *The Journal of Clinical Oncology*, 14 (10), 2843-2877.

Banfi, G., Bravi, S., Ardemagni, A., and Zerbi, A. (1996). CA19.9, CA242 and CEA in the diagnosis and follow-up of pancreatic cancer. *Int. Journal of Biological Markers*, 11(2), 77-81.

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Advisory Committee Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from numerous societies.

Start Date of Comment Period

08/05/1998

Start Date of Notice Period

11/01/2000

Revision History

Revision Number:	Original
Start Date of Comment Period:	08/05/1998
Start Date of Notice Period:	11/01/2000
	1st Quater 2001 Bulletin
Original Effective Date:	01/01/2001 ❖

84100: Serum Phosphorus

Policy Number
84100

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Serum Phosphorus

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Intermediary Manual, Section 3167
Coverage Issues Manual, Section 50-17

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
01/01/2001

Revision Effective Date
N/A

Revision Ending Effective Date
N/A

Policy Ending Date
N/A

LMRP Description
Phosphorus is a non-metallic chemical element. Most of the body's phosphorus is combined with calcium within the skeleton; however, approximately 15% of phosphorus exists in the blood as a phosphate salt. Phosphates help store and utilize body energy. Additionally, they help regulate calcium levels, carbohydrate and lipid metabolism, and acid-base balance. Vitamin D is important in the absorption and metabolism of phosphorus. Phosphorus levels are determined by calcium metabolism, parathyroid hormone, and to a lesser degree by intestinal absorption. Normal serum phosphorus is 2.5-4.5 mg/dl. Serum phosphate levels help to detect endocrine, skeletal, and calcium disorders, and aid in the diagnosis of renal disorders and acid-base imbalance.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider serum phosphorus testing medically reasonable and necessary under either of the two following circumstances:

1. Evaluation of patients with signs and symptoms of hypophosphatemia. Patients with mild hypophosphatemia usually have no clinical manifestations. Clinical findings below usually occur when the phosphate deficit is severe:

anorexia	hypercaliuria
nausea	osteomalacia
muscle weakness and soreness	rhabdomyolysis
bone pain	encephalopathy
apprehension	seizures
confusion	hemolysis
paresthesias	platelet dysfunction
mental obtundation	thrombocytopenia

Conditions in which serum phosphorus testing may be medically reasonable and necessary include, but are not limited to, the following which are related to hypophosphatemia:

- Decreased phosphate ingestion or absorption:
  - Malnutrition: alcoholism, starvation
  - Vitamin D deficiency
  - Malabsorption syndromes
  - Hyperalimentation without phosphate supplements
- Increased utilization or consequence of metabolism:
  - Pregnancy
  - Recovery from malnutrition or diabetic ketoacidosis: insulin and glucose therapy
  - Respiratory alkalosis: salicylate poisoning, gram-negative bacteremia
  - Lactate, sodium bicarbonate, or sodium chloride infusions
  - Absorption by bone following parathyroidectomy
- Excess losses of phosphate:
  - Dialysis
  - Diuretic therapy
  - Primary hyperparathyroidism
  - Renal tubular defects: congenital, after renal transplant, toxic, and diuretic phase following acute renal failure or burns
  - Oral antacid therapy
  - Hypomagnesemia

2. Evaluation of patients with hyperphosphatemia. Patients with hyperphosphatemia usually have no clinical symptoms *per se.* Symptoms may arise, however, from underlying conditions. Some signs of hyperphosphatemia can include, but are not limited to, the following:

   serum phosphorus level greater than 4.5 mg/dl on two fasting blood levels
   skeletal lesions on X-ray
   elevation of serum creatinine and alkaline phosphatase

Conditions in which serum phosphate testing may be medically reasonable and necessary include, but are not limited to, the following which are related to hyperphosphatemia:

84100: Serum Phosphorus (continued)

- Excess phosphate from exogenous sources:
  - Ingestion of dairy products
  - Ingestion of phosphate salts or use of phosphate enemas in patients with renal disease
  - Hypervitaminosis D
  - Sarcoidosis
- Excess phosphate from endogenous sources:
  - Metabolic or respiratory acidosis
  - Skeletal lesion, local: myeloma, Paget's disease, and metastatic carcinoma
  - Skeletal lesion, diffuse: prolonged skeletal immobilization, severe hyperparathyroidism secondary to renal disease
  - Phosphate release from tissue destruction or ischemia: irradiation or chemotherapy, hemolysis, lactic acidosis
- Impaired excretion of phosphate: renal disease, hypoparathyroidism

Even though a patient has a condition stated above, it is not expected that a serum phosphorus test be performed frequently for stable chronic symptoms that are associated with that disease.

Tests useful in the differential diagnosis include repeat serum phosphorus, alkaline phosphatase, calcium, parathyroid hormone, and skeletal X-ray.

In accordance with national Medicare coverage policy, serum phosphate laboratory tests are routinely covered at a frequency of once per month for hemodialysis, intermittent peritoneal dialysis, continuous cycling peritoneal dialysis, and hemofiltration beneficiaries. Services performed at a greater frequency are covered if medically necessary and used in timely medical decision making.

HCPCS Section & Benefit Category

Pathology and Laboratory/Chemistry

Type of Bill Code

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

Revenue Code

301 Laboratory, Chemistry

HCPCS Codes

84100 Phosphorus inorganic (phosphate)

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

135	Sarcoidosis
170.0-170.9	Malignant neoplasm of bone and articular cartilage
198.5	Secondary malignant neoplasm of bone and bone marrow
203.00-203.01	Multiple myeloma
238.6	Neoplasm of uncertain behavior of plasma cells (solitary myeloma)
252.0	Hyperparathyroidism
260-263.9	Nutritional deficiencies
268.0-268.9	Vitamin D deficiency
275.2	Disorders of magnesium metabolism (hypomagnesemia)
275.40-275.49	Disorders of calcium metabolism
276.0-276.9	Disorders of fluid, electrolyte, and acid-base balance
278.4	Hypervitaminosis D
278.8	Other metabolic disorders due to hyperalimentation (excess phosphate)
287.0-287.9	Purpura and other hemorrhagic conditions
293.0-293.1	Acute and subacute delirium (confusion)
298.9	Unspecified psychosis (mental obtundation)
348.3	Encephalopathy, unspecified
579.0-579.9	Intestinal malabsorption
580.0-588.9	Nephritis, nephrotic syndrome, and nephrosis
728.89	Other disorders of muscle, ligament, and fascia (rhabdomyolysis)
728.9	Unspecified disorder of muscle, ligament, and fascia (muscle weakness and soreness)
729.1	Myalgia and myositis, unspecified
731.0	Osteitis deformans without mention of bone tumor
733.90	Disorder of bone and cartilage, unspecified (bone pain)
753.9	Unspecified anomaly of urinary system (congenital renal tubular defects)
780.39	Other convulsions
782.0	Disturbance of skin sensation (paresthesias)
783.0	Anorexia
787.02	Nausea alone
790.6	Other abnormal blood chemistry
790.7	Bacteremia
793.0	Nonspecific abnormal findings on radiological examination of skull and head (skeletal lesions)
793.7	Nonspecific abnormal findings on radiological examination of musculoskeletal system (skeletal lesions)
799.2	Nervousness (apprehension)
965.1	Poisoning by salicylates
990	Effects of radiation, unspecified (phosphate release from tissue destruction or ischemia)
995.84	Adult neglect (nutritional)
E858.5	Accidental poisoning by water, mineral, and uric acid metabolism drugs
E933.3	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, alkalizing agents
E943.0	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antacids and antigastric secretion drugs
E944.0-E944.5	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, water, mineral, and uric acid metabolism drugs

84100: Serum Phosphorus (continued)

V45.89	Other postsurgical status (absorption by bone following parathyroidectomy)

Diagnosis that Support Medical Necessity

N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

Routine serum phosphate laboratory tests, those performed at a frequency of once per month for hemodialysis, intermittent peritoneal dialysis, continuous cycling peritoneal dialysis, and hemofiltration beneficiaries, are included in the *renal facility's* composite rate and may not be billed separately to the Medicare program. Services performed at a greater frequency than specified are separately billable if medically necessary. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of additional tests.

Documentation Requirements

Medical record documentation (e.g., office/progress notes) maintained by the ordering/referring physician must indicate the medical necessity for performing the test. Additionally, 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, 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.

Utilization Guidelines

In accordance with national Medicare coverage policy, serum phosphate laboratory tests are routinely covered at a frequency of once per month for hemodialysis, intermittent peritoneal dialysis, continuous cycling peritoneal dialysis, and hemofiltration beneficiaries. Services performed at a greater frequency are covered if medically necessary and used in timely medical decision making.

Other Comments

N/A

Sources of Information

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Advisory Committee Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from numerous societies.

Start Date of Comment Period

06/12/2000

Start Date of Notice Period

11/01/2000

Revision History

Revision Number:	Original
Start Date of Comment Period:	06/12/2000
Start Date of Notice Period:	11/01/2000
	1st Quarter 2001 Bulletin
Original Effective Date:	01/01/2001 ❖

95925: Somatosensory Testing

Policy Number
95925

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Somatosensory Testing

AMA CPT Copyright Statement

HCFA National Coverage Policy
N/A

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
01/01/2001

Revision Effective Date
N/A

Revision Ending Effective Date
N/A

Policy Ending Date
N/A

LMRP Description
Short-latency somatosensory evoked potentials (SEPs) represent early electrophysiologic responses of the somatosensory pathways to stimulation. Somatosensory testing involves the application of multiple brief electrical stimuli over peripheral nerves (e.g., the median, peroneal, and tibial nerves) and recording the evoked potentials over proximal portions of the nerves stimulated, the plexus, spine and/or scalp. These readings are then averaged by a computer and can be traced and recorded in the form of waveforms. A physician trained in interpreting clinical evoked potential studies then interprets these waveforms. The waveforms obtained should be described and the peak latencies, interpeak intervals (when appropriate), and amplitudes of the significant components detailed. The nerves most commonly stimulated are the median nerve at the wrist for testing in the upper extremity, and the common peroneal nerve (CPN) at the knee and the posterior tibial nerve at the ankle for the lower extremity.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider the use of short-latency somatosensory evoked potentials to be medically reasonable and necessary to assist in the diagnosis of certain neuropathologic states (as described below) in order to provide information for treatment and for intraoperative testing during spinal surgeries in which there is risk of additional nerve or spinal cord injury.

SEPs are used to evaluate the more proximal segments of nerves and the integrity of the central somatosensory pathways when slowing of conduction through the brain and/or brainstem, spinal cord, and/or peripheral nerves is suspected. This would include conditions such as multiple sclerosis, cervical spondylosis with myelopathy, coma, spinal cord trauma, hereditary and idiopathic peripheral neuropathies, inflammatory and toxic neuropathies, myoclonus, Friedreich's ataxia, syringomyelia, spinal cord tumors, spinal stenosis and other conditions where there is spinal cord compression.

HCPCS Section & Benefit Category
Medicine/Neurology and Neuromuscular Procedures

Type of Bill Code
Hospital – 12x, 13x
Skilled Nursing Facility – 21x, 22x, 23x
Rural Health Clinic – 71x
End Stage Renal Disease – 72x
Comprehensive Outpatient Rehabilitation Facility – 75x

Revenue Code
92x Other Diagnostic Services

HCPCS Codes

95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system, in upper limbs
95926	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system, in lower limbs
95927	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system, in the trunk or head

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

192.2	Malignant neoplasm of spinal cord
225.3	Benign neoplasm of spinal cord
237.5	Neoplasm of uncertain behavior of brain and spinal cord (spinal cord tumor)
250.61-250.63	Diabetes with neurological manifestations
333.2	Myoclonus
334.0	Friedreich's ataxia
334.1	Hereditary spastic paraplegia
336.0	Syringomyelia and syringobulbia
336.9	Unspecified disease of spinal cord (spinal cord compression)

95925: Somatosensory Testing (continued)

340	Multiple sclerosis
356.0-356.9	Hereditary and idiopathic peripheral neuropathy
357.0-357.9	Inflammatory and toxic neuropathy
721.1	Cervical spondylosis with myelopathy
723.0	Spinal stenosis in cervical region
724.02	Spinal stenosis, lumbar region
780.01	Coma
806.00-806.5	Fracture of vertebral column with spinal cord injury

Diagnosis that Support Medical Necessity

N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

Quantitative Sensory Testing (QST) performed with portable hand-held devices (e.g., current, vibration, thermal perception, or tactile) does not represent somatosensory evoked potential testing and should not be billed using the somatosensory codes (95925, 95926, or 95927). QST testing is considered part of the evaluation and management service, and therefore, should not be billed separately.

When billing for intraoperative somatosensory testing during spinal surgeries, procedure code 95920 (Intraoperative neurophysiology testing, per hour) should be billed in conjunction with the study performed (95925, 95926, or 95927). It would not be acceptable for the performing neurosurgeon to bill for the intraoperative monitoring, as another provider performs this while the surgery is in progress. Intraoperative monitoring performed by a technician is not separately reimbursable. It is not expected that intraoperative testing would be necessary for routine lumbar spinal surgeries where risk of additional injury to the nerves or spinal cord are not present.

Multiple services and/or the bilateral procedure modifiers do not apply, as the code descriptors for these services include "stimulation of any/all peripheral nerves or skin sites."

Documentation Requirements

Medical record documentation maintained by the performing physician must clearly indicate the medical necessity of the service being billed. There should be evidence in the medical record that the test results were noted and influenced or contributed to the patient's course of treatment. In addition, documentation that the service was performed must be included in the patient's medical record. This documentation should include a hard copy computer generated recording of the test results along with the physician's interpretation. This information is normally found in the office/progress notes, hospital records, and/or procedure notes.

Documentation should support the criteria for coverage as set forth in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

Adams, R., & Victor, M. (1993). *Principles of neurology* (5th edition). New York: McGraw-Hill.

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Advisory Committee Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from the Florida Neurological Society, the Florida Society of Physical Medicine & Rehabilitation, and the Florida Neurosurgical Society.

Start Date of Comment Period

08/15/2000

Start Date of Notice Period

11/01/2000

Revision History

Revision Number:	Original
Start Date of Comment Period:	08/15/2000
Start Date of Notice Period:	11/01/2000
	1st Quarter 2001 Bulletin
Original Effective Date:	01/01/2001 ❖

2001 HCPCS ANNUAL UPDATE

Annual Procedure Code Update

Effective for Services Rendered on or After January 1, 2001

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, 2001, refer to the coding changes in this publication. For dates of service in 2000, continue to use 2000 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 changed in its definition or code.

This special issue provides an overview of changes to the HCPCS coding structure for 2001. 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 2001. 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 2001 HCPCS update is divided into the following major sections:

Additions

The procedure/modifier codes listed in the "Modifiers and Procedure Codes Added for 2001" section (pages 33-35) are newly identified procedure codes and should be used only for services rendered on or after January 1, 2001.

Reactivations

The procedure/modifier codes listed in the "Modifiers and Procedure Codes Reactivated for 2001" section (page 37) identify previously discontinued procedure codes that are being reactivated and should be used only for services rendered on or after January 1, 2001

Revisions

The procedure/modifier codes listed in the "Modifiers and Procedure Codes Revised for 2001" section (pages 35-37) include procedure codes for which the descriptor has changed for 2001. When using these codes, refer to the *2001 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 2001" section (page 38) should not be used for service dates after December 31, 2000. However, Medicare contractors will continue to accept claims with discontinued procedure codes with 2001 service dates received prior to April 1, 2001. Services rendered in 2001 that are billed with discontinued procedure codes, will be allowed at 2001 payment rates (*2001 Fee Schedule Special Issue will be published by the end of December 2000*) when received between January 1, 2001, and March 31, 2001.

Effective for claims received on or after April 1, 2001, services for 2001 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 2001 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 2001 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 2001 Coding Books

Because of the many changes to the HCPCS coding structure, providers are strongly encouraged to purchase the 2001 *CPT* (Level I) book and/or the *2001 HCPCS Level II* coding book. Providers may purchase the 2001 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 2001 *CPT* book is $39.95 per copy for American Medical Association members, and $49.95 per copy for non-members. The 2001 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 *2001 CPT* book is also available on diskette. For additional information, call the toll-free number listed above.

Obtaining the 2001 HCPCS Alphanumeric Hardcopy

The 2001 alphanumeric hardcopy, titled *2001 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 2001 HCPCS Update

The 2000 HCFA Common Procedure Coding System (HCPCS) Update is effective for services provided **on or after January 1, 2001.** However, the Health Care Financing Administration extends a 90-day grace period where either 2000 or 2001 HCPCS codes are accepted. This grace period applies to claims received prior to April 1, 2001, which include 2000 discontinued codes for dates of service January 1, 2001 or later. The 3-month grace period also applies to discontinued HCPCS codes.

Therefore, effective January 1, 2001 through March 31, 2001, providers may use either 2000 and/or 2001 HCPCS codes. **Effective April 1, 2001, only the 2001 HCPCS codes will be accepted by Medicare.** ❖

Modifiers and Procedure Codes Added for 2001

MODIFIERS

GU
QQ
QV

HCFA ASSIGNED

A4290
A4319
A4324
A4325
A4331
A4332
A4333
A4334
A4348
A4396
A4464
A4561
A4562
A4608
A6021
A6022
A6023
A6024
A6231
A6232
A6233
A7018
A7019
A7020
A7501
A7502
A7503
A7504
A7505
A7506
A7507
A7508
A7509
A9508
A9510
A9700
C1009
C1010
C1011
C1012
C1013
C1014
C1016
C1017
C1018
C1019
C1135
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C1981
C2022
C2023
C2100
C2101
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C2104
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C2612
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C3003
C3004
C3510
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C4007
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C4009
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C4602
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C4606
C4607
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C5019
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C6201
C6202
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C8777
C8800
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C8830
C8890
C8891
C9011
C9107
C9700
C9701

Modifiers and Procedure Codes Added for 2001 (continued)

C9702
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E0149
E0168
E0298
E0571
E0572
E0574
E0617
E0756
E0757
E0758
E0765
E0786
E0830
E1035
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G0174
G0175
G0176
G0177
G0178
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G0192
G0193
G0194
G0195
G0196
G0197
G0198
G0199
G0200
G0201
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J1452
J1563
J2770
J2795
J2915
J2993
J2997
J3485
J7330
J7520
J7525
J8700
J9160
J9180
J9219
K0538
K0539
K0540
K0541
K0542
K0543
K0544
K0545
K0546
K0547
L3760
L3923
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L8044
L8045
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L8048
L8049
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P9032
P9033
P9034
P9035
P9036
P9037
P9038
P9039
P9040
P9041
P9042
P9043
P9044
Q2001
Q2002
Q2003
Q2004
Q2005
Q2006
Q2007
Q2008
Q2009
Q2010
Q2011
Q2012
Q2013
Q2014
Q2015
Q2016
Q2017
Q2018
Q2019
Q2020
Q2021
Q2022
Q3001
Q3002
Q3003
Q3004
Q3005
Q3006
Q3007
Q3008
Q3009
Q3010
Q3011
Q3012
V2790

CPT

00537
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00563
00566
00635
01112
01215
01951
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01953
15342
15343
16036
19102
19103
19295
21199
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22522
30465
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34800
34802
34804
34808
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34832
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36870
43231
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43240
43242
43256
43752
44132
44133
44135
44136
44370
44379
44383
44397
45327
45341
45342
45345
45387
47379
50545
50947
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64614
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71275
71551
71552
72191
72195
72197
73206
73218

Modifiers and Procedure Codes Added for 2001 (continued)

73219
73222
73223
73706
73718
73719
73722
73723
74175
74182
74183
75635
75952
75953
76012
76013
76393
76819
77522
77525
80157
80173
82373
82945
83090
83663
83664
83921
84152
84591
85307
85536
86001
86146
86294
86300
86301
86304
86611
86666
86683
86696
86757
87046
87071
87073
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87107
87149
87152
87168
87169
87172
87185
87254
87273
87275
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87281
87283
87300
87327
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87337
87339
87341
87400
87427
87451
87800
87801
87901
87903
87904
88400
89321
90723
90740
90743
90940
91132
91133

Modifiers and Procedure Codes Revised for 2001

MODIFIERS

AA
AD
GC
GX
KM
KN
QB
QK
QU
QY

HCFA ASSIGNED

A4206
A4207
A4232
A4364
A4365
A4381
A4470
A4480
A6222
A6223
A6224
A9900
A9901
B4150
B4151
B4152
B4153
B4154
B4155
B4156
E0424
E0431
E0439
E0441
E0442
E0443
E0444
E0457
E0575
E0616
E0749
E0781
E0784
E1800
E1805
E1810
E1815
E1825
E1830
E1900
G0108
G0109
G0111
G0112
G0113
G0114
G0115
G0116
J0895
J1100
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J2271
J2275
J2543
J3010
J7505
J7618
J7619
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L1620
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L1660
L1680
L1685
L1686
L1690
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L1800
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L2080
L2090
L2102
L2104
L2106
L2108
L2112

Modifiers and Procedure Codes Revised for 2001 (continued)

L2114
L2116
L2122
L2124
L2126
L2128
L2132
L2134
L2136
L3650
L3660
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L4396
L4398
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L5675
L5979
L8603
P9010
P9011
P9012
P9016
P9017
P9019
P9020
P9021
P9022
P9023
Q1001
Q1002
V5050

CPT

00145
00190
00215
00530
00534
00604
00670
00792
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00920
00942
01214
01482
15842
16035
19100
19101
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19125
19126
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21194
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27236
33615
33617
36831
36832
38500
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38520
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73701
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74150
74160
74170
74181
74185
75552
75553
75809
75989
76003
76010
76092
76095

Modifiers and Procedure Codes Revised for 2001 (continued)

76096	82465	87140	87450
76360	82595	87143	87797
76818	82787	87147	87798
76930	82947	87176	87799
76932	83013	87181	88170
76941	83030	87184	88172
76942	83033	87186	88173
76945	83661	87187	88180
76946	83662	87188	88307
76948	83898	87190	88329
76950	83918	87205	88331
76975	83919	87206	88332
76986	86147	87207	89125
77470	86316	87210	89250
77520	86704	87220	90378
77523	86708	87250	90471
77761	87015	87252	90472
77762	87040	87253	90669
77763	87045	87260	90702
77776	87070	87265	90718
77777	87075	87270	90732
77778	87076	87272	90742
77789	87081	87274	90744
77790	87086	87276	90747
78805	87088	87278	90945
80100	87101	87280	90947
80101	87106	87285	92525
80156	87109	87290	99374
81007	87110	87299	99377
82042	87116	87324	99379
82270	87118	87449	

Modifiers and Procedure Codes Reactivated for 2001

HCFA ASSIGNED	CPT
Q0136	67220

Modifiers and Procedure Codes Discontinued for 2001

Discontinued Code	Code(s) to Report
MODIFIERS	
KK	No Replacement
KL	No Replacement
HCFA ASSIGNED	
A4560	No Replacement
A5065	No Replacement
A5149	No Replacement
C1531	No Replacement
C8515	No Replacement
C8517	No Replacement
C0751	No Replacement
C1375	No Replacement
C1377	No Replacement
C1378	No Replacement
C1379	No Replacement
C1380	No Replacement
C1381	No Replacement
C1382	No Replacement
C1383	No Replacement
C1384	No Replacement
C1385	No Replacement
G0159	No Replacement
G0160	No Replacement
G0161	No Replacement
G0169	No Replacement
G0170	No Replacement
G0171	No Replacement
G0172	No Replacement
J1562	No Replacement
J2994	No Replacement
J2996	No Replacement
J7610	No Replacement
J7615	No Replacement
J7620	No Replacement
J7625	No Replacement
J7627	No Replacement
J7630	No Replacement
J7640	No Replacement
J7645	No Replacement
J7650	No Replacement
J7651	No Replacement
J7652	No Replacement
J7653	No Replacement
J7654	No Replacement
J7655	No Replacement
J7660	No Replacement
J7665	No Replacement
J7670	No Replacement
J7672	No Replacement
J7675	No Replacement
K0182	See A7018
K0269	See E0572
K0270	See E0574
K0280	See A4331
K0281	See A4332
K0283	See A7019
K0407	See A4333
K0408	See A4334
K0409	See A4319
K0410	See A4324
K0411	See A4325
K0440	See L8040
K0441	See L8041
K0442	See L8042
K0443	See L8043
K0444	See L8044
K0445	See L8045
K0446	See L8046
K0447	See L8047
K0448	See L8048
K0449	See L8049
K0450	See A4364
K0451	See A4365
K0456	See E0298
K0457	See E0168
K0458	See E0148
K0459	See E0149
K0501	See E0571
K0529	See A7020
K0535	See A6231
K0536	See A6232
K0537	See A6233
P9013	No Replacement
P9018	No Replacement
Q0034	No Replacement
Q0082	See G0176
Q0156	No Replacement
Q0157	No Replacement
Q0186	See A0432
Q0188	See A9700
CPT	
00900	See 00300, 00400
01784	See 01700, 01780
52335	See 52351
52336	See 52352
52337	See 52353
52338	See 52354
52339	See 32355
52340	See 52400
70541	See 70544-70546, 70547-70549
71036	See 76003
76365	See Appropriate Organ or Site and 76360
76934	See 32000 and 76942
76938	See Appropriate Organ or Site and 76942
76960	See 76950
82251	See 82247 and 82248
87060	See 87070 or 87081
87072	See 87081
87082	See 87081
87083	See 87081
87085	See 87086
87087	See 87088
87117	See 87015
87145	No Replacement
87151	See 87147
87155	See 87147
87163	See 87076 or 87077
87174	No Replacement
87175	No Replacement
87192	See 87181, 87184, 87186, 87187, or 87188
87208	No Replacement
87211	See 87177
97770	See 97532, 97533
99375	See G0181
99378	See G0182

www.floridamedicare.com — Florida Medicare Provider Website

The following outlines information that is available as of August 2000 on the First Coast Service Options, Inc. (FCSO) Florida Medicare provider website.

What's New

"*Medicare Hot Topics!*" — Provides a brief introduction to recent additions to specific areas of the site. Also provides items of immediate interest to providers.

Part A

- ***PPS*** - (Prospective Payment System) Includes Florida Special Issue newsletters and links to helpful information on the HCFA website (www.HCFA.gov) such as satellite broadcasts, hospital outpatient PPS reference guide, home health PPS main web page, and more.
- ***Reason Codes*** - A listing of codes used by Part A to explain actions taken on line items/claims.
- ***Draft and Final LMRPs*** - FCSO's final and draft Part A Local and Focused Medical Review Policies (LMRPs/ FMRPs).
- ***Fraud & Abuse*** - Articles of interest concerning fraud, abuse, and waste in the Medicare program.
- ***Publications*** - *Medicare A Bulletins* from 1997 through the present.

Part B

- ***Draft and Final LMRPs*** - FCSO's final and draft Part B Local and Focused Medical Review Policies (LMRPs/ FMRPs).
- ***Fraud & Abuse*** - Articles of interest concerning fraud, abuse and waste in the Medicare program.
- ***MEDIGAP Insurer Listing*** - Information about claim crossovers (e.g., list of auto-crossovers, etc.).
- ***Publications*** - *Medicare B Updates!* from 1997 through the present.

Shared (information shared by Part A and Part B)

- ***Education*** - Medicare Educational resources and a Calendar of Events.
- ***Fee Schedules***
- ***UPIN Directory***
- ***MEDPARD Directory***
- ***Forms*** - Various enrollment applications and materials order forms (e.g., HCFA Form 855, claim review request, etc.).

EDI (Electronic Data Interchange)

- ***HIPAA*** - Information regarding the Health Insurance Portability and Accountability Act
- ***Forms*** - Various EDI applications' enrollment forms such as EMC, ERN, electronic claims status, etc.
- ***Specs*** - Florida specific format specification manuals for programmers.
- ***HCFA*** - Link to HCFA website for ANSI specification manuals
- ***Other*** - EDI Vendor List and other important news and information.

Extra

- ***Site Help***
- ***Contact Us*** - Important telephone numbers and addresses for Medicare Part A and Part B and website design comment form (to Webmaster).
- ***Links*** - Helpful links to other websites (e.g., HCFA, Medicare Learning Network, etc.).

Search

Enables visitors to search the entire site or individual areas for specific topics or subjects. ❖

ORDER FORM - PART A MATERIALS

The following materials are available for purchase. To order, please complete and submit this form along with your check/money order (PAYABLE TO: First Coast Service Options, Inc. account number 756134)

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
_____	***Medicare A Bulletin* Subscriptions** - One subscription of the Medicare A Bulletin is sent free of charge to all providers with an active status with the Medicare Part A program. Non-providers (e.g., billing agencies, consultants, software vendors, etc.) or providers who need additional copies at other office facility locations may purchase an annual subscription. This subscription includes all Medicare bulletins published during calendar year 2001 (back issues sent upon receipt of the order). Please check here if this will be a: [ ] Subscription Renewal or [ ] New Subscription	756134	$75.00

Subtotal $ _____

Tax **(6.5%)** $ _____

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Mail this form with payment to:

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Medicare Publications - ROC 6T

P.O. Box 45280

Jacksonville, FL 32232-5280

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Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Attention:_____ Area Code/Telephone Number:_____

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NOTE: *The Medicare A Bulletin is available* ***free of charge*** *online at www.FloridaMedicare.com.*

A

B

C

D

E

E (continued)

F

H

I

I (continued)

L

M

N

O

O (continued)

P

Diagnostic Tests, 70010-89399 (continued)

Medicine, 90281-99199

Medicine, 90281-99199 (continued)

HCPCS Codes

* Special *Bulletins*

* This special issue is available only on the website ***www.floridamedicare.com***

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

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

ELECTRONIC CLAIM FILING

"DDE Startup"
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

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

Phone Numbers

PROVIDERS

Automated Response Unit
904-355-8899

Customer Service Representatives:
904-355-8899

BENEFICIARY

904-355-8899

ELECTRONIC MEDIA CLAIMS

EMC Start-Up:
904-791-8767

Electronic Eligibility
904-791-8131

Electronic Remittance Advice
904-791-6865

Direct Data Entry (DDE) Support:
904-791-8131

PC-ACE Support
904-355-0313

Testing:
904-791-6865

Help Desk (Confirmation/ Transmission)
904-905-8880

Medicare Websites

PROVIDERS

Florida Medicare Contractor
www.floridamedicare.com
Health Care Financing Administation
www.hcfa.gov

BENEFICIARIES

Florida Medicare Contractor
www.medicarefla.com
Health Care Financing Administation
www.medicare.gov

Medicare A Bulletin

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