Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Features

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HCFA Health Care Financing Administration

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

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A PHYSICIAN'S FOCUS

Preventive Medicine: More Than Just a Screening Test

The 1990s saw major changes in the health care environment. Concerns were raised that the modification of fee-for-service medicine left patients without physicians and other health care providers as advocates. The explosion of health-related information and the technology to disseminate it, as well as advances in health care technology itself, have also revised patients' expectations of their physicians and health plans. Within this context, preventive medicine has received renewed interest.

Clinical preventive medicine includes the evaluation of an individual's health risk factors and the use of appropriate interventions. It is an expertise of all primary care specialties, such as internal medicine, family medicine, pediatrics, and obstetrics and gynecology, and it is practiced to some extent by most other specialties and allied health care providers. Risk assessment is the collection of risk factors that increase the likelihood a patient has or will develop a disease. Risk factors are personal characteristics (e.g., smoking, family history), physiological parameters (e.g., lipid profiles, weight), symptoms, or pre-clinical disease states. Appropriate preventive interventions depend on a good history and risk assessment.

The United States Preventive Task Force (USPTF) classified clinical preventive services that practitioners should provide as screening tests, immunizations, chemoprophylaxis, and counseling interventions. Screening tests are special tests or standardized examinations for the early detection of preclinical disease (Pap smear for cervical cancer) or risk factors (elevated LDL cholesterol for coronary artery disease) in asymptomatic people. Immunizations include vaccines and immunoglobulins to prevent selected infectious diseases. Chemoprophylaxis is the use of drugs or supplements in asymptomatic persons to prevent disease (estrogen replacement therapy in menopausal women). Counseling interventions are efforts to educate patients about risk factor modification (tobacco use, saturated fat diet). Most preventive services are classified as counseling interventions that can be incorporated into any workplace, school, or home environment. In 1996, the USPTF published evidence-based recommendations; more than half are behavior counseling. Other groups have issued reports on prevention recommendations, including the Canadian Task Force on the Periodic Health Examination and the American College of Physicians.

A useful concept that has reemerged is Leavell's levels of prevention. The Leavell's levels of prevention include:

- *Primary prevention*—with the desired outcome of health promotion and specific protection
- *Secondary prevention*—with the desired outcome of presymptomatic diagnosis and treatment
- *Tertiary prevention*—with the desired outcome of disability limitation for early symptomatic disease and rehabilitation for late symptomatic disease.

These levels define strategies that are available to practitioners to promote health and prevent disease. Though some interventions do not classify neatly, the concept is most useful in differentiating among preventive services. For example, screening interventions, a secondary prevention strategy, are frequently confused as a primary prevention strategy. Therefore, patients should be educated to follow screening guidelines for re-testing. Some examples of the levels of prevention include primary prevention such as counseling against smoking and immunization for influenza. Secondary prevention frequently uses screening tests, such as screening asymptomatic women for breast cancer with mammography, or screening asymptomatic men and women for colon cancer with sigmoidoscopy. Tertiary prevention relates to therapy for a condition, such as treatment of high LDL cholesterol after heart attack and occupational therapy following a stroke.

Preventive Medicine: More than Just A Screening Test (continued)

Good practice of clinical preventive medicine incorporates the concepts of evidence-based medicine, requiring the integration of individual clinical expertise with the best available evidence from peer-reviewed research. Understanding the sensitivity and specificity of screening tests, as well as predictive values and the efficacy and safety of preventive interventions is very important. A systematic approach, with the application of protocols, identification of staff with responsibility, measurement of goals, and ongoing education of providers and patients can be effective and rewarding for all involved.

The Health Care Financing Administration (HCFA), as overseer of the Medicare and Medicaid programs, is encouraging the practice of preventive medicine in its mission, vision, goals, and objectives communicated to the public. Though one can always argue the need for the expansion of benefits and coverage, there are many opportunities to practice preventive medicine in the current Medicare program. Health care providers are encouraged to coordinate their efforts and direct preventive interventions that lead to improved outcomes and healthier lifestyles.

Sincerely,

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

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About *The Medicare A Bulletin*

The *Medicare A Bulletin* is a comprehensive, bimonthly magazine for all Florida Part A providers. It is published six times annually (every two months), plus the annual special issue for the HCFA Common Procedure Coding System and Medicare Outpatient Fee Schedule Database Update.

The *Bulletin* is mailed during the first half of the first month of publication (e.g., early August for the August/ September issue).

Who Receives the *Bulletin*?

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

What Is in the *Bulletin*?

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

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

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

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

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

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AMBULANCE SERVICES

Clarification of Medicare Policies Concerning Ambulance Services

This is to notify providers of revisions to Medicare policies concerning ground ambulance transportation services published in the January 25, 1999 ***Federal Register***, pages 3637-3650. The final rule became effective on February 24, 1999.

Since the publication of the final rule and subsequent release of the operational guidelines, the Health Care Financing Administration (HCFA) received several requests for clarification on the requirement that the physician certification statement be obtained *prior to nonemergency, scheduled* trips or *within 48 hours of unscheduled, nonemergency* ambulance transports.

Background

On September 21, 1999, HCFA responded to an inquiry requesting that enforcement of the requirements for obtaining the physician certification statement for nonemergency ambulance services be suspended. The inquiry suggested that the experiences of ambulance suppliers has shown that in a substantial percentage of trips ordered by physicians, ambulance suppliers have been unable to obtain the required certification. The inquiry specifically addressed the 48-hour time frame requirement addressed in the final rule under "Special Rule for Nonemergency, Unscheduled Ambulance Services." The final rule specifies that, in cases where a beneficiary living in a facility who is under the direct care of a physician requires nonemergency unscheduled transport, the physician's certification can be obtained 48 hours after the transport has been provided. For beneficiaries not under the direct care of a physician, whether they reside at home or in a facility (e.g., an extended care or assisted living facility), a physician certification statement is not required.

The September 21, 1999 response noted that *the 48-hour time frame is the standard required by regulation*, but acknowledged that there may be instances when meeting the requirement may not be possible. In response, HCFA agreed to clarify the circumstances when it is acceptable for the ambulance supplier to obtain the physician's signature before the bill is submitted for the service. Further review of this issue indicated that, in addition to establishing instructional guidelines to address this issue, guidelines are also needed to address how Medicare contractors are to proceed with processing claims when an ambulance transport has been furnished and the ambulance supplier, after making several attempts, does not receive the requested documentation from the physician. It has been noted that pending the issuance of guidance from HCFA, some ambulance suppliers have been holding ambulance claims that could not be submitted because of the absence of a signed physician certification statement.

Guidelines for Obtaining the Physician Certification Statement

Whenever possible, ambulance suppliers should obtain the signed certification statement prior to the transport. However, there may be instances in which ambulance suppliers have provided transports but are experiencing difficulty in obtaining the required physician certification statement. In cases where an ambulance supplier has transported a beneficiary but is unable to obtain a signed physician certification statement, for claims for services furnished on or after October 1, 1999, Medicare will process these claims as follows:

> Within 90 days following the submission of such claims (or 90 days following January 31, 2000, if the claims have already been submitted), to certify the medical necessity of the furnished service, ambulance suppliers must obtain a signed physician certification statement from the attending physician. ***If the ambulance supplier is unable to obtain a signed certification statement from the attending physician the supplier must obtain:***
>
> - A signed certification statement from either a physician assistant (PA), clinical nurse specialist (CNS), nurse practitioner (NP), registered nurse (RN) or discharge planner who is employed by the hospital or facility where the beneficiary is being treated, with knowledge of the beneficiary's condition at the time the transport was ordered or the service was furnished;
>
> ***OR***
>
> - The ambulance supplier must document its attempt to obtain such a statement from the attending physician. Acceptable documentation must include a signed return receipt from the U.S. Postal Service or other similar delivery service. Such a return receipt will serve as proof that the supplier attempted to obtain the required signature from the attending physician.

For services furnished **on or after January 31, 2000**, ambulance suppliers must follow these procedures:

- Before submitting a claim, ambulance suppliers must obtain a signed certification statement from the attending physician. If the ambulance supplier is unable to obtain the signed certification statement from the attending physician, a signed physician certification statement must be obtained from either the PA, NP, CNS, RN, or discharge planner who is employed by the hospital or facility where the beneficiary is being treated, with knowledge of the beneficiary's condition at the time the transport was ordered or the service was furnished;

OR

- If the supplier is unable to obtain the required physician certification statement within 21 calendar days following the date of service, the ambulance supplier must document its attempt to obtain the requested physician certification statement in the same manner as described above and may then submit the claim.

Clarification of Medicare Policies Concerning Ambulance (continued)

In all cases, the appropriate documentation must be kept on file and, upon request, presented to Medicare. It is important to note that neither the presence nor absence of the signed physician certification statement necessarily proves (or disproves) whether the transport was medically necessary. ***The ambulance service must meet all other coverage criteria in order for payment to be made.***

These changes are being implemented by Florida Medicare on February 28, 2000, and are effective for services rendered on or after January 31, 2000. ❖

Ambulance Services - Questions and Answers

Florida Medicare has received several inquiries from ambulance suppliers regarding the clarifications to the ambulance policy. Below are the questions and replies:

Q1: The new transmittal includes a registered nurse and discharge planner to the list of acceptable signatures. Does this mean that if we receive a physician certification statement (PCS) form with a registered nurse's signature at the time of the transport, we no longer have to pursue getting a physician signature?

A1: The regulation requires an ambulance supplier to obtain a signed certification statement from the attending physician before submitting a claim. It is when the supplier is unable to obtain the signed certification statement from the attending physician that signatures may be sought from the other qualified personnel. It is not appropriate to initially nor only seek the signature of an RN or discharge planner at the time of transport.

Q2: If a PCS form is not obtained at the time of transport, can we pursue getting the RN signature or do we have to get the physician's signature?

A2: Again, the requirement is for the ambulance supplier to obtain the physician's signature. It is only when the supplier is unable to obtain the signed certification statement from the attending physician that a signature may be sought from the other qualified personnel. It would be appropriate to obtain an RN signature after the transport, if the supplier was unable to obtain the attending physician's signature.

Q3: What is the definition of a discharge planner?

A3: A discharge planner is an employee so titled by the hospital or facility where the beneficiary is being treated, who has knowledge of the beneficiary's condition at the time the transport was ordered or the service was furnished. Discharge planners typically are licensed clinical social workers, but this is not a requirement.

Q4: Is a fax confirmation acceptable documentation for showing attempt to get a required signature?

A4: It is acceptable for the supplier to initially fax the attending physician's standard PCS form. A copy of the form, which has been signed and faxed back by the physician, is also acceptable to keep on file. If no response to the initial fax is received from the attending physician, the fax confirmation slip is *not sufficient* documentation showing an attempt was made. Acceptable documentation must include a signed return receipt from the U.S. Postal Service or other similar delivery service that can provide evidence the request was delivered and received by the intended party.

Q5: In the transmittal, it states that August 30,1999, and after was the implementation date for the PCS form. According to the October/November 1999 *Medicare A Bulletin,* the implementation date was for "service furnished on or after October 1, 1999." Please provide clarification.

A5: HCFA released program memorandum AB-99-83 in late August. Contractors had thirty days to notify the ambulance suppliers and implement the regulations. Hence, this contractor's effective date is October 1, 1999.

Q6: Could all outstanding PCS forms (October 1999-January 2000.) be mailed as return receipt now without further attempts at getting a PCS?

A6: According to this transmittal suppliers can now submit claims with dates of service between October 1, 1999 and January 30, 2000, if they meet one of three conditions within 90 days of submitting such claims:

1. Obtain the attending physician's signature on the PCS form
2. Obtain a signature from other qualified personnel
3. Document a good faith attempt to obtain a PCS from the attending physician (e.g., signed return receipt postal service or other similar delivery system).

Q7: Does the 48-hour period no longer apply?

A7: The transmittal indirectly re-states that the 48-hour time frame is the standard required by regulation for suppliers to obtain a signed certification statement from the attending physician. What transmittal B-00-09 does, is provide guidance to suppliers for cases when they are unable to meet the regulatory standard.

Q8: For claims from October 1999 to January 2000, if we do not get the PCS form signed within 90 days, do we have to make a refund to Medicare?

A8: As stated in response to question six, for claims between October 3, 1999 and January 30, 2000 the ambulance supplier has until April 30, 2000 to either:

Ambulance Sercices - Questions and Answers (continued)

1. Obtain a qualified signature on the PCS form, or
2. Provide acceptable proof of the attempt to obtain the signature of the attending physician.

In the event the supplier did not perform either requirement, then yes, a refund for submitted claims would be expected.

Q9: We have a critical care transportation unit that performs a number of inter-facility transports from one hospital to another for a higher level of care. Though this is a scheduled transport, we provide ALS services, will a PCS form be required?

A9: Yes. A physician certification statement is required for all non-emergency transports, regardless of the level of care provided.

Q10: Can multiple PCS forms be sent in one envelope to a physician and one return receipt obtained?.

A10: The ambulance supplier must clearly list on the cover letter each beneficiary's name, the date of service and the organization's account number for every PCS form enclosed in the envelope. A copy of the cover letter, PCS form and return receipt must be kept in the account file. ❖

PROSPECTIVE PAYMENT SYSTEM

Claim Expansion and Line Item Processing

In preparation for the implementation of outpatient prospective payment system (OPPS), the first transition step is the claim expansion line item processing (CELIP) project, which will enable the intermediary to adjudicate services at the line level.

Providers billing claims for outpatient, home health, and hospice services are affected. Upon implementation of CELIP, the Health Care Financing Administration (HCFA) will extend the claim size for Revenue/HCPCS reporting to 450 lines.

The CELIP enhancement includes several changes to the claim. Providers will be required to:

- Report outpatient services using HCFA Common Procedure Coding System (HCPCS) codes, as well as a modifier (if applicable) in form locator 44 (HCPCS/Rates)
- Submit line item dates of services for every line where a HCPCS code is reported on an outpatient bill
- Revise the process for reporting hospital outpatient services in form locator 45 (service date)
- Redefine "units" as the number of times the service or procedure being reported was performed in form locator 46 (units of service). ❖

Questions and Answers Regarding Prospective Payment System (PPS) for Outpatient Rehabilitation Services

The following question and answer article was prepared by the Health Care Financing Administration to respond to numerous inquiries related to prospective payment system (PPS) for outpatient rehabilitation services. This article does not provide clarification regarding the financial limitation as this limitation has been suspended for two years based on the Balanced Budget Refinement Act of 1999.

Coding Guidelines – Applicable to Intermediaries

Q1: Is it HCFA's intent that CPT codes 11040, 11041, 11042, 11043, and 11044 be billable on all bill types listed except 13x and 83x and paid on the Medicare Physician Fee Schedule (MPFS)?

A1: Yes, except for hospital outpatient departments, codes 11042, 11043, and 11044 are paid under the MPFS. (Refer to Q&A #9 under the heading "Coding Guidelines –Intermediaries and Carriers" which will be a more appropriate way to code these services.)

Q2: Codes 11042, 11043, and 11044 when billed on a 13x bill are changed by the outpatient code editor (OCE) to 83x and paid under the ambulatory surgical center (ASC) pricer. What do we do about billing for these codes?

A2: Until system changes are completed to edit for the reporting of therapy modifiers appended to codes 11042, 11043, and 11044 to clearly distinguish when these debridement procedures are being billed in the hospital outpatient setting as surgical procedures versus therapy modalities, it is appropriate for 13x bills to be processed in this manner. Currently, these codes on a hospital outpatient bill are treated as surgical procedures subject to the ASC payment blend.

Questions and Answers - Prospective Payment System (continued)

Q3: The OCE rejects as noncovered, CPT codes 92551, 92559, 92560, 92590, 92593, 92594, and 92595 when billed by any provider other than a home health agency (HHA). You cannot get past the OCE edit unless you manually override it. What do we do in this situation?

A3: These codes are noncovered for all providers including HHAs. They were deleted from the list of audiology codes in PM AB-00-01.(see January 25, 1999, *Medicare A Bulletin* G-361, pages 3-6.) However, they were not deleted from the note (page 5 of the PM) due to an oversight. Please disregard these codes.

Q4: If hospitals are exempt from the payment caps, why is it necessary for them to report modifiers?

A4: HCFA has identified certain codes as therapy codes, e.g., the debridement codes cited in questions one and two above, which the American Medical Association (AMA) classifies as surgical procedures and are routinely performed as surgery in the hospital outpatient setting. By law, these procedures must be paid under the MPFS when furnished as an outpatient therapy service in the hospital outpatient setting and on the ASC blended payment method when provided as an outpatient surgical procedure. When the new hospital outpatient PPS is implemented in 2000, these procedures would be paid under the hospital outpatient PPS. Therefore, when system renovations are completed, use of the therapy discipline-specific modifiers would facilitate appropriate payment for these procedures. In the meantime, hospitals would become accustomed to properly billing therapy procedures.

Additionally, the Balanced Budget Act (BBA) of 1997 requires HCFA to submit a report to Congress by January 1, 2001, which recommends establishing coverage policy for beneficiaries based on diagnostic categories and prior use of services in both inpatient and outpatient settings rather than on the current dollar limitations. Use of the discipline-specific modifiers by hospitals would greatly enhance HCFA's collection of data for the study it must develop as required by Congress.

Q5: If audiologists perform the services, are they required to report one of the modifiers? For example, if the CPT code is 92552 and the revenue code is 470, is modifier GN, GO, or GP required?

A5: If an audiologist performs an audiology procedure (e.g., CPT code 92552), a modifier is not required.

Q6: Is a therapy modifier, GN, GO, or GP, required if the claim is for partial hospitalization services which are billed with condition code 41?

A6: No. These modifiers are not required on partial hospitalization claims.

Q7: Some intermediaries have indicated that they would not pay for the three V codes listed in PM AB-00-01. These codes are for speech, language, and dysphagia screening and are priced by the carriers. In addition, some intermediaries have indicated that they will not pay for some codes, including certain codes within the 97000 series and the debridement codes (11040-11043). With respect to codes specifically listed in PM AB-00-01, do intermediaries have the discretion to universally deny use of these codes? Can the intermediaries universally prohibit the reporting of a code (or codes)?

A7: Yes, intermediaries have the discretion to universally deny certain codes but they do not have the discretion to prohibit reporting of them. The listing of codes in PMs A-99-35 dated August 1999 (formerly PM A-98-24 dated July 1998) and AB-00-01 dated January 2000 is not related to coverage as indicated in the note on page 2 of PM A-99-35. Intermediaries should determine whether any of the reported codes are covered and medically necessary.

Coding Guidelines – Applicable to Intermediaries and Carriers

Q1: Payment cannot be made for code 97010 when billed alone. Should this code be bundled, and if so with which codes?

A1: Yes, code 97010 should be bundled. It may be bundled with any therapy code. Regardless of whether code 97010 is billed alone or in conjunction with another therapy code, payment is never made.

Q2: Should contractors edit when codes 97504 and 97116 are both reported in appropriate clinical situations?

A2: In general, codes 97504 and 97116 should not be billed together. However, if code 97504 was performed on an upper extremity and code 97116 (gait training) was also performed, both codes may be billed with a modifier to denote a separate anatomic site.

Q3: Is modifier 59 the correct modifier to use when 97504 and 97116 are both billed?

A3: Yes, 59 is the correct modifier to use.

Questions and Answers - Prospective Payment System (continued)

Q4: Explain the difference between CPT codes 97139 and 97799.

A4: Code 97139 is an unlisted therapeutic procedure, which the CPT defines as "a manner of effecting change through the application of clinical skills and/or services that attempt to improve function" in one or more areas, each 15 minutes. Performance of this code requires that a physician or therapist have direct (one-to-one) patient contact.

Code 97799 denotes an unlisted physical medicine/rehabilitation service or procedure, including tests and measurements.

Q5: Does Medicare allow re-evaluation for speech therapy? There are physical and occupational therapy HCPCS codes for re-evaluation. If speech re-evaluation is allowed, what is the appropriate HCPCS code to report?

A5: Yes, Medicare does make payment for speech re-evaluation services when medically necessary and appropriate. The appropriate code to report in billing such services is 92506.

Q6: Is CPT code 92525 valid for speech therapy when billing a patient for a modified barium swallowing to evaluate swallowing ability?

A6: Yes.

Q7: Is there a specific CPT code or range of CPT codes to report for cognitive speech therapy training?

A7: For cognitive speech therapy, a speech and language pathologist could use either code 92507 or 97770 but not both for the same treatment.

Q8: What resources are available for providers who have specific questions about coding?

A8: Specific-coding questions should be directed to the AMA or to a therapy association.

Q9: We understand there is a new HCPCS code G0169. Can you describe when this code should be reported?

A9: G0169, a new HCPCS Level II code was created for use starting January 1, 2000. It is defined to describe the type of active debridement performed by therapists. (A more complete description can be found in the ***Federal Register***, November 2, 1999, p. 59426.) This code can be used to describe active debridement, whether performed with a scissors, scalpel, or waterjet regardless of the depth of tissue involved. There is no global period on this code. Dressings placed on the wound after debridement are included in this code. We expect therapists to start using this code instead of 11040-11044 and 97799 as soon as is feasible.

Billing Guidelines – Applicable to Intermediaries

Q1: If a splint (CPT code 97504) is provided by an occupational therapist, what revenue code should be reported?

A1: Revenue code 430.

Q2: Was it HCFA's intent that providers change their charge masters mid-cost report year to accommodate the change from visit to modality?

A2: It was not HCFA's intent to require providers to change their charge masters. However, in order to be paid appropriately, providers will need to make changes to their charge masters. Our intent was to implement section 4541 of the BBA in a timely fashion and allow as much lead time as possible for providers to make necessary changes to their internal systems.

Q3: Will HHA type of bills eventually be included in OCE edits?

A3: There are no plans to include the HHA type of bills in the OCE.

Q4: When reporting line item dates of service, in what order should revenue codes be reported?

A4: Revenue codes should be reported in revenue code order by date of service.

Q5: If you have more than one CPT/HCPCS code for the same revenue code during a single visit, how is that illustrated on the UB-92 claim form?

A5: Each CPT/HCPCS code should be reported with the appropriate revenue code on a separate line item.

Q6: When billing for services not subject to line item date of service reporting, does it matter where on the claim these services are reported?

A6: Services that do not require line item date of service reporting may be reported before or after line item services at either the top or the bottom of the claim.

Billing Guidelines – Applicable to Intermediaries and Carriers

Q1: Do providers have to bill other payers by modalities?

A1: Our understanding is that some providers bill other payers by modalities; however, it depends on the payer.

Q2: If a patient has therapy (any type) for three minutes, would a provider charge for 15 minutes?

A2: No, this would not constitute a therapy session. (See section on CPT coding, pages 12-14.)

Questions and Answers - Prospective Payment System (continued)

Q3: If a patient has therapy (any type) for 20 minutes, would a provider charge for 15 minutes?

A3: Yes. (See section on CPT coding, pages 12-14.)

Q4: Are unused minutes in excess of 15 or 30 minutes charged for future visits?

A4: No. (See section on CPT coding, pages 12-14.)

Q5: How should code 97010 be processed when billed alone? We suggest returning the claim to the provider or subjecting it to line item denial.

A5: The code should be denied and existing Explanation of Medicare Benefits/Medicare Summary Notice (EOMB/MSN) language used.

Q6: In regards to bundled services, does the time for the bundled service get counted in the time for the primary service? This comes up especially with hot/cold packs, 97010. For example, if a patient has a 25-minute visit with a hot pack for ten minutes and therapeutic exercises for 15 minutes, does this get billed as two units of 97110? Or is the hot pack time not counted and only one unit of 97110 billed?

A6: The scenario described is one unit of therapeutic exercise, 97110. The time of the hot and cold pack is not skilled and thus does not count in the total time.

Payment Guidelines – Applicable to Intermediary

Q1: The MPFS abstract file contains a technical component price, a professional component price, and a global price for codes 92587 and 92588. Which price should intermediaries apply in making payment for these services?

A1: Intermediaries should pay for these services based on the relative value unit of the technical component indicated in the file.

Q2: How will drugs be paid for in comprehensive outpatient rehabilitation facilities (CORFs)?

A2: Some medications are included in the practice expenses, (e.g., local anesthetics) and other medications have Level II HCPCS codes. Because of Y2K issues, we were unable to make the systems modifications necessary for the payment of drugs and biologicals. Payment for drugs and biologicals furnished in a CORF, therefore, will continue to be paid on a cost basis until the Y2K issues are resolved.

Q3: What is the payment for outpatient rehabilitation services furnished on or after January 1, 1999?

A3: Generally, for outpatient rehabilitation services furnished on or after January 1, 1999, Medicare payment is equal to 80 percent of the lesser of (1) the actual charges for the service or (2) the physician fee schedule amount after the Part B deductible is met. The only exception to this method of payment is for those services specifically cited in PM AB-00-01 as being paid for on a cost basis in hospital outpatient departments.

Q4: How is payment determined for a CORF that performs rehabilitation services; for example, if the bill type is 75x, the revenue code is 41x, and the CPT code is 97110?

A4: Payment is based on CPT/HCPCS code, not the revenue code. Payment for CORF services under the MPFS is limited to the procedures identified by CPT/HCPCS codes in PM AB-00-01. All other CORF services at this time should be paid on a reasonable cost basis until our Y2K changes are completed. Since code 97110 is listed as a rehabilitation service in the PM, it should be paid under the MPFS, regardless of the revenue code with which it is billed.

Payment Guidelines – Applicable to Intermediaries and Carriers

Q1: How do intermediaries obtain prices for therapy services that are not priced on the MPFS abstract file?

A1: A service with a code that is not priced on the MPFS indicates it is carrier priced. Intermediaries should request all required documentation from the provider and forward a copy of the claim with all supporting documentation to the carrier for pricing. To establish documentation requirements, contact the appropriate local carrier for the jurisdiction that is being billed. Each carrier will have discretion as to what documentation is needed to price a particular service. There are certain services that carry a restricted status on the MPFS database. If the carrier reviews the necessary documentation and determines that the service is noncovered, you will be instructed to deny the claim.

Miscellaneous Guidelines – Applicable to Intermediaries

Q1: How can providers that bill the intermediary obtain the MPFS amounts?

A1: Intermediaries should forward their providers the abstract file they retrieved from HCFA. Providers requesting the entire MPFS should be advised of its availability via HCFA's Web site at *www.hcfa.gov/stats/pufiles.htm,* then scroll down to National Physician Fee Schedule Relative Value File.

Questions and Answers - Prospective Payment System (continued)

Q2: How is coinsurance calculated for providers?

A2: Medicare payment is made at 80 percent of the lower of the actual charge or the MPFS amount. The remaining 20 percent is the beneficiary's coinsurance obligation.

Q3: Are rehabilitation agencies and CORFs required to continue submitting cost reports? If so, will provider cost reports be revised to reflect (1) the movement from a cost based payment methodology to the MPFS and/or (2) imposition of the $1500 limitation?

A3: Yes, providers (including rehabilitation agencies and CORFs) are required to file cost reports, notwithstanding the fact that therapy services are paid under the MPFS. A revised cost report will reflect the movement from cost based payment to MPFS payment.

Q4: Does the 62.5 percent limit on mental health services apply to services paid to a CORF under the MPFS? If so, how does the limit apply?

A4: Yes, the outpatient mental health treatment limitation applies to mental health services delivered in a CORF and paid under the MPFS. Hence, if the MPFS amount for a mental health treatment service provided in a CORF is $100, this amount is multiplied by 62.5 percent (the mental health treatment limitation). The resulting amount of $62.50 is then multiplied by 80 percent which yields the Medicare payment of $50. The remaining 20 percent or the balance of $12.50 is the coinsurance responsibility of the beneficiary.

Miscellaneous Guidelines – Applicable to-Intermediaries and Carriers

Q1: Can occupational therapist and physical therapist dressing changes for wounds be charged?

A1: No. Dressing changes are bundled into the MPFS payment for the service.

Q2: Can a facility charge for home exercise programs or any education program unattended when the patient is exercising at home?

A2: No. No charge can be made for a home therapy program (or for an unsupervised program conducted in another part of the facility). Payment is made only for the face-to-face time involved in teaching the exercise.

Q3: Are providers and practitioners required to charge Medicare and non-Medicare patients the same amounts for outpatient rehabilitation services?

A3: No. Providers and practitioners may charge different amounts for outpatient rehabilitation services furnished to Medicare and non-Medicare patients. However, section 1128(b)(6) of the Social Security Act provides that the Secretary may exclude from participation in the Medicare program and from participation in any State health care program, individuals and entities that charge substantially in excess of their usual charges for furnished services. The Office of the Inspector General makes the determination of whether a charge substantially exceeds a usual charge. ❖

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

Clarification on Physical Medicine Current Procedural Terminology (CPT) Coding Guidance

The following article was prepared by the Health Care Financing Administration to provide guidance and clarification on the coding guidelines regarding the use of physical medicine CPT codes 97032-97036, 97110-97124, 97140, 97504-97542, and 97703-97770.

Determining What Time Counts Towards 15-Minute Timed Codes

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre-and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as "intraservice care" begins when the therapist or physician or an assistant under the supervision of a physician or therapist is delivering treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment.

The time counted is the time the patient is treated. For example, if gait training for a patient with a recent stroke requires both a therapist and an assistant, or even two therapists to manage the patient or the parallel bars, each 15 minutes the patient is being treated can only count as one unit of 97116. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

Clarification on Physical Medicine Coding Guidelines (continued)

Determining How to Bill Units for 15-Minute Timed Codes

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any calendar day** using CPT codes and the appropriate number of units of service. For any single CPT code, providers bill a single 15 minute unit for treatment greater than or equal to eight minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then two units should be billed. Time intervals for larger numbers of units are as follows:

3 units	≥ 38 minutes to < 53 minutes
4 units	≥ 53 minutes to < 68 minutes
5 units	≥ 68 minutes to < 83 minutes
6 units	≥ 83 minutes to < 98 minutes
7 units	≥ 98 minutes to < 113 minutes
8 units	≥ 113 minutes to < 128 minutes

The pattern remains the same for treatment times in excess of two hours. Providers should not bill for services performed for eight minutes or less. The expectation (based on the work values for these codes) is that a provider's time for each unit will average 15 minutes in length. If a provider has a practice of billing less than 15 minutes for a unit, these situations will be subject to review.

The above schedule of times is intended to provide assistance in rounding time into 15 minute increments. It does not imply that any minute until the 8th should be excluded from the total count as the timing of active treatment counted includes all time.

It is advisable that the beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. **If more than one CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time**, see examples below.

Example 1: If 24 minutes of 97112 and 23 minutes of 97110 were furnished, then the total treatment time was 47 minutes, so only three units can be billed for the treatment. The correct coding is two units of 97112 and one unit of 97110, assigning more units to the service that took more time.

Example 2: If a therapist delivers five minutes of 97035 (ultrasound), six minutes of 97140 (manual techniques), and ten minutes of 97110 (therapeutic exercise), then the total minutes are 21 and only one unit can be paid. Bill one unit of 97110 (the service with the longest time) and the clinical record will serve as documentation that the other two services were also performed.

Other Timed Physical Medicine Codes

Providers report code 96105, assessment of aphasia with interpretation and report, in one-hour units. This code represents formal evaluation of aphasia with an instrument such as the Boston Diagnostic Aphasia Examination. If this formal assessment is performed during treatment, it is typically performed only once during treatment and its medical necessity should be documented. If the test is repeated during treatment, the medical necessity of the repeat administration of the test must also be documented. It is common practice for regular assessment of a patient's progress in therapy to be documented on the chart, and this may be done using test items taken from the formal examinations. This is considered to be part of the treatment and should not be billed as 96105 unless a full, formal assessment is completed.

Other timed physical medicine codes are 97545 and 97546. The interval for 97545 is two hours and for 97546, one hour. These are specialized codes to be used in the context of rehabilitating a worker to return to a job. The expectation is that the **entire** time period specified in the codes 96545 or 97546 would be the treatment period, since a shorter period could be coded with another code such as 97110, 97112, 97114, or 97537. (These codes were developed for reporting services to persons in the Workers' Compensation program, thus we do not expect to see them reported for Medicare patients except under very unusual circumstances.)

Proper Reporting of Code G0128 by Comprehensive Outpatient Rehabilitation Facilities

G0128 was created for use by comprehensive outpatient rehabilitation facilities (CORFs) to report nursing services provided to beneficiaries as part of their plan of treatment but not bundled into other services billed to the beneficiary (either by the CORF or by a physician or other practitioner associated with the CORF). The definition of this code is as follows:

G0128 Direct (face-to-face with the patient) skilled nursing services of a registered nurse provided in a comprehensive outpatient rehabilitation facility, each 10 minutes beyond the first 5 minutes.

Thus, G0128 is used to bill for services that are specified in the beneficiary's plan of treatment that are not part of other services. Examples of services that cannot be billed under G0128 are:

- If a nurse participates in a physician service, e.g., taking the history or reviewing medication as part of an evaluation and management visit (HCPCS codes 99201-99275) or as part of a service during the global surgical period, assisting in a procedure, teaching the patient regarding a procedure or treatment suggested during the physician or other practitioner visit; providing information to the patient about consequences or complications of a treatment; or responding to telephone calls resulting from

Clarification on Physical Medicine Coding Guidelines (continued)

the physician visit, then the nursing services are part of the physician visit and cannot be separately billed by the CORF.

- If a nurse takes vital signs (pulse, blood pressure, weight, respiratory rate) associated with a physician or therapy visit, this time cannot be billed using G0128.
- If a wound dressing is required after a debridement (HCPCS 11040-11044) or whirlpool treatment (HCPCS 97022) and the nurse dresses the wound, the payment for the dressing change is included in the code for debridement or whirlpool and cannot be separately billed under G0128.
- Collecting a laboratory specimen, including phlebotomy.

Co-treatment by a nurse with a physical or occupational therapist or speech and language pathologist, generally will not be allowed unless a separate nursing service is clearly identifiable in the plan of treatment and in the documentation.

The definition of skilled services is that it generally requires the skill of a registered nurse to perform the service. Some examples would include procedures such as insertion of a urinary catheter, intramuscular injections, bowel disimpaction, nursing assessment, and education. Education, for example, would include teaching a patient proper techniques for "in-and-out" urethral catheterization, skin care for decubitus ulcer, and care of a colostomy.

Administrative tasks or documentation should not be billed under G0128. ❖

GENERAL INFORMATION

End of Grace Period for 2000 HCPCS Update

The Health Care Financing Administration Common Procedure Coding System (HCPCS) update for calendar year 2000 was provided in the December 1999 *Medicare A Bulletin Special Issue: 2000 HCFA Common Procedure Coding System and Medicare Outpatient Fee Schedule Database Update.* Information regarding added, changed, or discontinued procedure codes and modifiers begins on page 5 of that publication.

Historically, HCFA extends a 90-day grace period where either 1999 or 2000 HCPCS codes are accepted. This grace period applies to services provided on or after January 1, 2000, and received prior to April 1, 2000. The three-month grace period also applies for discontinued HCPCS codes. Refer to the December 1999 *Medicare A Bulletin Special Issue,* pages 15-16, for an inclusive list of discontinued CPT and HCPCS codes and modifiers. (See "Clinical Diagnostic Laboratory Organ or Disease Panels" article published in the February/March 2000 **Medicare A Bulletin,** pages 8-9 for an exception to this guideline.)

Effective April 1, 2000, only the 2000 HCPCS codes will be accepted by Medicare. Claims reporting discontinued CPT and HCPCS codes and modifiers will be returned to providers. ❖

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.

Effective February 2, 2000, the interest rate applied to Medicare overpayments is **13.50** percent, based on the new revised PCR rate. The following table lists previous interest rates.

Period	Interest Rate
October 28, 1999 - February 1, 2000	13.375%
August 4, 1999 - October 27, 1999	13.25%
May 05, 1999 - August 3, 1999	13.375%
February 1, 1999 - May 04, 1999	13.75%
October 23, 1998 - January 31, 1999	13.50%
July 31, 1998 - October 22, 1998	13.75%
May 13, 1998 - July 30, 1998	14.00 %
January 28, 1998 - May 12, 1998	14.50%
October 24, 1997 - January 27, 1998	13.875%
July 25, 1997 - October 23, 1997	13.75%
April 24, 1997 - July 24, 1997	13.50%
January 23, 1997 - April 23, 1997	13.625%
October 24, 1996 - January 22, 1997	13.375% ❖

Tips to Submit Medical Review Documentation After a Utilization Audit

During recent provider meetings, several issues regarding medical record submission were discussed. As a result of suggestions made at the recent "Let's Talk" sessions, the following document was developed to help providers submit medical record documentation to the Utilization Audit Department.

This article will address frequently asked questions and provide some helpful tips for submitting complete and timely documentation.

Mailing Packet

1. **Follow the address on the letter requesting records *exactly***. Any variations or additions to the address listed may cause packages to be routed improperly.

   Address packages for utilization audit as follows:

MEDICARE PART A

Standard Mail *or*	**Certified or Express Mail**
Utilization Audit, 7T-ROC	Utilization Audit, 7T-ROC
Medicare Part A	Medicare Part A
P.O. Box 44159	532 Riverside Ave.
Jacksonville, FL 32231-4159	Jacksonville, FL 32202

MEDICARE PART B

Standard Mail *or*	**Certified or Express Mail**
Utilization Audit, 7T-ROC	Utilization Audit, 7T-ROC
Medicare Part B	Medicare Part B
P.O. Box 44288	532 Riverside Ave.
Jacksonville, FL 32231-4288	Jacksonville, FL 32202

2. Files may be sent via standard mail, or via certified or express mail. Standard mail will assure more rapid processing through the mail processing areas.

Documentation Preparation

1. **Place a copy of the letter requesting the records *on top* of the file(s) being sent**. This letter should be the first item seen when the mail package is opened by the Intermediary/Carrier. This enables the mail handlers to deliver the mail more rapidly and with greater accuracy to the appropriate area.
2. **Do not place the files in folders**. Simply place the medical record documentation in a logical order from admission to discharge. Prepare each beneficiary's record separately. **Simply enclose the record packet in a rubber band or staple documents together**.

Frequently Asked Questions

Q1: What documentation should I send for review?

A1: Part A providers: Send what is listed on the additional development request (ADR) letter. Part B providers: Send the information/documentation requested in the prepayment review letter in Attachment 1.

Q2: What is the preferable way to send records to your office?

A2: The best way is to send records regular mail to the post office box specified in the ADR letter or prepayment review letter. The mail moves through the correct channels to our department more rapidly this way. Certified mail must be routed differently and may delay the review process for your facility or practice.

Q3: Do I have to copy the chart four times if I have four requests on the same beneficiary?

A3: No, if you receive multiple requests for documentation on the same beneficiary, you may attach all the ADRs, or a cover letter listing the dates of service billed, to one copy of the medical record. Please make sure if you choose to do this, you verify that all dates of service requested are supported by the documentation submitted. If not, a service or claim may be denied as not documented.

Q4: Sometimes my records are returned. What should I do if this happens?

A4: If records are returned, verify the address against those listed above. Then resend the records.

Q5: How will I know you have received the records if I do not send the return receipt?

A5: Part A providers: Monitor the direct data entry (DDE) system for the claim to be moved from a "S" suspense location to a "M" manual location. You should also monitor the DDE system for the final adjudication decision. Part B providers: Monitor your provider remittance notice (PRN) or your electronic remittance notice (ERN) for final adjudication decisions. ❖

Services Provided in Religious Nonmedical Health Care Institutions (RNHCIs)

The Balanced Budget Act of 1997 amended the Social Security Act to provide Medicare coverage of services equivalent to a hospital or extended care level of care in a religious nonmedical health care institution (RNHCI), if a beneficiary elects to receive such benefits.

The beneficiary or his or her legal representative must attest that the individual is conscientiously opposed to acceptance of nonexcepted medical treatment and that the individual's acceptance of such treatment would be inconsistent with the individual's sincere religious beliefs.

The signed election must include a statement that the receipt of nonexcepted medical services would constitute a revocation of the election and may limit further receipt of payment of religious nonmedical health care services. Medicare will not pay for any religious aspects of care provided in an RNHCI. These services are processed by the specialty contractor Riverbend Government Benefits Administrator. Questions regarding this policy should be directed to Riverbend GBA at:

Riverbend Government Benefits Administrator
730 Chestnut Street
Chattanooga, TN 37402-1790
Customer Services telephone number: (423) 755-5955 ❖

Correct Coding Initiative Edits

With the implementation of the upcoming prospective payment system for hospital outpatient services scheduled for July 1, 2000, the fiscal intermediary outpatient code editor (OCE) will be modified to include, among other functions, a number of correct coding initiative (CCI) edits and unit edits.

According to Medicare guidelines, when two or more billed procedures are subject to a CCI edit, Medicare allows the code identified by CCI as the primary procedure, and denies the remaining code(s). The National Technical Information Service (NTIS) develops and maintains sets of procedure code listings that are "bundled" together. The listings may be ordered by code ranges that parallel the American Medical Association's *Current Procedural Terminology* (CPT) book.

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.

For additional information on claim denials, contact Provider Customer Service at (904) 355-8899. ❖

L8614: Cochlear Device System—Correction to Fee Schedule Allowance

The Medicare fee schedule allowance for cochlear devices system (L8614) was published in the December 1999 Special Issued of the *Medicare A Bulletin* (page 61) as $4,499.58.

However, the correct Medicare fee schedule allowance for cochlear devices system (L8614) is $14,499.58. ❖

Settlement Agreement—INAMED

On April 30, 1999, the Health Care Financing Administration (HCFA) entered into a settlement agreement with INAMED, a silicone gel breast implant manufacturer, and the class plaintiffs who brought a class action against the manufacturer for injuries and damages caused by their silicone gel implants. Because of INAMED's financial problems and because the plaintiffs and defendants decided to enter into a limited fund settlement, HCFA agreed to accept payment from the parties in full satisfaction of HCFA's Medicare as secondary payer claims against class members and INAMED.

Medicare beneficiaries, who receive payments under the INAMED settlement, are not required to reimburse Medicare from the settlement proceeds. Medicare contractors will advise the beneficiaries that the release of HCFA's claims in the INAMED case does not relieve a beneficiary of the obligation to cooperate with HCFA by providing requested information, nor does it release that person's obligation to reimburse HCFA if the beneficiary collects funds from another source or a different defendant in connection with a breast implant claim.

Providers are reminded that Medicare remains secondary payer as to claims or suits against any other manufacturer or defendant. However, providers do not need to take any action concerning this settlement. ❖

UPIN Directory Available on CD-ROM

Florida Medicare now has available an electronic version of the unique provider identification number (UPIN) directory on CD-ROM. This directory is free to providers, upon request. The CD-ROM contains a complete national listing of all providers' UPIN records. The CD-ROM is current through July 1999 and will be updated yearly. This directory replaces all prior printed versions.

Publication of the UPIN CD-ROM satisfies the needs of laboratories, suppliers, physicians and other providers in complying with Medicare billing requirements for identifying attending, referring and ordering physicians when filing claims.

To obtain a copy of the CD-ROM, call the Customer Service Department at (904) 355-8899. ❖

GENERAL COVERAGE

G0166: External Counterpulsation for Severe Angina - Revision to Policy

The medical policy for external counterpulsation (ECP), commonly referred to as enhanced external counterpulsation (EECP), was published in the December 1999/January 2000 *Medicare A Bulletin,* pages 28-29. Since then, the Health Care Financing Administration has revised the national coverage policy by replacing all references to the acronym EECP with the acronym ECP, and by removing the word "enhanced."

In addition, the requirement stating "Coverage is further limited to those enhanced counterpulsation systems that have sufficiently demonstrated their medical effectiveness in treating patients with severe angina in well-designated trials" has been removed from the policy.

External counterpulsation for severe angina services furnished on or after January 1, 2000, must be reported using HCPCS code G0166 until a CPT code is established.

External counterpulsation for severe angina services furnished from July 1, 1999, through December 31, 1999, must be reported using HCPCS code 93799 - Unlisted cardiovascular service or procedure. ❖

Clinical Diagnostic Laboratory Organ or Disease Panel - Correction

An article for clinical diagnostic laboratory organ or disease panel was published in the February/March 2000 *Medicare A Bulletin,* pages 8-9. Under the hepatic function panel (80076) for calendar year 2000, the chemistry test for protein, total (84155) was unintentionally left out of the panel.

Therefore, hepatic function panel (80076) for calendar year 2000 contains the following chemistry test panels:

82040	Albumin
84075	Alkaline phosphatase
84460	ALT (SGPT)
84450	AST (SGOT)
82247	Bilirubin, total
82248	Bilirubin, direct
84155	Protein, total ❖

New CLIA Waived Tests

Listed below are the latest tests approved by the Center for Disease Control as waived tests under the Clinical Laboratory Improvement Amendments (CLIA). The Current Procedural Terminology (CPT) codes for these new tests must have the QW modifier to be recognized as a waived test

- Roche Diagnostics/Boehringer Mannheim Chemstrip 101 Urine Analyzer
- LXN IN CHARGE Diabetes Control System
- Fisher HealthCare Sure-Vue Strep A (direct from throat swab)
- Meridian ImmunoCard STAT Mono (for whole blood)
- Applied Biotech SureStep H. pylori WB Test (whole blood),

New waived CPT codes have been assigned for the following tests:

- 82055QW for the STC Diagnostics Q.E.D. A150 Saliva Alcohol Test
- 82055QW for the STC Diagnostics Q.E.D. A350 Saliva Alcohol Test

The CPT code 86588QW (Infectious agent detection by immunoassay with direct optical observation; Streptococcus Group A) was discontinued on 12/31/1999 and has been replaced with the code 87880QW. The following tests were affected by this change:

- QuickVue In-Line One-Step Strep A Test;
- Binax NOW Strep A Test;
- Wyntek Diagnostics OSOM Strep A Test;
- BioStar Acceava Strep A Test (direct specimen only);
- SmithKline ICON Fx Strep A Test (from throat swab only);
- Abbott Signify Strep A Test (from throat swab only);
- Applied Biotech SureStep Strep A (II) (direct from throat swab);
- Meridian Diagnostics ImmunoCard STAT Strep A (direct from throat swab);
- Jant Pharmacal AccuStrip Strep A (II) (direct from throat swab);
- Becton Dickinson LINK 2 Strep A Rapid Test (direct from throat swab);
- Mainline Confirms Strep A Dots Test (direct from throat swab); and
- Gnzyme Contrast Strep A (direct from throat swab).

For 2000, code 82120 was established for amines, vaginal fluid, qualitative. In addition, for the combined amines and pH test, the CPT instructs the use of codes 82120 and 83986. Therefore, the Litmus Concepts FemExam TestCard (from vaginal swab) CPT codes have been changed to 82120QW and 83986QW.

New CLIA Waived Tests continued next page

New CLIA Waived Tests (continued)

TEST NAME	MANUFACTURER	CPT CODE(S)	USE
QuickVue In-Line One-Step Strep A Test	Quidel	87880QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
Binax NOW Strep A Test	Binax	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
Wyntek Diagnostics OSOM Strep A Test	Wyntek Diagnostics, Inc	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
BioStar Acceava Strep A Test (direct specimen only)	Wyntek Diagnostics, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
SmithKline ICON Fx Strep A Test (from throat swab only)	Binax	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
Abbott Signify Strep A Test (from throat swab only)	Wyntek Diagnostics, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
Applied Biotech SureStep Strep A (II) (direct from throat swab)	Applied Biotech, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
*STC Diagnostics Q.E.D. A150 Saliva Alcohol Test	STC Technologies Inc.	82055QW**	Quantitative determination of alcohol (ethanol) in saliva
*STC Diagnostics Q.E.D. A350 Saliva Alcohol Test	STC Technologies Inc.	82055QW**	Quantitative determination of alcohol (ethanol) in saliva
Meridian Diagnostics ImmunoCard STAT Strep A (direct from throat swab)	Applied Biotech, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
Jant Pharmacal AccuStrip Strep A (II) (direct from throat swab)	Applied Biotech, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
Becton Dickinson LINK 2 Strep A Rapid Test (direct from throat swab)	Applied Biotech, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
Mainline Confirms Strep A Dots Test (direct from throat swab)	Applied Biotech, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
Genzyme Contrast Strep A (direct from throat swab)	Genzyme Diagnostics	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever

****** This test may not be covered in all instances. Contact your Medicare contractor for claim instructions

New CLIA Waived Tests (continued)

TEST NAME	MANUFACTURER	CPT CODE(S)	USE
*Roche Diagnostics/Boehringer Mannheim Chemstrip 101 Urine Analyzer	Roche Diagnostics/Boehringer MannheimCorporation	81003QW	Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
*LXN IN CHARGE Diabetes Control System	LXN Corporation	82962, 82985QW	Monitoring of blood glucose levels and measures fructosamine which is used to evaluate diabetic control, reflecting diabetic control over a 2-3 week period.
*Fisher HealthCare Sure-Vue Strep A (direct from throat swab)	CASCO-NERL Diagnostics	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
*Meridian ImmunoCard STAT Mono (for whole blood)	Meridian Diagnostics, Inc.	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis
*Applied Biotech SureStep H. pylori WB Test (whole blood)	Applied Biotech, Inc.	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to *Helicobacter pylori* in whole blood

* Newly-added waived test system

Clarification on Adult Liver Transplantation Policy

This article was prepared by the Health Care Financing Administration to clarify change in coverage to the national adult liver transplantation policy, based on the removal of hepatitis B as a noncovered condition for Medicare patients with end stage liver disease. This change was published in the December 1999 Special Issue of the Medicare A Bulletin, *page 53.*

Q1: Is transplantation of a donor liver from a hepatitis B donor acceptable, or is this still considered investigational?

A1: There is no national Medicare policy on organ donors. Hospitals are required to abide by any Organ Procurement Transplant Network (OPTN) rule that may be applicable (42 CFR 482.45). If a contractor learns of a transplant center that is not in compliance with the OPTN rules, it should report the information to HCFA so that a review can be initiated. The penalty for noncompliance is the potential loss of certification of the hospital as a transplant center rather than noncoverage of an individual claim.

Q2: Is there any limit to the number of retransplantations; and/or are there any requirements clarifying reasonable and necessary for retransplants.

A2: There are no national Medicare policies that limit the number of retransplantations or clarify when retransplantation is reasonable and necessary, and thus, contractor discretion applies.

Q3: Is hepatitis B immunoglobulin or intravenous immunoglobulin (IVIG) for prevention of reinfection of the transplant and its recipient with hepatitis covered?

A3: There is no national Medicare policy on either hepatitis B immunoglobulin or IVIG. Coverage is left to contractor discretion.

Q4: Is it correct that transplantation for other hepatitis types, e.g., hepatitis C, is covered?

A4: Yes. National coverage instructions provide for coverage of liver transplantation for all end-stage liver disease other than malignancy. No type of hepatitis would exclude a person from Medicare coverage.

Q5: Is tumor size an issue in regard to the malignancy exclusion?

A5: No, tumor size is not considered when making a "reasonable and necessary" determination. Malignancy (e.g., liver neoplasm) remains an exclusion to coverage of liver transplantation.

Q6: Should any of the questions above be handled with local medical review policies (LMRPs)?

A6: Contractors may develop LMRPs when there is no national policy or they believe there is potential program abuse or aberrant utilization patterns in their area. ❖

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. 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 **May 15, 2000**, and after, unless otherwise noted.

Medical Policy Table of Contents

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 Web site (**www.floridamedicare.com**) and the Medicare Online BBS.

84436: Thyroid Function Tests, 93000: Electrocardiography, 93501: Cardiac Catheterization—Correction to the Effective Date

Articles for Thyroid Function Tests - 84436 and Electrocardiography - 93000 policies, and the entire medical policy for Cardiac Catheterization - 93501 were published in the February/March *2000 Medicare A Bulletin* (pages 20 and 26-29) with an effective date of March 15, 2000.

Since then, the effective date for the revision to the Thyroid Function Tests policy has been changed to **February 18, 2000.** The effective date for the revision to the Electrocardiography policy and the Cardiac Catheterization policy has been changed to **February 10, 2000.** ❖

93965: Noninvasive Evaluation of Extremity Veins—Addition to Policy

The local medical review policy (LMRP) for Noninvasive Evaluation of Extremity Veins - 93965 was published in the February/March 2000 *Medicare A Bulletin* (pages 33-34). Since that time, a revision has been made to include diagnosis code 794.2 for abnormal lung scan to the "ICD-9-CM Codes That Support Medical Necessity" section of the policy.

Therefore, effective May 15, 2000, the following ICD-9-CM code is added to the policy:

794.2 Abnormal lung scan. ❖

99183: Hyperbaric Oxygen Therapy (HBO Therapy)—Delay in Coverage Policy

The Health Care Financing Administration has further delayed the release of the final guidelines to the revised hyperbaric oxygen therapy (HBO therapy) - 99183 policy. This delay will allow the coverage and analysis staff in the Office of Clinical Standards and Quality to thoroughly review the medical evidence regarding HBO and wound healing therapies and to issue a national coverage decision.

Therefore, the local medical review policy for HBO therapy, published in the December 1999 Special Issue of the *Medicare A Bulletin* (pages 40-44) remains in effect. ❖

93922: Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries

Description

Noninvasive physiologic studies are functional measurement procedures that include Doppler ultrasound studies, blood pressure measurements, transcutaneous oxygen tension measurements, or plethysmography. These studies are useful to confirm and document arterial insufficiency.

The purpose of this policy is to define the circumstances for which Florida Medicare will consider noninvasive physiologic studies of upper or lower extremity arteries to be medically necessary and, therefore, covered.

Type of Bill

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

Revenue Code

921 Other Diagnostic Services, Peripheral Vascular Lab

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider noninvasive physiologic studies of the upper or lower extremity arteries to be medically necessary under any of the following circumstances:

- Claudication of less than one block or of such severity that it interferes significantly with the patient's occupation or lifestyle. The diabetic patient with absent or diminished pulses with or without neuropathies may have no symptoms of claudication due to their neuropathy type symptoms. Slowing down of their gait patterns, also, may not cause claudication symptomatology.
- Rest pain (typically including the forefoot), usually associated with absent pulses, which becomes increasingly severe with elevation and diminishes with placement of the leg in a dependent position.
- Tissue loss defined as gangrene or pregangrenous changes of the extremity, or ischemic ulceration of the extremity occurring in the absence of pulses.
- Aneurysmal disease.
- Evidence of thromboembolic events.
- Evidence of compression/occlusion of the vascular structures supplying the upper extremity.
- Blunt or penetrating trauma (including complications of diagnostic and/or therapeutic procedures).
- For evaluation of dialysis access, see procedure code 93990.
- Transcutaneous oxygen tension measurements (TpO_2) are utilized in conditions for which hyperbaric oxygen therapy (HBO) is being considered, as well as for monitoring the course of HBO therapy. Medicare has identified on a national level, the medical conditions covered for HBO therapy. The following conditions are considered medically indicated uses for TpO_2 testing prior to, and during the course of, HBO therapy: acute traumatic peripheral ischemia, crush injuries and suturing of severed limbs, progressive necrotizing infections, acute peripheral arterial insufficiency, preparation and preservaton of compromised skin grafts, and soft tissue radionecrosis as an adjunct to conventional treatment.
- Transcutaneous oxygen tension measurements (TpO_2) used to determine a line of demarcation between viable and non-viable tissue when surgery or amputation is anticipated.

A routine history and physical examination, which includes Ankle/Brachial Indices (ABIs), can readily document the presence or absence of ischemic disease in a majority of cases. It is not medically necessary to proceed beyond the physical examination for minor signs and symptoms such as hair loss, absence of a single pulse, relative coolness of a foot, shiny thin skin, or lack of toe nail growth unless related signs and/or symptoms are present which are severe enough to require possible invasive intervention. Examples of additional signs and symptoms that do not indicate medical necessity include:

- Continuous burning of the feet is considered to be a neurologic symptom.
- "Leg pain, nonspecific" and "Pain in limb" as single diagnoses are too general to warrant further investigation unless they can be related to other signs and symptoms.
- Edema rarely occurs with arterial occlusive disease unless it is in the immediate postoperative period, in association with another inflammatory process or in association with rest pain.
- Absence of relatively minor pulses (e.g., dorsalis pedis or posterior tibial) in the absence of symptoms. The absence of pulses is not an indication to proceed beyond the physical examination unless it is related to other signs and/or symptoms.

While the HBO Society has not published a practice parameter regarding the use of TpO_2 monitor the response to HBO therapy, literature supports repeating the TpO_2 value after 20 treatments. Comparison is made with the baseline study to determine the response to therapy.

In general, noninvasive studies of the arterial system are to be utilized when invasive correction is contemplated, but not to follow noninvasive medical treatment regimens (e.g., to evaluate pharmacologic intervention). The latter may be followed with physical findings and/or progression or relief of signs and/or symptoms.

HCPCS Codes

93922 Non-invasive physiologic studies of upper or lower extremity arteries, single level, bilateral (e.g., ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)

93922: Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries (continued)

93923	Non-invasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study (e.g., segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmography, segmental transcutaneous oxygen tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia)
93924	Non-invasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, complete bilateral study

ICD-9-CM Codes That Support Medical Necessity

440.0	Atherosclerosis of aorta
440.20-440.24	Atherosclerosis of native arteries of the extremities
440.30-440.32	Atherosclerosis of bypass graft of the extremities
441.00-441.03	Dissection of aorta
442.0	Other aneurysm of artery of upper extremity
442.3	Other aneurysm of artery of lower extremity
443.0	Raynaud's syndrome
443.1	Thromboangiitis obliterans [Buerger's disease]
443.81	Peripheral angiopathy in diseases classified elsewhere
443.9	Peripheral vascular disease, unspecified
444.0	Arterial embolism and thrombosis of abdominal aorta
444.1	Arterial embolism and thrombosis of thoracic aorta
444.21-444.22	Arterial embolism and thrombosis of arteries of the extremities
444.81-444.89	Arterial embolism and thrombosis of other specified artery
447.0	Arteriovenous fistula, acquired
447.1	Stricture of artery
447.2	Rupture of artery
707.1	Ulcer of lower limbs, except decubitus
707.8	Chronic ulcer of other specified sites
785.4	Gangrene
903.00	Injury to axillary vessel(s), unspecified
903.02	Injury to axillary vein
903.1	Injury to brachial blood vessels
903.2	Injury to radial blood vessels
903.3	Injury to ulnar blood vessels
903.4	Injury to palmar artery
903.5	Injury to digital blood vessels
903.8	Injury to other specified blood vessels of upper extremity
904.0	Injury to common femoral artery
904.1	Injury to superficial femoral artery
904.41	Injury to popliteal artery
904.51	Injury to anterior tibial artery
904.53	Injury to posterior tibial artery
904.6	Injury to deep plantar blood vessels
904.7	Injury to other specified blood vessels of lower extremity
996.1	Mechanical complication of other vascular device, implant, and graft
996.70-996.79	Other complications of internal (biological) (synthetic) prosthetic device, implant, and graft
998.11-998.13	Hemorrhage or hematoma or seroma complicating a procedure
998.2	Accidental puncture or laceration during a procedure

Medical conditions covered by Coverage Issues Manual 35-10 for HBO therapy with associated transcutaneous oxygen tension measurements (TpO_2):

444.21-444.22	Arterial embolism and thrombosis of arteries of the extremities
444.81	Arterial embolism and thrombosis of iliac artery
686.01-686.09	Pyoderma (Meleney's ulcer)
728.86	Necrotizing fasciitis
733.41-733.49	Aseptic necrosis of bone
902.53	Injury to iliac artery
903.01	Injury to axillary artery
903.1	Injury to brachial blood vessels
904.0	Injury to common femoral artery
904.41	Injury to popliteal artery
927.00-927.09	Crushing injury of shoulder and upper arm
927.10-927.11	Crushing injury of elbow and forearm
927.20-927.21	Crushing injury of wrist and hand(s), except finger(s) alone
927.8	Crushing injury of multiple sites of upper limb
927.9	Crushing injury of unspecified site
928.00-928.01	Crushing injury of hip and thigh
928.10-928.11	Crushing injury of knee and lower leg
928.20-928.21	Crushing injury of ankle and foot, excluding toe(s) alone
928.3	Crushing injury of toe(s)
928.8-928.9	Crushing injury of multiple sites and unspecified site of lower limb
929.0-929.9	Crushing injury of multiple and unspecified sites
990	Effects of radiation, unspecified
996.52	Mechanical complication due to graft of other tissue, not elsewhere classified
996.90-996.99	Complications of reattached extremity or body part

HCPCS Section and Benefit Category

Medicine/Non-Invasive Vascular Diagnostic Studies

HCFA National Coverage Policy

Coverage Issues Manual 50-6, 50-7, 35-10

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Sources of Information

Radiometer Medical A/S (1997). Transcutaneous monitoring of TpO_2 in hyperbaric medicine. *Patient Focus Circle.*

Coding Guidelines

Duplex scanning (93925, 93926, 93930, and 93931) and physiologic studies (93922, 93923, and 93924) are reimbursed during the same encounter if the physiologic studies are abnormal and/or to evaluate vascular trauma, thromboembolic events or aneurysmal disease. Medical record documentation must demonstrate the medical necessity of performing both duplex scanning and physiologic studies on the same date of service.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of non-invasive physiologic studies of the upper or lower extremity arteries. Also, the results of arterial studies must be included in the patient's medical record. If performing procedure code 93924, documentation must include results of resting studies **and** after treadmill stress testing studies. This information is normally found in the office/progress notes and test results.

If the provider of noninvasive physiologic studies of arteries of the upper or lower extremity is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies. When ordering arterial studies from another provider, the ordering/referring physician must state the reason for the studies in his order for the tests.

Vascular testing that is billed excessively may be considered medically necessary when there is a change in the patient's symptoms (acceptable ICD-9-CM code) or there is the presence of a new condition (acceptable ICD-9-CM code).

Other Comments

N/A

CAC Notes

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

Start Date of Comment Period:	11/15/99
Start Date of Notice Period:	4/1/00, April/May 2000 *Bulletin*
Original Effective Date:	**05/15/2000** ❖

J1561: Intravenous Immune Globulin

Description

Intravenous Immune Globulin is a solution of human immunoglobulins specifically prepared for intravenous infusion. Immunoglobulin contains a broad range of antibodies that specifically act against bacterial and viral antigens.

Type of Bill

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

Drug requiring detailed coding - 636
Pharmacy general classification - 250 (CORF only)

Indications and Limitations of Coverage and/or Medical Necessity

The use of intravenous Immune Globulin should be reserved for patients with serious defects of antibody function. The goal is to provide IgG antibodies to those who lack them. Florida Medicare will provide coverage for intravenous Immune Globulin when it is used in treatment of the following conditions:

- Primary Humoral Immunodeficiency
- Common variable immunodeficiency
- Wiskott-Aldrich syndrome
- X-linked agammaglobulinemia
- Severe combined immunodeficiency

- Recurrent severe infection and documented severe deficiency or absence of IgG subclass

- Clinically significant functional deficiency of humoral immunity as evidenced by documented failure to produce antibodies to specific antigens **and** a history of recurrent infections.

- Idiopathic Thrombocytopenic Purpura (ITP)
- Doses should be based on the patient's clinical appearance and platelet count. Infusions are usually administered when there are signs and symptoms of bleeding and/or a platelet count less than 30,000/mm3

- Chronic Lymphocytic Leukemia with associated hypogammaglobulinemia
- There should be evidence of specific antibody deficiency and the presence of repeated bacterial infections.

- Symptomatic Human Immunodeficiency Virus (HIV)-less than 13 years of age **and** CD4+ lymphocyte count 200/mm3 or greater
- Indications for intravenous immunoglobulin would include:
  Children less than 13 years of age
  Entry CD4+ lymphocyte counts greater than or equal to 200/mm3
  Clinically symptomatic or asymptomatic but immunologically abnormal

- Low-birth weight infants weighing between 500 and 1750 grams at birth
- Indications for intravenous immunoglobulin would include:
  Weight at birth between 500-1750 grams
  Expected to survive for more than 48 hours
  Stable cardiovascular function
  Intravenous access for medical therapy

- Bone marrow transplantation
- Indications for intravenous immunoglobulin would include:
  Patients 20 years of age or older
  Seropositive for cytomegalovirus (CMV) before transplantation
  Seronegative, had seronegative marrow donors, and undergoing allogeneic transplantation for hematologic neoplasms

- Kawasaki Disease (mucocutaneous Lymph Node Syndrome)

For diagnoses of Guillain Barre syndrome, chronic inflammatory demyelinating polyneuropathy, autoimmune hemolytic anemia, autoimmune neutropenia, acquired inhibitor of clotting factor VIII, immune thrombocytopenic purpura in pregnancy, myasthenia gravis, refractory polymyositis and refractory dermatomyositis. It is noted that not all patients with these diseases need treatment with intravenous immunoglobulin. Intravenous immunoglobulin may be recommended when **other therapy has failed or is contraindicated, and for potentially severe or life threatening manifestations of these diseases.**

- Acute Inflammatory Demyelinating Polyradiculoneuropathy, Guillain-Barre Syndrome, and Myasthenia Gravis:
- It is noted that not all patients with these diseases need treatment with intravenous immunoglobulin. The following situations would constitute appropriate indications:
  Other therapy has failed or is contraindicated
  Difficulty with venous access for plasmapheresis
  Recommended for rapidly progressive forms of these diseases

- Autoimmune Hemolytic Anemia
- It is noted that not all patients with this disease need treatment with intravenous immunoglobulin. Intravenous immunoglobulin should be used for patients whose condition is resistant to conventional forms of therapy and/or demonstrates severe or life threatening manifestations of this disease.

- Autoimmune Neutropenia
- This disease is usually benign and self-limiting, and does not require treatment. Not all patients with this disease need treatment with intravenous immunoglobulin. Occasionally, however, it is marked by repeated infection. Intravenous immunoglobulin may be recommended for the treatment of patients with an absolute neutrophil count less than 800/mm3 with recurrent bacterial infections.

J1561: Intravenous Immune Globulin (continued)

- Coagulopathy due to inhibitors or antihemophilic factor (Factor VIII)
- This is a relatively rare bleeding disorder caused by circulating autoantibodies against Factor VIII. Not all patients with this disease need treatment with intravenous immunoglobulin. Patients who develop serious hemorrhage may be administered intravenous immunoglobulin, in addition to other appropriate therapies.
- Immune Thrombocytopenic Purpura in Pregnancy
- Pregnant women with this disease are at risk for delivering thrombocytopenic infants. Protection of the fetus becomes an important consideration in the management of a pregnant woman with immune thrombocytopenic pupura. Intravenous immunoglobulin can be recommended in the following:
  Pregnant women who have previously delivered infants with autoimmune thrombocytopenia
  Pregnant women who have platelet count less than 75,000/mm3 during the current pregnancy
  Pregnant women with past history of splenectomy
- Inflammatory Myopathies: Refractory Polymyositis and Refractory Dermatomyositis
- The criteria for the use of intravenous immunoglobulin in polymyositis or dermatomyositis is: patients who are **refractory** to standard therapy which includes patients who are refractory to corticosteroids; patients who have been unable to successfully taper corticosteroids below moderately high doses; patients developing **severe** side effects due to steroid therapy; **and** patients who have also failed at least one immunosupressive agent (e.g., azathioprine, Methotrexate, cyclophosphamide, cyclosporine).

HCPCS Codes

J1561	Injection, immune globulin, intravenous, 500 mg
J1562	Injection, immune globulin, intravenous 5 g

ICD-9-CM Codes That Support Medical Necessity

042	Human immunodeficiency virus (HIV) disease
204.10	Chronic lymphoid leukemia without mention of remission (with associated hypogammaglobulinemia)
204.11	Chronic lymphoid leukemia in remission (with associated hypogammaglobulinemia)
279.03	Other selective immunoglobulin deficiencies
279.04	Congenital hypogammaglobulinemia
279.06	Common variable immunodeficiency
279.09	Other deficiency of humoral immunity
279.12	Wiskott-Aldrich syndrome
279.2	Combined immunity deficiency
283.0	Autoimmune hemolytic anemias
286.0	Congenital factor VIII disorder
287.3	Primary thrombocytopenia
288.0	Agranulocytosis
357.0	Acute infective polyneuritis
357.8	Inflammatory and toxic neuropathy, other
358.0	Myasthenia gravis
446.1	Acute febrile mucocutaneous lymph node syndrome (MCLS)
710.3	Dermatomyositis (refractory)
710.4	Polymyositis (refractory)
765.02-765.07	Disorders relating to short gestation and unspecified low birth weight; extreme immaturity
996.85	Complications of transplanted organ, bone marrow

HCPCS Section and Benefit Category

Drugs and Biologicals

HCFA National Coverage Policy

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Sources of Information

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J1561: Intravenous Immune Globulin (continued)

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Coding Guidelines

All hospital, skilled nursing facility, rural health clinic and ESRD facility providers of service must bill Intravenous Immune Globulin under Revenue Code 636 - Drugs requiring detailed coding. In addition, HCPC J1561 or J1562 must be included to identify which product was administered. ESRD facility providers must bill procedure code X0051 for gamimune N 5% - 500 mg. Comprehensive outpatient rehabilitation facility (CORF) providers may bill this service if it is directly related to the skilled rehabilitation services required by the beneficiary. CORF providers must identify the HCPC J1561 or J1562 in addition to Revenue Code 250- drugs and biologicals.

IV immune globulin maybe billed by an ESRD facility only if it is actually administered in the facility by the facility staff. Staff time used is covered under the composite rate and may not be billed separately. However, the supplies used to administer this drug may be billed in addition to the composite rate.

Documentation Requirements

Medical record documentation maintained by the treating physician/facility must clearly document the medical necessity to initiate intravenous Immune Globulin therapy and the continued need thereof. Required documentation of medical necessity should include:

- history and physical
- office/progress note(s)
- test results with written interpretation
- an accurate weight in kilograms should be documented prior to the infusion since the dosage is based mg/kg/dosage

Other Comments

Terms Defined:

Antibody—a protein substance developed in response to, and interacting specifically with, an antigen. This antigen-antibody reaction forms the basis of immunity.

Antigen—a substance that induces the formation of antibodies that interact specifically with it.

CAC Notes

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

Start Date of Comment Period:	N/A	
Start Date of Notice Period:	4/1/00, April/May 2000 Bulletin	
Original Effective Date:	01/19/95 (AI)	
Revision Date/Number:	**05/15/2000**	#4

To remove requirement regarding IgG trough levels and revise language in policy to reflect current policy terminology.

J1561: Intravenous Immune Globulin (continued)

Revision History:

Start Date of Comment Period: N/A
Start Date of Notice Period: October/November 1999 *Bulletin*
Original Effective Date: 01/19/95 (AI)
Revision Date/Number: 11/15/1999 #3

To add a covered ICD-9-CM code for covered indication chronic inflammatory demyelinating polyneuropathy when other therapy has failed or is contraindicated and for a potentially severe or life threatening manifestation.

Start Date of Comment Period: N/A
Start Date of Notice Period: N/A
Original Effective Date: 01/19/95 (AI)
Revision Date/Number: N/A #2a
(Informational only)

Start Date of Comment Period: N/A
Start Date of Notice Period: 1/23//98
Original Effective Date: 01/19/95 (AI)
Revision Date/Number: 01/01/98 #2
1998 HCPCS

Start Date of Comment Period: N/A
Start Date of Notice Period: N/A
Original Effective Date: 01/19/95 (AI)
Revision Date/Number: 07/02/97 #1

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

Original Effective Date: 01/19/95 (AI) ❖

Policy Overview: The final local medical review policy (LMRP) for APHPPROG—Psychiatric Partial Hospitalization Program was previously published in the Medicare Part A Bulletin, G-343 issued July 29, 1998. Implementation of this policy was placed on hold pending further evaluation of the content material. The policy was subsequently redrafted and published for comment in the November 15, 1999 Draft Local Medical Review Policy issue of the Medicare A Bulletin*. Following is the final LMRP for PHPPROG (Psychiatric Partial Hospitalization Program), which will be effective May 15, 2000.*

Policy Number: PHPPROG

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Psychiatric Partial Hospitalization Program

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HCFA National Coverage Policy
Title XVIII of the Social Security Act, Section 1862 (a) (1) (A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Social Security Act, Section 1861 (ff) and 1832 (a). These sections define the partial hospitalization benefit and provide coverage of partial hospitalization in a hospital or CMHC setting.

The Social Security Act, Section 1861(s) (2) (B). This section references partial hospitalization in a hospital outpatient setting.

The Social Security Act, Section 1835 (a). This section references physician certification.

The Social Security Act, Section 1833 (e). This requires services to be documented in order for payment to be made.

42 Code of Federal Regulations 410.2, 410.3, 410.43, 410.110, and 424(e)

Federal Register 2/11/94, (59 FR 6570)

Medicare Hospital Manual, Section 230.5 and 452

Medicare Intermediary Manual (MIM), Section 3112.7, 3190, 3651, 3661

Outpatient Physical Therapy, Comprehensive Outpatient Rehabilitation Facility and Community Mental Health Manual, Section 260 and 414

Coverage Issues Manual (CIM) 35-14, 35-27, 35-92, 80-1

Program Memorandum, 6/95, HCFA Transmittal No. A-95-8

Program Memorandum, 7/96, HCFA Transmittal No. A-96-2

Program Memorandum, 10/96, HCFA Transmittal No. A-96-8

Program Memorandum, 9/99, HCFA Transmittal No. A-99-39

HCFA R 97-1, 2/97

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
05/15/2000

Revision Effective Date
N/A

Revision Ending Effective Date
N/A

Policy Ending Date
N/A

LMRP Description
Individuals requiring psychiatric care generally receive services along a continuum of care which involves three levels - inpatient, partial hospitalization, and outpatient.

Psychiatric partial hospitalization is a distinct, organized, ambulatory, and intensive psychiatric outpatient treatment of less than 24 hours of daily care. It is designed to provide patients with profound or disabling mental health conditions an individualized, intensive, comprehensive, and multidisciplinary treatment program not provided in a regular outpatient setting. Partial hospitalization services are furnished by a hospital or community mental health center (CMHC) to patients with acute mental illness in lieu of inpatient care. Patients are generally directly admitted (transitioned) to a partial hospitalization program (PHP) from an inpatient psychiatric stay or from a failed attempt at being managed as an outpatient.

Partial Hospitalization requires admission and certification of need by a physician (M.D./D.O.) trained in the diagnosis and treatment of psychiatric illness. PHPs differ from inpatient hospitalization and outpatient management in day programs in 1) the intensity of the treatment programs and frequency of participation by the patient and 2) the comprehensive structured program of services provided that are specified in an individualized treatment plan, formulated by a physician and the multidisciplinary team, with the patient's involvement.

PHPPROG: Psychiatric Partial Hospitalitation Program (continued)

Indications and Limitations of Coverage and/or Medical Necessity

Eligibility Requirements

The following are facilities eligible for reimbursement for partial hospitalization services and the associated physician supervision requirements of each:

- **Outpatient hospital** - Partial hospitalization services rendered within a hospital outpatient department are considered "incident to" a physician's (MD/DO) services and require physician supervision. The physician supervision requirement is presumed to be met when services are performed on hospital premises (i.e., certified as part of the hospital). If a hospital outpatient department operates a PHP offsite, the services must be rendered under the direct personal supervision of a physician (MD/DO). Direct supervision means that the physician must be physically present in the same office suite and immediately available to provide assistance and direction throughout the time the employee is performing the service.
- Community mental health center (CMHC) - The CMHC must meet applicable certification or licensure requirements of the state in which they operate, and additionally be certified by Medicare. A CMHC is a Medicare provider of services only with respect to the furnishing of partial hospitalization services under Section 1866(e)(2) of the Act. Health Care Finance Administration definition of a CMHC is based on Section 1916 (c)(4) of the Public Health Service (PHS) Act. The PHS definition of a CMHC is cross-referenced in Section 1861(ff) of the Act.

Partial hospitalization services provided in a CMHC require general supervision and oversight of the program by a physician (MD/DO). General supervision means the physician must at least be available by telephone.

Patients eligible for Medicare reimbursement for PHP services are:

- Those patients who are directly discharged or transitioned from an inpatient hospital treatment program and the PHP admission is in lieu of continued inpatient treatment.
- Those patients who, in the absence of the partial hospitalization, would require inpatient hospitalization. *It is generally expected that less intensive treatment in an outpatient setting be attempted prior to admission to partial hospitalization. Documentation for such patients should support these attempts, as well as the patient's failure at or inability to be managed in a less intensive outpatient setting.*

The following eligibility requirements must also be met:

- The services must be reasonable and necessary for the diagnosis or active treatment of the individual's condition.
- The patient must be under the care of a physician (M.D./D.O.) trained in the diagnosis and treatment of psychiatric illness, who is knowledgeable about the patient and certifies the need for partial hospitalization.
- The patient or legal guardian must provide written informed consent for partial hospitalization treatment.
- The patient must require comprehensive, multimodal treatment requiring medical supervision and coordination because of a mental disorder, which *severely* interferes with multiple areas of daily life including social, vocational, and/or educational functioning. *Such dysfunction must be an acute illness or exacerbation of a chronic illness (acute in nature).*
- The patient must have the capacity for active participation in all phases of the multidisciplinary and multimodal program (i.e., the patient is medically stable and not limited by another serious medical condition, the patient demonstrates an appropriate level of cognition).
- There must be reasonable expectation of improvement in the patient's disorder and level of functioning as a result of the active treatment provided by the PHP.
- The active treatment must directly address the presenting problems necessitating admission to the PHP. Active treatment consists of clinically recognized therapeutic interventions including individual, group, and family psychotherapies, occupational, activity, and psychoeducational groups pertinent to the patient's current illness. Medical and psychiatric diagnostic evaluation and medical management are also integral to active treatment. Evidence of active monitoring of the patient's physical status, which could impact the patient's psychiatric condition, is required.
- The individualized treatment plan is developed by a physician and the multidisciplinary team, with the patient's involvement.
- A physician must provide supervision and evaluation of the patient's treatment and the extent to which the therapeutic goals are being met.
- The program must be prepared to appropriately treat the co-morbid substance abuse disorder when it exists (dual diagnosis patients). Dual diagnosed individuals suffer from concomitant mental illness and chemical dependency. Sobriety, as an initial clinical goal, is essential for further differential diagnosis and clinical decisions about appropriate treatment. *It is not generally expected that a patient who is actively using a chemical substance be admitted to or engaged in a partial hospitalization program, as a patient under the influence of a chemical substance would not be capable of actively participating in his/her psychiatric treatment program.*

Admission Criteria (Intensity of Service)

In general, patients should be treated in the least intensive and restrictive setting which meets the needs of their illness.

Patients admitted to a PHP must:

- Not require a 24-hour a day level of care as provided in an inpatient setting. *Therefore, it is not expected for the patient to be an inpatient.*

PHPPROG: Psychiatric Partial Hospitalitation Program (continued)

- Have an adequate support system to sustain/maintain themselves outside the partial program. *The patient is expected to have an identifiable significant support system while he/she is not actively engaged in the program (i.e., in the evening, on the weekend, or anytime the PHP services are not available).*
- Require PHP services at a level of intensity and frequency comparable to patients in an inpatient setting for similar psychiatric illnesses.

Admission Criteria (Severity of Illness)

Patients admitted to a PHP must:

- Have an acute onset or decompensation of a covered Axis I mental disorder, as defined by the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) published by the American Psychiatric Association (1994), which severely interferes with multiple areas of daily life.
- Demonstrate a degree of impairment severe enough that without care or treatment, the person is likely to suffer from neglect or refuse to care for him or herself and such neglect or refusal poses a real and present threat of substantial harm to his or her well being. This degree of impairment requires a multidisciplinary structured program, but is not so severe that the patient is incapable of participating in and benefiting from an active treatment program and be maintained outside the program.
- Not be an immediate/imminent danger to self, others, or property. *There may be a recent history of self-mutilation, serious risk taking, or other self-endangering behavior. Evidence of appropriate safety measures should be in place to accommodate at-risk patients (e.g., a no harm contract with a specified emergency plan signed by the patient upon admission and re-affirmed upon the end of each treatment day.)*

Discharge Criteria (Intensity of Service):

Patients are appropriate for discharge from a partial hospitalization program, based on intensity of service, when:

- The patient requires stepping up to an inpatient level of care. The inpatient psychiatric admission (24 hour supervision) becomes necessary when the probability for self-harm, or harm to others exists.
- The patient requires stepping down to a less intensive level of outpatient care. Stepping down to a less intensive level of service than a partial hospitalization would be considered when the patient no longer requires the multidisciplinary or multimodal program.

  If transitioning is required prior to discharge from the partial hospitalization program, the medical need for transitioning should be documented in the treatment plan.

  In the **rare circumstance** of inability or failure to transition to a less intensive level, medical records must substantiate the need for a continuation in the PHP.

Discharge Criteria (Severity of Illness):

Patients are appropriate for discharge from a PHP, based on severity of illness, when:

- The patient's clinical condition declines and the individual requires inpatient psychiatric care (24-hour supervision).
- The patient's clinical condition improves or stabilizes and the individual no longer benefits from or requires the intensive, multimodal treatment of the PHP. This would be evidenced by a reduced impairment in daily functioning, symptom reduction, improved capacity to access community supports, accomplishment of treatment goals to extent possible, and ability to return to increased levels of independence in day-to-day activities.

Covered Services:

- Medically necessary diagnostic services related to mental illness.
- Individual or group psychotherapy rendered by physicians (MD/DO), psychologists, or other mental health professionals licensed or authorized by Florida State law. ** Professional services furnished by physicians, physician assistants, nurse practitioners, and clinical psychologists to patients in PHPs *must* be billed to the carrier.
- Occupational therapy, requiring the skills of an occupational therapist (OT), which is a component of the physician's treatment plan for the patient. The occupational therapy services must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals. The physician's treatment plan must clearly justify the need for each occupational therapy service modality utilized, and explain how it fits into the treatment of the patient's mental illness and functional deficits. *Providers must not bill occupational therapy services as individual or group psychotherapy services.*
- Services of other staff (social workers, psychiatric nurses and others) trained to work with psychiatric patients.
- Drugs and biologicals that cannot be self-administered and are furnished for psychotherapeutic purposes. *The medication must be safe and effective, and approved by the Food and Drug Administration. It cannot be experimental or administered under investigational protocol.*
- Individualized activity therapy that is not primarily recreational or diversionary. The activity therapy group must be individualized and essential for the treatment of the patient's diagnosed psychiatric condition and for progress toward treatment goals. The physician's treatment plan must clearly justify the need for each activity therapy modality utilized and explain how it fits into the treatment of the patient's illness and functional deficits. *Providers must not bill activity therapies as individual or group psychotherapy services.*

PHPPROG: Psychiatric Partial Hospitalitation Program (continued)

- Family counseling services for which the primary purpose is the treatment of the patient's condition. Such services include the need to observe the patient's interaction with the family for diagnostic purposes, or to assess the capability of and assist the family members in aiding in the management of the patient.
- Patient training and education, when the training and educational sessions are closely and clearly related to the individual's care and treatment of their diagnosed psychiatric condition. *Providers must not bill training and education as individual or group psychotherapy services. Providers must also not bill for general education (e.g., providing information in a group setting regarding a medication the patient is not receiving, information regarding the PHP's schedule, policies, changes in personnel, etc.).*

HCPCS Section and Benefit Category

Medicine, Psychiatry, Central Nervous System Assessments/Tests, Physical Medicine and Rehabilitation

Type of Bill Codes

Hospital Outpatient - 13x, 14x
Community Mental Health Center - 76x

Revenue Codes

250 General classification for drugs and biologicals
43X Occupational therapy
904 Activity therapy
910 General classification for psychiatric/ psychological services
914 Individual therapy
915 Group therapy
916 Family therapy
918 Testing
942 Education training

HCPCS Codes

There are no specific CPT or HCPCS codes for partial hospitalization "programs". However, outpatient hospitals are required to report the following appropriate HCPCS codes for the individual or specific partial hospitalization services provided. Effective for dates of services on or after April 1, 2000, Community Mental Health Centers will also be required to utilize the same HCPCS codes for reporting partial hospitalization services.

90801 Psychiatric diagnostic interview examination
90802 Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication
90816 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20-30 minutes face-to-face with the patient;
90818 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;
90821 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75-80 minutes face-to-face with the patient;
90823 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20-30 minutes face-to-face with the patient;
90826 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45-50 minutes face-to-face with the patient;
90828 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75-80 minutes face-to-face with the patient;
90846 Family psychotherapy (without the patient present)
90847 Family psychotherapy (conjoint psychotherapy) (with patient present)
90849 Multiple-family group psychotherapy
90853 Group psychotherapy (other than of a multiple-family group)
90857 Interactive group psychotherapy
90875 Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes
90876 Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 45-50 minutes
90899 Unlisted psychiatric service or procedure
96100 Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, eg, WAIS-R, Rorschach, MMPI) with interpretation and report, per hour
96115 Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour
96117 Neuropsychological testing battery (eg, Halstead-Reitan, Luria, WAIS-R) with interpretation and report, per hour

PHPPROG: Psychiatric Partial Hospitalitation Program (continued)

97770	Development of cognitive skills to improve attention, memory, problem solving, includes compensatory training and/or sensory integrative activities, direct (one on one) patient contact by the provider, each 15 minutes
G0129	Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day
G0172	Training and educational services furnished as a component of a partial hospitalization treatment program, per day
Q0082	Activity therapy furnished as a component of a partial hospitalization treatment program (e.g., music, dance, art or play therapies that are not primarily recreational), per day

There are HCPCS codes on this list that may not be reimbursable through Medicare due to existing national or Local Medical Review Policies. Please refer to the applicable Medicare manuals and Local Medical Review Policies for coverage criteria information regarding each service.

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

A diagnosis that falls within the range of ICD-9 codes for mental illness (290.0-319). *The diagnosis itself is not the sole determining factor for coverage.*

Diagnosis that Support Medical Necessity

NA

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

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reason for Denial

- Services furnished by a facility other than an outpatient hospital or a community mental health center (CMHC)
- The treatment of chronic conditions without acute exacerbation
- Individual or group psychotherapy rendered by someone who is not licensed or authorized by Florida State Law
- Professional services of physicians, physician assistants, nurse practitioners, and clinical psychologists billed to the Intermediary
- Occupational therapy services related primarily to specific employment opportunities, work skills, or work settings
- Activity therapy that is primarily recreational or diversionary
- Any service that does not have a specific treatment goal
- Daycare programs, which provide primarily social, recreational, or diversional activities, custodial or respite care
- Psychosocial programs attempting to maintain psychiatric wellness (e.g., daycare programs for the chronically mentally ill which provide only a structured environment, socialization, and/or vocational rehabilitation)
- Services to a skilled nursing facility or nursing home resident that should be expected to be provided by the nursing facility staff (e.g., adjustment difficulties related to their placement in the skilled nursing facility or nursing home)
- Services to hospital inpatients
- Meals
- Transportation
- Self-administered medications
- Vocational training
- General education (e.g., information provided about the partial hospitalization program's schedule, policies, changes in staffing, etc.)
- Biofeedback therapy for ordinary muscle tension or psychosomatic conditions
- Transcendental meditation
- Electroconvulsive therapy (ECT).

Beneficiaries ineligible for partial hospitalization services:

- Patients who do not meet admission criteria for partial hospitalization services;
- Patients who cannot or refuse to participate (due to their behavioral, cognitive or emotional status) with the active treatment of their mental disorder, or who cannot tolerate the intensity of a partial hospitalization program;
- Patients who require 24 hour supervision inpatient hospitalization because of the severity of their mental disorder or their safety or security risk;
- Patients who require primarily social, recreational, custodial, or respite care;
- Patients with multiple unexcused absences or who are persistently non-compliant;
- Individuals with an organic brain disorder(i.e., Dementia, Delirium, Alzheimer's), or other psychiatric or neurologic conditions (Severe Head Trauma) which have produced a severe enough cognitive deficit to prevent establishment of a relationship with the therapist or other group members, or participation in insight oriented processes;
- Patients who have met the criteria for discharge from the partial hospitalization program to a less intensive level of outpatient care.

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

PHPPROG: Psychiatric Partial Hospitalitation Program (continued)

Coding Guidelines

Community mental health centers (CMHCs) and hospital outpatient departments must report the following when billing for PHP services:

- Acceptable revenue codes (form locator 42). The following are allowable revenue codes for PHP services: 250, 43X, 904, 910, 914, 915, 916, 918 and 942.
- HCFA specifies "Service Units" as the number of times the service or procedure, as defined by the HCPCS code, was performed when billing for the partial hospitalization services. When reporting service units for HCPCS codes where the definition of the procedure does not include any time frame (either minutes, hours, or days), providers should not bill for sessions of less than 45 minutes duration. When reporting service units for HCPCS codes where the procedure is not defined by a specific time frame, providers should report "1" unit in FL 46. Providers that have previously reported visits should no longer report these visits as units for these services. For each session billed, documentation should be maintained in the medical record to validate that a treatment session occurred. The Fiscal Intermediary will return to provider (RTP) claims that contain more than one unit for HCPCS codes G0129, Q0082, and G0172, or that do not contain service units for a given HCPCS code.

Note: Service units are not required to be reported for drugs and biologicals (Revenue Code 250).

HCPCS Coding and Line Item Date of Service Reporting (Form Locators 44 and 45)

Hospital providers are required to utilize the HCPCS coding structure when billing for outpatient partial hospitalization services. HCPCS codes are reported in FL 44 of the UB-92 claim form. Effective April 1, 2000, CMHCs will also be responsible for claim filing utilizing HCPCS codes and line item dates of service per revenue code line for partial hospitalization claims. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45 "Service Date" (MMDDYY). The Intermediary will return to provider (RTP) claims if a line item reported falls outside of the statement coverage period. The HCPCS/CPT coding structure indicated below should be reported, as appropriate.

Revenue Codes	HCPCS Codes
43X	G0129
904	Q0082
910	90801, 90802, 90875*, 90876*, 90899, or 97770
914	90816, 90818, 90821, 90823, 90826, or 90828
915	90849, 90853, or 90857
916	90846, 90847, or 90849
918	96100, 96115, or 96117
942	G0172

* Coverage Issues Manual 35-27 restricts the use of biofeedback. Medicare does not cover biofeedback for the treatment of psychiatric disorders.

Note: Revenue code 250 (Pharmacy) does not currently require HCPCS/CPT coding.

In addition, Intermediary edits are performed to ensure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes.

- Supervisory duties, attending patient conferences, nursing assessments, psychosocial evaluations, participating in the development of the treatment plan, preparing clinical and progress reports, participating in discharge planning and inservice programs, etc. are considered administrative costs of the facility and are settled at cost audit. These must not be line item billed.
- A patient who requires inpatient hospitalization for a medical condition during the course of receiving PHP services **must be discharged** from the PHP services. There is not a patient "hold" status.
- The hospital must also report Condition Code 41 (in form locator 24-30) to indicate the claim is for partial hospitalization services. If condition code 41 is not reported, the facility will be notified. CMHCs are not required to report a condition code.

Bundling Issues

The professional services (listed below) provided in a CMHC or hospital outpatient department are separately covered and paid as the professional services of physicians and independent practitioners. These direct professional services are "unbundled" and these practitioners (other than physician assistants, [PAs]), may bill the Medicare Part B carrier directly for the professional services furnished to hospital outpatient PHP patients and CMHC partial hospitalization patients. The hospital or CMHC can also serve as a billing agent for these professionals, by billing the Part B carrier on their behalf for their professional services (via the HCFA-1500 billing format). The professional services of a PA can be billed to the carrier only by the PA's employer. The following direct professional services are **unbundled** and **not paid as partial hospitalization services**:

- Physician services that meet the criteria for payment on a fee schedule basis (in accordance with 42 CFR 414)
- Physician assistant services (as defined in section 1861(s)(2)(K)(I) of the Act)
- Clinical psychologist services (as defined in section 1861(ii) of the Act) and
- Advanced Registered Nurse Practitioners and Clinical Nurse Specialists (as defined in section 1861(s)(2)(K)(ii) of the Act).

The services of other practitioners, including licensed clinical social workers (LCSWs), are bundled when furnished under the PHP benefit. These bundled services are billed to the Medicare Part A intermediary via the HCFA-1450 (UB-92) billing format, and payment is made on a reasonable cost basis. Administrative (rather than professional) services remain bundled. The distinction between professional and administrative services is whether the services are directly furnished to an individual patient or are

performed indirectly under the partial hospitalization program (outpatient hospital or CMHC). Currently, reimbursement for administrative services is made via the provider's cost report settlement. Therefore, administrative services are not separately billable to either the Part A intermediary (via the HCFA-1450) or the Part B carrier (via the HCFA-1500). In addition, effective July 1, 2000, payment for partial hospitalization programs will be made under the hospital outpatient prospective payment system.

Outpatient Mental Health Treatment Limitation

The outpatient mental health treatment limitation may apply to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologist, NPs, CNSs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation does not apply to such mental health treatment services billed to the Intermediary as partial hospitalization services.

Documentation Requirements

The following documentation **must** be maintained in the patient's medical record:

PHYSICIAN CERTIFICATION - A physician trained in the diagnosis and treatment of psychiatric illness must certify that the patient being admitted to the partial hospitalization program would require inpatient psychiatric hospitalization if the partial hospitalization services are not provided. The certification must also include an attestation that the services will be furnished while the individual is under the care of a physician, and that the services will be furnished under a written plan of care. It is generally expected that the physician certification will be completed within 24 hours of the patient's admission to the partial hospitalization program.

PHYSICIAN RECERTIFICATION - Periodic recertification by the physician who is directing or regularly involved in the care of the patient is required at least every 31 days. Recertification should be based on a thorough re-evaluation of the treatment plan in relation to the reason for admission and the progress of the patient.

Certifications may use any format desired and may be part of the treatment plan. However, the following statement must be used.

Certification Language:
"I certify that the patient would require Inpatient psychiatric care if the Partial Hospitalization services were not provided, and services will be furnished under the care of a physician, and under a written Plan of Treatment."

Physician signature:_____Date:_____

Recertification Language:
"I certify that continued Partial Hospitalization services are medically necessary to improve and/or maintain (circle one) the patient's condition and functional level and to prevent relapse or hospitalization."

Physician signature:_____Date:_____

Certifications are prospective; the physician (M.D./D.O.) certifies that future services are required. A physician certification must cover all periods of service. Stamped signatures are not acceptable. A physician certification is required, but does not guarantee approval of services.

A psychologist is not considered a physician for the purpose of establishing a certification or recertification.

INITIAL PSYCHIATRIC EVALUATION - The initial psychiatric evaluation with medical history and physical examination must be performed and placed in the chart generally within 24 hours of admission in order to establish the medical necessity for partial hospitalization services. If the patient is being directly discharged from an inpatient psychiatric admission to a partial hospitalization program, an appropriate update to the inpatient psychiatric evaluation and medical history and physical is acceptable, as long as it is reflective of the patient's condition upon admission to the PHP.

The initial evaluation should include the following documentation to support the medical necessity of the admission:

- Referral source;
- Patient's chief complaint;
- Description of the precipitating event and date of onset of the acute illness or exacerbation of chronic illness requiring admission, including whether the patient is being admitted directly from a psychiatric inpatient hospitalization or has experienced a failed attempt at or inability to benefit from less intensive outpatient services;
- Description of the failed attempt at or inability to be managed in the outpatient setting (if applicable). The description should include the length of time patient has received outpatient services, the outpatient regime, and duration of symptomatology indicating a worsening in the patient's condition;
- Current medical history, including medications and their dosage, frequency, and level of compliance;
- Past psychiatric and medical history;
- History of substance abuse including the type of substance used, frequency, amount and duration as well as symptoms of withdrawal or other complications (e.g., hepatitis or AIDS resulting from the use of contaminated needles);
- Family, vocational, and social history, including documentation of an adequate support system to sustain/maintain the patient outside the partial hospitalization program;
- Mental status examination, including general appearance and behavior, orientation, affect, motor activity, thought content, long and short term memory, estimate of intelligence, capacity for self harm or harm to others, insight, judgment, and capacity for activities of daily living (ADLs) with examples of specifics in each category and the method of elicitation when applicable;

PHPPROG: Psychiatric Partial Hospitalitation Program (continued)

- Physical examination (if not done within the past 30 days and/or not available from another provider for inclusion in the medical record);
- Formulation of the patient's status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms, as a result of the active treatment provided by the partial hospitalization program;
- ICD-9-CM/DSM-IV diagnoses, including all five axes of the multiaxial assessment as described in DSM-IV, to assist in establishing the patient's baseline functioning;
- An initial treatment plan, including long and short term goals related to the active treatment of the reason for admission and the specific types, amount, duration, and frequency of therapy services required to address the goals; and
- Certification by the physician that the course of the patient's current episode of illness would result in psychiatric inpatient hospitalization if the partial hospitalization services are not initiated at this time.

TREATMENT PLAN - An individualized formal treatment plan must be signed and dated by a physician and established within 7 days of admission to the program. *NO STAMPED SIGNATURES WILL BE ACCEPTED.*

The treatment plan **must** include the following:

- Physician's diagnosis;
- Specific problems to be addressed which are pertinent to the crisis/precipitators to admission. The problem list should identify current functional deficits and the cause of each (e.g., cognitive, communicative, emotional, psychosocial, behavioral);
- Type, amount, frequency and duration of each active treatment modality to be rendered (e.g., individual psychotherapy 3 times per week for 50 minutes for 2 weeks).
- The interventions or what the staff will do to assist the patient in meeting specific functional outcomes that are directly related to the reason for admission;
- Short and long term goals for each service provided that is directly related to an expected functional outcome. The treatment goals are the basis for evaluating the patient's response to treatment. *The treatment goals must be measurable, functional, time-framed, and directly related to the reason for admission;*
- Psychotherapeutic medications the patient is receiving concurrent with therapy services (including dosages, negative and/or positive effects); and
- A proposed discharge plan that is initiated at the time of admission and is addressed throughout treatment.

The frequency of treatment plan updates is always contingent upon an individual patient's needs. The treatment planning updates must be based on the physician's periodic consultation with therapists and staff, review of medical records, and patient interviews.

PROGRESS NOTES - A separate progress note must be written for each HCPCS or revenue code billed. The progress note should be legible, dated and signed, and include the credentials of the rendering provider.

The progress note must be written by the team member rendering the service and **must** include the following:

- The type of service rendered (name of the specific psychotherapy group, educational group, etc. if applicable);
- The problem/functional deficit to be addressed during the session, and how it relates to the patient's current condition, diagnosis, and problem/deficit identified in the treatment plan;
- The content of the therapeutic session, as well as a clear description of the intervention used to assist the patient in reaching the related treatment goal;
- The patient's status (behavior, verbalizations, mental status) during the session; and
- The patient's response to the therapeutic intervention including benefit from the session and how it relates to progress made toward the short/long term goal in measurable and functional terms. Functional improvement is considered to be the patient's increasing ability to function outside of the direction or support of a therapist and or therapeutic environment. Measures of functional improvement may include, but are not limited to, patient appearance, patient participation in therapy, or the patient's performance of activities of daily living.

PHYSICIAN SUPERVISION AND EVALUATION - Evidence must be documented in the patient's medical record that a physician has provided direct patient care, provided supervision and direction to the therapist(s) and staff, reviewed the medical record, and determined the extent to which the therapeutic goals are being met.

ITEMIZED STATEMENT - An itemized statement must be maintained which identifies the date, HCPCS code, revenue code, and charge for each individual service rendered.

Utilization Guidelines

N/A

Other Comments

Psychotherapy is the treatment of mental illness and behavior disturbances, in which definitive therapeutic communication attempts to alleviate the emotional disturbances, reverse or change the maladaptive patterns of behavior and encourage personality growth and behavior.

Sources of Information

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Kiser, L.J., Lefkovitz, P.M., et. al. (1996). *The continuum of ambulatory mental health services.* Association for Ambulatory Behavioral Healthcare.

Wagner, B.D., Plotkin, D.A., et. al. (1997). *Standards and guidelines for partial hospitalization geriatric programs* (2nd ed.). Association for Ambulatory Behavioral Healthcare.

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 Psychiatric Society."

Start Date of Comment Period

11/15/1999

Start Date of Comment Period

04/01/2000, April/May 2000 *Bulletin*

Revision History

Revision Number: N/A
Revised Effective Date: N/A
Explanation of Revision: N/A ❖

OUTPATIENT HOSPITAL SERVICES

Outpatient Services Prospective Payment System (PPS) Background

The following article has been provided by the Health Care Financing Administration and compiles significant issues related to the implementation of the outpatient services prospective payment system. This article is informational only. Specific claim processing instructions will be forthcoming.

Section 1833(t) of the Social Security Act (the Act) as added to the Act by section 4523 of the Balanced Budget Act of 1997, authorizes HCFA to implement a prospective payment system (PPS) for hospital outpatient services including Part B services furnished to inpatients who have no Part A coverage. The law also includes coverage of partial hospitalization services furnished by community mental health centers (CMHCs) under the new PPS. On November 29, 1999, President Clinton signed new legislation which incorporates the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) that contains a number of major provisions that affect the development of a hospital outpatient PPS. These provisions, in part, are:

- Extend the 5.8 percent reduction in operating costs and ten percent reduction in capital costs (that was due at sunset on December 31, 1999) through the first date the PPS is implemented.
- Require annual updating of the PPS payment weights, rates, payment adjustments and groups.
- Require annual consultation with an expert provider advisory panel in the review and updating of payment groups.
- Establish budget neutral outlier adjustments based on the charges, adjusted to costs, for all services included on the submitted outpatient bill for services furnished before January 1, 2002 and thereafter based on the individual services billed using the appropriate department-specific cost-charge ratio for each services.
- Provide transitional pass-through for the additional costs of new and current medical services, drugs, and biologicals for at least two years but not more than three years.
- Include under the PPS payment for implantable devices including durable medical equipment (DME), prosthetics and those used in diagnostic testing.
- Establish transitional payments to limit hospital losses under the PPS; the additional payments are three years for most hospitals and low volume rural hospitals (no more than or equal to 100 beds), and permanent for the ten cancer hospitals.
- Limit beneficiary copayments for services paid under the PPS to the inpatient hospital deductible.

The Secretary has the authority under section 1833(t) of the Act to determine which services are included under the PPS (with the exception of ambulance services and physical, occupational, and speech therapies, for which fee schedules are or have been separately created). Medicare will continue to pay for chronic renal dialysis using the composite rate and for most laboratory services, surgical dressings, orthotics, and nonimplantable DME and prosthetics on their respective fee schedules. Acute dialysis, e.g., for poisoning, will be paid under the PPS.

Although the ten cancer centers are specifically exempt from inpatient PPS, the outpatient PPS system will apply to these facilities effective July 1, 2000. However, the provision entitles these ten cancer centers to additional payments, on a permanent basis, which are designed to limit hospital losses. Conversely, the additional (or transition) payments are provided for most hospitals for only three years. Certain hospital outpatient services furnished by Maryland hospitals are under a PPS waiver and will not be paid under this system. Critical access hospitals will also be excluded from this system and will continue to be paid on a cost basis.

Effective Dates

The implementation date for the outpatient prospective payment system is July 1, 2000. The editing with the revised outpatient code editor (OCE) will begin July 1, 2000.

Payment Groups

The PPS will consist of groups of services known as Ambulatory Payment Classification (APC) groups. Services within an APC are similar clinically and require similar resource use. APC groups require no changes in coding or billing forms. Discounting of multiple surgical procedures performed during the same operative session will apply. Payment for multiple APC groups is possible for a given patient on a given day.

APC Payment Rates

In keeping with the statutory requirements, an APC relative weight is calculated based on the median cost (operating and capital) of the services included in the group using calendar year 1996 hospital outpatient claims and the most recent cost report.

Outpatient Services PPS Backgroung (continued)

Coinsurance

Under current law, coinsurance for hospital outpatient services is based on 20 percent of the hospital billed charges. PPS freezes coinsurance at 20 percent of the national median charge for each APC (wage adjusted for the hospital geographic area). As the total payment to the hospital increases each year based on market basket updates, the present or *frozen* coinsurance amount will become a smaller portion of the total payment, until coinsurance represents 20 percent of the total payment. Once coinsurance becomes 20 percent of the payment amount, the annual updates will also increase coinsurance so that it continues to account for 20 percent of the total payment. As previously stated the coinsurance for a service paid under the PPS cannot exceed the inpatient deductible amount.

A hospital or CMHC may elect to reduce its copayment to no less than 20 percent of the total Medicare payment (for any individual or all services) and advertise these reduced rates. This election is made yearly and cannot be changed during the year.

Medicare will specify at a later date how hospitals and CMHCs will elect coinsurance and how the contacts with the insurers with whom there is a trading partnership agreement/Medigap insurance will be handled.

HCFA Common Procedure Coding System (HCPCS)

Section 9343(g) of the Omnibus Budget Reconciliation Act (OBRA) of 1986 requires hospitals to report claims for outpatient services using HCPCS coding. HCPCS includes CPT-4 codes. In preparation for outpatient prospective payment, revisions to this requirement include:

— Editing date of service for every line where a HCPCS code is reported on hospital outpatient bills.

— Redefining the reporting of service units for hospital outpatient services.

Specific instructions addressing line item dates of service and changes to service units were released in the Medicare Intermediary Manual Transmittal #1787 and Hospital Manual Transmittal #747. System testing of these new requirements begins April 1, 2000.

Outpatient Code Editor

Outpatient code editor (OCE) will be run in fiscal intermediary contractor systems for dates of service on or after July 1, 2000. The OCE will be modified in preparation of hospital outpatient PPS. There will be two main functions of the OCE, setting a series of flags that will be used by the outpatient PRICER program in the determination of payment (e.g., flag to indicate which procedures are discounted); and editing of claims to identify errors. In general, the OCE should perform all functions that require specific reference to HCPCS codes, HCPCS modifiers and ICD-9-CM diagnosis codes. Since HCPCS codes, HCPCS modifiers and ICD-9-CM codes are complex and annually updated, the centralization of the direct reference to these codes and modifiers in a single program will reduce effort and reduce the chance of inconsistent editing.

A number of correct coding initiative (CCI) edits and unit edits will be included in the OCE. These edits will be similar to those developed for carrier processing. OCE will produce additional error messages, which will indicate the HCPCS codes that have failed the CCI or unit edits and will be denied. This will require line item denial capability. (See page 16 for information on CCI.)

Specific instructions regarding the modified OCE will be issued in the future.

Modifiers

The use of modifiers is an integral part of the outpatient PPS payment process. Modifiers add clarification and specificity to procedures and assist in promoting claims processing accuracy**. Providers must begin using modifiers April 1, 2000.** Modifiers are addressed in the MIM, Transmittal 1729 and the Medicare Hospital Manual (HCFA Pub. 10), Transmittal 726.

Specific instructions addressing the use of modifiers in the outpatient hospital setting are outlined in CR 937, PM-A-99-41*: Clarification of Modifier Usage in Reporting Outpatient Hospital Services,* published in the December 1999/January 2000 *Medicare A Bulletin,* pages 11-14.

Outpatient Pricer

HCFA developed software will determine the APC line item price based on several data sources:

- National APC amounts
- Outpatient Provider Specific File
- HCPCS
- Wage indices by MSA
- Multiple surgical procedure discounts

Hospital Outpatient Partial Hospitalization Services

Partial Hospitalization services provided in the hospital outpatient department or in a CMHC will be paid under the hospital outpatient PPS based on a per diem. Sections 3651 and 3661 of the Part A Intermediary Manual, Part 3 have been updated to provide coding changes necessary for proper payment under this system in July 2000.

These coding changes are effective April 1, 2000.

Medical Review

No changes will occur in the medical review guidelines instructions regarding the medical review of hospital outpatient claims or hospital outpatient partial hospitalization services. ❖

Addition of Modifiers for Reporting Outpatient Hospital Services

Effective April 1, 2000, reporting outpatient hospital services requires the use of modifiers as an integral part of the outpatient hospital prospective payment system (PPS) implementation. This implementation is scheduled for July 1, 2000.

Four additional modifiers—25, 58, 78, and 79—have been approved for hospital outpatient use. The Current Procedural Terminology (CPT) definitions for these modifiers are:

- Modifier 25—a significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.
- Modifier 58—a staged or related procedure or service by the same physician during the postoperative period.
- Modifier 78—a return to the operating room for a related procedure during the postoperative period.
- Modifier 79—an unrelated procedure or service by the same physician during the postoperative period.

Modifiers Approved for Reporting Outpatient Hospital Services

Below is a complete list of modifiers and their short definitions approved for outpatient hospital use and for proper reporting under outpatient PPS. Extended definitions may be found in the current CPT guide, Appendix A. In addition, general guidelines clarifying the correct use of some modifiers were published in the December 1999/ January 2000 *Medicare A Bulletin,* pages 10-11.

Level I CPT Modifiers

25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
50	Bilateral Procedure
52	Reduced Services
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Service
59	Distinct Procedural Service
73	Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia
74	Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After the Administration of Anesthesia
76	Repeat Procedure by Same Physician
77	Repeat Procedure by Another Physician
78	Return to the Operating Room for a Related Procedure During the Postoperative Service
79	Unrelated Procedure or Service by the Same Physician During the Postoperative Service
91	Repeat Clinical Diagnostic Laboratory Test

Level II HCPCS/National Modifiers

LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the left side of the body)
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
LC	Left circumflex coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
LD	Left anterior descending coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
RC	Right coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
QM	Ambulance services provider under arrangement by a provider of services
QM	Ambulance services furnished directly by a provider of services
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit

NOTE: ***Use of modifiers applies to services/procedures performed on the same calendar day.***

Other valid modifiers that are used under other payment methods are still valid and should continue to be reported: for example, those used to report outpatient rehabilitation and ambulance services. Modifiers may be applied to surgical, radiology, and other diagnostic procedures. Providers must use any applicable modifier where appropriate.

Correction to Previously Published Article

The December 1999/January 2000 *Medicare A Bulletin,* page 11, "Outpatient Hospital Service" section, "Reporting Modifiers on the HCFA-1450 (UB-92) claim form," stated that, with the upcoming claim expansion, up to five modifiers could be placed on the line.

However, the following claim filing form and formats can accommodate only **TWO** modifiers: HCFA-1450 (UB-92) claim form, UB-92 version 5.0, and UB-92 version 6.0. Please disregard language allowing five modifiers. ❖

INPATIENT HOSPITAL SERVICES
SKILLED NURSING FACILITY SERVICES

Pre-Discharge Delivery of Durable Medical Equipment and Prosthetic and Orthotic Devices for Fitting and Training

The Health Care Financing Administration has issued clarification to the policy and billing procedures regarding the circumstances under which durable medical equipment, prosthetics and orthotics—but not supplies — may be delivered to a beneficiary who is an inpatient in a facility that does not qualify as the beneficiary's home.

Conditions That Must Be Met

In some cases it would be appropriate for a supplier to deliver a medically necessary item of DME, a prosthetic, or an orthotic—but not supplies—to a beneficiary who is an inpatient in a facility not qualifying as the beneficiary's home. HCFA will presume that the pre-discharge delivery of a DME, prosthetic, or orthotic (hereafter "item") is appropriate if the following conditions are met:

- The item is medically necessary for use by the beneficiary in the beneficiary's home.
- The item is medically necessary on the date of discharge (i.e., there is a physician's order with a stated initial date of need that is no later than the date of discharge for home use).
- The supplier delivers the item to the beneficiary in the facility solely for the purpose of fitting the beneficiary for such item or training the beneficiary in the use of such item and the item is for subsequent use in the patient's home.
- The supplier delivers the item to the beneficiary no earlier than two days before the day the beneficiary is discharged from the facility.
- The supplier ensures that the beneficiary takes the item home, or the supplier picks up the item at the facility and delivers it to the beneficiary's home on the date of discharge.
- The item furnished by the supplier is not for the purpose of eliminating the responsibility of the facility to provide an item that is medically necessary for use or treatment of the beneficiary while the beneficiary is in a facility. Such items are included in the diagnosis related group (DRG) and prospective payment system (PPS) rates.
- The supplier does not claim payment for the item for any day prior to the date of discharge.
- The supplier does not claim payment for any additional costs that may be incurred by the supplier in ensuring that the item is delivered to the beneficiary's home on the date of discharge. The supplier cannot bill the beneficiary for redelivery.
- The beneficiary's discharge must be to a qualified place of service (home, custodial facility, etc.), but not to another facility (inpatient, skilled nursing, etc.) that does not qualify as the beneficiary's home.

Date of Service for Claims Processing

As a general rule, the date of service is the date of delivery. However, the rule for predischarge delivery of items is that the date of service is the date of discharge. The following three scenarios illuminate both this latter rule (when the date of service is the date of discharge) and its exceptions.

- If the supplier leaves the item with the beneficiary at the facility two days prior to the date of discharge, and if the supplier, as a practical matter, need do nothing further to effect delivery of the item to the beneficiary's home (because the beneficiary or a caregiver takes it home), then the date of discharge is deemed to be the date of delivery of the item, and such date shall be the date of service **for the purpose of claim submission.** (This is not an exception to the general DMEPOS rule that the date of service must be the date of delivery. Rather, it recognizes the supplier's responsibility—per condition indicated above—to ensure that the item is actually delivered to the beneficiary's home on the date of discharge.) No billing can be made for days prior to the date of discharge.
- If the supplier fits the beneficiary for the item or trains the beneficiary in its use while the beneficiary is in the facility, but thereafter removes the item and subsequently delivers the item to the beneficiary's home, then the date of service shall be the date of actual delivery of the item, provided such date is not earlier than the date of discharge.
- If the supplier leaves the item at the facility and the item is not taken home by the beneficiary, or sent or taken to the beneficiary's home by a third party, or otherwise (re)delivered to the beneficiary's home by the supplier on or before the date of discharge, then the date of service may not be earlier than the actual date of delivery of the item (i.e., the actual date the item arrives, by whatever means, at the beneficiary's home).

Facility Responsibilities during the Transition Period:

- A facility remains responsible for furnishing medically necessary items to a beneficiary for the full duration of the beneficiary's stay. Such items are covered by the DRG and PPS rates.
- A facility may not delay furnishing a medically necessary item for the use or treatment of a beneficiary while the beneficiary is in the facility nor may a facility prematurely remove a medically necessary item from the beneficiary's use or treatment on the basis that a supplier has delivered a similar or identical item to the beneficiary for purpose of fitting or training.
- A facility may not, through the stratagem of relying upon a supplier to furnish such items, improperly shift to Medicare Part B its costs for furnishing medically necessary items to a beneficiary who is a resident in the facility.
- Nevertheless, beginning two days before the beneficiary's discharge, a facility may take reasonable actions to permit a supplier to fit or train the beneficiary with the medically necessary item that is for subsequent use in the beneficiary's home. These actions may include the substitution of the supplier-furnished item, in whole or in part, for the facility-furnished item during the beneficiary's last two inpatient days provided such substitution is both reasonable and necessary for fitting or training and the item is intended for subsequent use at the beneficiary's home.
- For prosthetic and orthotic items, the above restrictions apply to residents in a covered Part A stay. For DME, the above restrictions apply in a covered Part A or a Part B stay. ❖

SKILLED NURSING FACILITY SERVICES

Consolidated Billing for Skilled Nursing Facilities (SNFs)

The Balanced Budget Refinement Act of 1999 (BBRA) provides updated information concerning consolidated billing for SNFs. Consolidated billing for SNF residents in a Part B stay is still delayed until further notice. Consolidated billing continues to apply to all the services and supplies that an SNF resident receives while in an SNF PPS Part A stay, other than those services that are specifically identified as being excluded from this requirement (e.g., renal dialysis services that are covered under Part B). When a resident receives a type of service that is excluded from consolidated billing, the outside entity that furnishes the service must submit a bill directly to Medicare rather than through the SNF. When billing Medicare directly, the outside entity must bill the Part B carrier, the durable medical equipment regional carrier (DMERC), or the Part A fiscal intermediary as appropriate for the services and supplies rendered to the resident.

The BBRA makes certain additions to the statutory exclusion list at section 1888(e)(2)(A) of the Social Security Act, effective for services furnished **on or after April 1, 2000.** First, it expands the existing statutory exclusion of Part B covered dialysis services to encompass ambulance services that are furnished in conjunction with the excluded dialysis services. Thus, for ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services, the ambulance supplier will bill Medicare directly rather than through the SNF.

In addition, this provision identifies certain individual excluded services within several broader categories of services that are not excluded. The CPT/HCPCS codes for the excluded services appear below, by service category. Thus, within these categories, the specific services are separately billable by an outside entity when furnished to an SNF resident. All other services within these categories remain subject to consolidated billing and must be billed by the SNF itself when furnished to an SNF resident while in an SNF PPS Part A stay.

Chemotherapy Items

The excluded codes for chemotherapy items are:

J9000	J9015	J9020	J9040	J9045	J9050	J9060	J9062
J9065	J9070	J9080	J9090	J9091	J9092	J9093	J9094
J9095	J9096	J9097	J9100	J9110	J9120	J9130	J9140
J9150	J9151	J9170	J9181	J9182	J9185	J9200	J9201
J9206	J9208	J9211	J9230	J9245	J9265	J9266	J9268
J9270	J9280	J9290	J9291	J9293	J9310	J9320	J9340
J9350	J9360	J9370	J9375	J9380	J9390	J9600	

Chemotherapy Administration Services

The excluded codes for chemotherapy administration services are:

36260	36261	36262	36489	36530	36531	36532	36533
36534	36535	36640	36823	96405	96406	96408	96410
96412	96414	96420	96422	96423	96425	96440	96445
96450	96520	96530	96542				

Radioisotope Services

The excluded codes for applicable radioisotope services are:

79030	79035	79100	79200	79300	79400	79420	79440

Customized Prosthetic Devices

The excluded codes for applicable customized prosthetic devices are:

(Note: these procedures must be billed to the DMERC. Florida Medicare is providing this information solely as a convenience)

L5050	L5060	L5100	L5105	L5150	L5160	L5200	L5210
L5220	L5230	L5250	L5270	L5280	L5300	L5310	L5320
L5330	L5340	L5500	L5505	L5510	L5520	L5530	L5535
L5540	L5560	L5570	L5580	L5585	L5590	L5595	L5600
L5610	L5611	L5613	L5614	L5616	L5617	L5618	L5620
L5622	L5624	L5626	L5628	L5629	L5630	L5631	L5632
L5634	L5636	L5637	L5638	L5639	L5640	L5642	L5643
L5644	L5645	L5646	L5647	L5648	L5649	L5650	L5651
L5652	L5653	L5654	L5655	L5656	L5658	L5660	L5661
L5662	L5663	L5664	L5665	L5666	L5667	L5668	L5669
L5670	L5672	L5674	L5675	L5676	L5677	L5678	L5680

Consolidated Billing for Skilled Nursing Facilities (continued)

L5682	L5684	L5686	L5688	L5690	L5692	L5694	L5695
L5696	L5697	L5698	L5699	L5700	L5701	L5702	L5704
L5705	L5706	L5707	L5710	L5711	L5712	L5714	L5716
L5718	L5722	L5724	L5726	L5728	L5780	L5785	L5790
L5795	L5810	L5811	L5812	L5814	L5816	L5818	L5822
L5824	L5826	L5828	L5830	L5840	L5845	L5846	L5850
L5855	L5910	L5920	L5925	L5930	L5940	L5950	L5960
L5962	L5964	L5966	L5968	L5970	L5972	L5974	L5975
L5976	L5978	L5979	L5980	L5981	L5982	L5984	L5985
L5986	L5988	L6050	L6055	L6100	L6110	L6120	L6130
L6200	L6205	L6250	L6300	L6310	L6320	L6350	L6360
L6370	L6400	L6450	L6500	L6550	L6570	L6580	L6582
L6584	L6586	L6588	L6590	L6600	L6605	L6610	L6615
L6616	L6620	L6623	L6625	L6628	L6629	L6630	L6632
L6635	L6637	L6640	L6641	L6642	L6645	L6650	L6655
L6660	L6665	L6670	L6672	L6675	L6676	L6680	L6682
L6684	L6686	L6687	L6688	L6689	L6690	L6691	L6692
L6693	L6700	L6705	L6710	L6715	L6720	L6725	L6730
L6735	L6740	L6745	L6750	L6755	L6765	L6770	L6775
L6780	L6790	L6795	L6800	L6805	L6806	L6807	L6808
L6809	L6810	L6825	L6830	L6835	L6840	L6845	L6850
L6855	L6860	L6865	L6867	L6868	L6870	L6872	L6873
L6875	L6880	L6920	L6925	L6930	L6935	L6940	L6945
L6950	L6955	L6960	L6965	L6970	L6975	L7010	L7015
L7020	L7025	L7030	L7035	L7040	L7045	L7170	L7180
L7185	L7186	L7190	L7191	L7260	L7261	L7266	L7272
L7274	L7362	L7364	L7366				

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES

Prospective Payment System for All Comprehensive Outpatient Rehabilitation Facility Services

The Balanced Budget Act of 1997 (BBA '97) requires payment under a prospective payment system for all comprehensive outpatient rehabilitation facility (CORF) services. The Medicare physician fee schedule (MPFS) is used as the prospective payment system for reimbursement of these services.

Effective with claims with dates of service **on or after July 1, 2000,** CORFs are required to report all the services rendered using CPT and HCPCS codes.

Additional CORF HCPCS Codes

The following CPT and HCPCS codes have been added to the list for reporting CORF services. These codes are in addition to the codes published in the *Medicare A Bulletin* G-361, dated January 21, 1999. Reimbursement for these services is made based on the Medicare outpatient services fee schedule:

A4220	A4221	G0101	G0102	G0169
90804	90805	90806	90807	90808
90809	90810	90811	90812	90813
90814	90815	90845	90846	90847
90849	90853	90857		

The 2000 fee schedules for outpatient rehabilitation, audiology, and CORF services were published in the February/March 2000 *Medicare A Bulletin,* pages 16-17. ❖

FRAUD AND ABUSE

Office of Inspector General—Special Fraud Alert

The Office of Inspector General (OIG) was established at the Department of Health and Human Services (DHHS) by Congress in 1976 to identify and eliminate fraud, abuse and waste in DHHS's programs and to promote efficiency and economy in departmental operations. The OIG carries out this mission through a nationwide program of audits, investigations and inspections.

To reduce fraud and abuse in the federal health care programs, including Medicare and Medicaid, the OIG actively investigates fraudulent schemes that are used to obtain money from these programs and, when appropriate, issues Special Fraud Alerts that identify practices in the health care industry that are particularly vulnerable to abuse.

This Special Fraud Alert focuses on the rental of space in physicians' offices by persons or entities that provide health care items or services (suppliers)*(1)* to patients who are referred either directly or indirectly by their physician-landlords. In this Special Fraud Alert, we describe some of the potentially illegal practices the OIG has identified in such rental relationships.

Questionable Rental Arrangements for Space in Physician Offices

A number of suppliers that provide health care items or services rent space in the offices of physicians or other practitioners. Typically, most of the items or services provided in the rented space are for patients, referred or sent, either directly or indirectly, to the supplier by the physician-landlord. In particular, we are aware of rental arrangements between physician-landlords and:

- comprehensive outpatient rehabilitation facilities (CORFs) that provide physical and occupational therapy and speech-language pathology services in physicians' and other practitioners' offices;
- mobile diagnostic equipment suppliers that perform diagnostic related tests in physicians' offices; and
- suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) that set up "consignment closets" for their supplies in physicians' offices

The OIG is concerned that in such arrangements, the rental payments may be disguised kickbacks to the physician-landlords to induce referrals. We have received numerous credible reports that in many cases, suppliers, whose businesses depend on physicians' referrals, offer and pay "rents" – either voluntarily or in response to physicians' requests – that are either unnecessary or in excess of the fair market value for the space to access the physicians' potential referrals.

The Anti-Kickback Law Prohibits Any Payments to Induce Referrals

Kickbacks can distort medical decision-making, cause overutilization, increase costs and result in unfair competition by freezing out competitors who are unwilling to pay kickbacks. Kickbacks can also adversely affect the quality of patient care by encouraging physicians to order services or recommend supplies based on profit rather than the patients' best medical interests.

Section 1128B(b) of the Social Security Act (the Act) prohibits knowingly and willfully soliciting, receiving, offering or paying anything of value to induce referrals of items or services payable by a Federal health care program. Both parties to an impermissible kickback transaction are liable. Violation of the statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five years, or both. The OIG may also initiate administrative proceedings to exclude persons from federal health care programs or to impose civil money penalties for fraud, kickbacks and other prohibited activities under sections 1128(b)(7) and 1128A(a)(7) of the Act.*(2)*

Suspect Rental Arrangements for Space in Physician Offices

The questionable features of suspect rental arrangements for space in physicians' offices may be reflected in three areas:

- the appropriateness of rental agreements;
- the rental amounts; and
- time and space considerations

Below, we examine these suspect areas, which separately or together may result in an arrangement that violates the anti-kickback statute, in order to help identify questionable rental arrangements between physicians and the suppliers to which they refer patients. This list is not exhaustive, but rather gives examples of indicators of potentially unlawful activity.

Appropriateness of Rental Agreements. The threshold inquiry when examining rental payments is whether payment for rent is appropriate at all. Payments of "rent" for space that traditionally has been provided for free or for a nominal charge as an accommodation between the parties for the benefit of the physicians' patients, such as consignment closets for DMEPOS, may be disguised kickbacks. In general, payments for rent of consignment closets in physicians' offices are suspect.*(3)*

Rental Amounts. Rental amounts should be at fair market value, be fixed in advance and not take into account, directly or indirectly, the volume or value of referrals or other business generated between the parties. Fair market value rental payments should not exceed the amount paid for comparable property.

Moreover, where a physician rents space, the rate paid by the supplier should not exceed the rate paid by the physicians in the primary lease for their office space, except in rare circumstances.

Examples of suspect arrangements include:

- rental amounts in excess of amounts paid for comparable property rented in arms-length transactions between persons not in a position to refer business;
- rental amounts for subleases that exceed the rental amounts per square foot in the primary lease;
- rental amounts that are subject to modification more often than annually;
- rental amounts that vary with the number of patients or referrals;
- rental arrangements that set a fixed rental fee per hour, but do not fix the number of hours or the schedule of usage in advance (i.e., "as needed" arrangements);
- rental amounts that are only paid if there are a certain number of federal health care program beneficiaries referred each month; and
- rental amounts that are conditioned upon the supplier's receipt of payments from a federal health care program.

Time and Space Considerations. Suppliers should only rent premises of a size and for a time that is reasonable and necessary for a commercially reasonable business purpose of the supplier. Rental of space that is in excess of suppliers' needs creates a presumption that the payments may be a pretext for giving money to physicians for their referrals. Examples of suspect arrangements include:

- rental amounts for space that is unnecessary or not used. For instance, a comprehensive outpatient rehabilitation facility (CORF) requires one examination room and rents physician office space one afternoon a week when the physician is not in the office. The CORF calculates its rental payment on the square footage for the entire office, since it is the only occupant during that time, even though the CORF only needs one examination room;
- rental amounts for time when the rented space is not in use by the supplier. For example, an ultrasound supplier has enough business to support the use of one examination room for four hours each week, but rents the space for an amount equivalent to eight hours per week;
- non-exclusive occupancy of the rented portion of space. For example, a physical therapist does not rent space in a physician's office, but rather moves from examination room to examination room treating patients after the physician has seen them. Since no particular space is rented, we will closely scrutinize the proration of time and space used to calculate the therapist's "rent."

In addition, rental amount calculations should prorate rent based on the amount of space and duration of time the premises are used. The basis for any proration should be documented and updated as necessary. Depending on the circumstances, the supplier' rent can consist of three components: (1) exclusive office space; (2) interior office common space; and (3) building common space.

1. *Apportionment of exclusive office space* - The supplier's rent should be calculated based on the ratio of the time the space is in use by the supplier to the total amount of time the physician's office is in use. In addition, the rent should be calculated based on the ratio of the amount of space that is used exclusively by the supplier to the total amount of space in the physician's office.
2. *Apportionment of interior office common space* - When permitted by applicable regulations, rental payments may also cover the interior office common space in physicians' offices that are shared by the physicians and any subtenants, such as waiting rooms. If suppliers use such common areas for their patients, it may be appropriate for the suppliers to pay a prorated portion of the charge for such space. The charge for the common space must be apportioned among all physicians and subtenants that use the interior office common space based on the amount of non-common space they occupy and the duration of such occupation. Payment for the use of office common space should not exceed the supplier's pro rata share of the charge for such space based upon the ratio of the space used exclusively by the supplier to the total amount of space (other than common space) occupied by all persons using such common space.
3. *Apportionment of building common space* - Where the physician pays a separate charge for areas of a building that are shared by all tenants, such as building lobbies, it may be appropriate for the supplier to pay a prorated portion of such charge. As with interior office common space, the cost of the building common space must be apportioned among all physicians and subtenants based on the amount of non-common space they occupy and the duration of such occupation. For instance, in the example in number one above, the supplier's share of the additional levy for building common space could not be split 50/50.

The Space Rental Safe Harbor Can Protect Legitimate Arrangements

We strongly recommend that parties to rental agreements between physicians and suppliers to whom the physicians refer or for which physicians otherwise generate business make every effort to comply with the space rental safe harbor to the anti-kickback statute. (See 42 CFR 1001.952(b), as amended by 64 FR 63518 (November 19, 1999)). When an arrangement meets all of the criteria of a safe harbor, the arrangement is immune from prosecution under the anti-kickback statute. The following are the safe harbor criteria, all of which must be met:

- The agreement is set out in writing and signed by the parties.
- The agreement covers all of the premises rented by the parties for the term of the agreement and specifies the premises covered by the agreement. If the agreement is intended to provide the lessee with access to the premises for periodic intervals of time rather than on a full-time basis for the term of the rental agreement, the rental agreement specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals.
- The term of the rental agreement is for not less than one year.
- The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions, and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or a state health care program.
- The aggregate space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

Arrangements for office equipment or personal services of physicians' office staff can also be structured to comply with the equipment rental safe harbor and personal services and management contracts safe harbor. (See 42 CFR 1001.952(c) and (d), as amended by 64 FR 63518 (November 19, 1999)). Specific equipment used should be identified and documented and payment limited to the prorated portion of its use. Similarly, any services provided should be documented and payment should be limited to the time actually spent performing such services.

What To Do If You Have Information About Fraud and Abuse Against Medicare or Medicaid Programs

If you have information about physicians, DMEPOS suppliers, CORFs or other suppliers engaging in any of the activities described above, contact any of the regional offices of the Office of Investigations of the Office of Inspector General, U.S. Department of Health and Human Services, at the following locations:

Field Offices	States Served	Telephone
Boston MA	VT, NH, ME, RI, CT	617-565-2664
New York NY,	NJ, PR, VI	212-264-1691
Philadelphia PA,	MD, DE, WV, VA, DC	215-861-4586
Atlanta GA,	KY, NC, SC, FL, TN, AL, MS	404-562-7603
Chicago IL,	MN, WI, MI, IN, OH, IA,	312-353-2740
Dallas TX,	NM, OK, AR, LA, CO, UT, WY, MT, ND, SD, NE, KS, MO	214-767-8406
Los Angeles	AZ, NV, So. CA	714-246-8302
San Francisco	No. CA, AK, HI, OR, ID, WA	415-437-7961

(1.) Persons or entities may be either suppliers or providers. For purposes of this Special Fraud Alert, we will refer to such persons as suppliers

(2.) Some of the arrangements identified as suspect in this Special Fraud Alert may also implicate the Ethics in Patient Referrals Act, also known as the Stark law (section 1877 of the Act). The interpretation of the Stark law is under the jurisdiction of the Health Care Financing Administration (HCFA).

(3.) This Special Fraud Alert does not address the appropriateness of consignment closet arrangements under HCFA's DMEPOS supplier standards. The interpretation of the DMEPOS supplier standards is a matter under HCFA's jurisdiction.

A Word From the Vice President

The "Let's Talk with Medicare Part A Senior Leadership" Session Was a Success!

First Coast Service Options, Inc. (FCSO) hosted the second quarterly fiscal year 2000 "Let's Talk with Medicare Part A Leadership" session on January 18, 2000, in Orlando, Florida. These meetings continue to focus on encouraging members of the provider community to meet with the fiscal intermediary leadership team to discuss Medicare Part A issues. The Florida Hospital Association (FHA), represented by Kathy Reep, Vice President, co-sponsored this session. Much appreciation goes to Kathy and the FHA for their wonderful hospitality and ongoing support of the Florida Medicare program!

The meeting began with introductions and follow-up responses to questions received at the previous meeting. (See next article for a list of these questions and answers.) The development of a charter was reviewed. The Y2K update was positive, with First Coast Service Options, Inc. reporting no Florida Medicare system problems.

The vice president of the Florida Hospital Association discussed the Balanced Budget Refinement Act of 1999 provisions, including information about:

* Moratorium of the Outpatient Rehabilitation Limitations
* Skilled Nursing Facility Prospective Payment Changes
* Ambulatory Payment Calculation (APC)
* Outpatient Prospective Payment System
* Home Care Prospective Payment System
* Medicare Secondary Payer Questionnaires

FCSO's Director of Medicare Part A Operations reviewed the following:

* Intermediary Performance Statistics
* Claims Expansion and Line Item Processing (CELIP) Project
* Beneficiary Customer Service Impacts

The Director of the Program Relations Department shared educational initiatives for fiscal year 2000. In addition, the Director of Medical Policy and Review provided an update of proposed changes to the Carrier Advisory Committee (CAC) and the addition of the Intermediary Advisory Committee.

Feedback was solicited from the audience regarding the format of future meetings. Participants shared general issues that impact all Medicare Part A providers, their expectations of the fiscal intermediary, and topics for discussion at future "Let's Talk with Medicare Part A Leadership" sessions. FCSO would like to thank those providers in attendance.

We invite you to meet with us at the next "Let's Talk with Medicare Part A Leadership" session, on Wednesday, May 24, 2000. At this session, we will discuss a number of pertinent Medicare topics with a focus on how to eliminate "paperwork" and thus make the Medicare Program more efficient. Please take advantage of this opportunity to affect change with us!

Sincerely,

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

"Let's Talk with Medicare Senior Leadership" - Questions & Answers

The following question and answer article is a follow-up to the issues brought up for clarification and discussion by Medicare Part A providers in the "Let's Talk with Medicare Senior Leadership" session, held on January 18, 2000.

Q 1: Providers mentioned that the statistical report did not balance with their 201 report.

A 1: There are several reasons why the statistical report may not balance with the fiscal intermediary share system (FISS) 201 report.

- The FISS 201 report is produced on a weekly basis, and the provider consolidated statistical report is produced at the end of each month. Therefore, normally the two reports would not balance.
- When the FISS 201 report is produced on the same date as the consolidated statistical report, the two reports are not produced at the same point in the claim processing cycle. Therefore, the number of claims pending shown for a particular provider may differ between the two reports, since some additional claims may have been processed during the time interval.
- The 201 report is part of the FISS standard system, and the consolidated statistical report is a report that has been programmed by the fiscal intermediary, and is not part of the FISS core system. For this reason, the two reports are not run in the same point in the processing system, and there may be some differences in the logic between the two reports.

  Once Y2K impact is weathered, FCSO can look more closely at some possible differences between the two reports, and determine whether it is feasible to make modifications that would match up the two reports.

Q2: Providers indicate that the direct date entry (DDE) system does not accept modifiers.

A2: There is not a problem with DDE accepting modifiers. However, the entry and placement of modifiers on the screen sometimes appear to be a problem. The modifiers are placed next to the CPT or HCPCS code. When the provider enters the CPT or HCPCS code, the system automatically skips to the first modifier field ready for entry. The research of the issues has indicated that some providers are depressing the tab key (after the system has already moved into place for entry) causing the cursor to move to the second modifier field, leaving blank the first modifier field.

Q3: Providers report problems with cost outliers and the new occurrence code 47.

A3: Refer to the *"Use of Modifiers for Reporting Outpatient Hospital Services"* article, published in the December 1999/January 2000 *Medicare A Bulletin,* pages 11 & 12.

Q4: Providers are reporting having difficulty with canceling claims that include ancillary services.

A4: First Coast Service Options, Inc. (FCSO) is not aware of a problem in this area. However, if more specific examples could be provided, this issue may be researched further.

Q5: Providers continue to report problems with Medicare secondary payer (MSP) auto occurrence code 24.

A5: This issue continues to surface, however due to the Y2K issue, testing could not be completed. Once this issue is resolved, providers will be notified through an article in the *Medicare A Bulletin.*

Q6: Providers report that repeatedly their paid subscriptions of the *Part A Bulletin* are not sent until they contact FCSO.

A6: The database for subscriptions of the *Medicare A Bulletin* has been expanded to include the department and/or the person requesting the paid subscription. The subscription order form has also been modified. Since some of the facilities are quite large, it is understandable that mail delivery may be cumbersome

Q7: Providers report that claims are processing through DDE, but do not show on the provider remittance notice.

A7: There could be many reasons for this to occur. To give more specific answers, examples to research this issue will be required.

Q8: Providers report having difficulty canceling claims with partial denials secondary to medical necessity requirements once a medical review of the service has been conducted and the result is a denial.

A8: Providers cannot cancel claims that have been partially denied. The provider must request an appeal. ❖

Billing for Services During the Time of Evacuations

Many questions surfaced regarding appropriate billing for patients during the time of evacuations. Below is a compilation of these questions with the appropriate answers.

Q1: How should the following situation be handled relative to Medicare billing: hospital "A" is evacuated and patients are sent to hospital "B". The same patients are later moved into a shelter because hospital "B" is forced to evacuate?

A1: Hospital "A" would dischargce the patient and reflect a transfer to hospital "B" indicating the appropriate patient status (form locator 21 of the UB-92 claim form). The type of facility the patient is transferred, determines the appropriate patient status:

- 02–transferred to another acute hospital
- 03–transferred to a skilled nursing facility (SNF)
- 04–transferred to a nursing home not considered a skilled facility
- 05–transferred to any other type of medical facility.

Hospital "B" reflects the patient admitted on the day of transfer from hospital "A". At such time as hospital "B" is forced to evacuate, hospital "B" discharges the patient and reflects the appropriate patient status code, once again, on the UB-92 claim form. The third hospital or health care facility ("C") reflects the patient admitted on the day of transfer from hospital "B."

Q2: If a patient was transferred from hospital "A" to hospital "B" and the patient is planning to return to hospital "A", how are the two facilities to bill their claims and receive reimbursement?

A2: If this occurs, both hospitals should be permitted to bill for cases involving the transfer of patients as a result of the disaster. Payment for the initial stay in the first hospital as well as the stay in the second hospital, upon transfer back to the first hospital, would be based on per diem, not to exceed the hospitals' respective diagnosis related group (DRG) reimbursement (inclusive of cost outlier payments if the criteria are met). In addition, the first hospital would also be paid a full DRG rate for the readmission of the Medicare patient from the previously transferred to hospital.

Q3: Due to the unexpected emergent nature of the acute prospective payment system (PPS) hospital evacuation, time did not permit the completion of a financial arrangement with the receiving health care institution. Are PPS hospitals responsible to reimburse the receiving hospital for full charges or how can assistance be provided if problems arise with post evacuation reimbursement negotiations?

A3: Financial agreements between providers are a private matter between the two parties. The Health Care Financing Administration (HCFA) cannot dictate the terms of these agreements or interfere in the providers' negotiations. However, each facility may bill for its respective services as stated in answer #1, page 51.

Q4: Due to evacuation of an acute (PPS) hospital, the Medicare patients were transferred to a non-Medicare medical facility. How are the claims to be billed?

A4: The acute (PPS) hospital should bill Medicare for all days and charges associated with the patient's care as if the patient was never evacuated from the PPS facility. The PPS facility must make arrangements to reimburse the non-Medicare facility for services/charges associated with the period of time the Medicare patient was in that facility.

Q5: Patients are taken to a second facility for chemotherapy services (or any other service the originating facility is unable to render) because the equipment at the original facility is not operating, how should this be billed?

A5: The originating medical facility must bill for these services as part of the original inpatient stay and reimburse the second facility for the use of the chemotherapy services. It is important that this occur so claims are not submitted with overlapping dates of service. If the services were rendered in an outpatient setting at both facilities, both facilities may bill for their own services as long as the dates of service do not overlap.

Q6: Will a hospital be eligible for additional reimbursement for rendering services to patients that remain in the hospital due to the fact that they have no home to go back to or need special medical requirement and continue to need medical care less than acute level?

A6: Medicare will pay the DRG rate and any cost outlier (if criteria are met) for the entire stay until the patient can be moved to a residence or nursing facility.

Q7: If acute care facilities receive patients with a lesser level of care condition (e.g., SNF patients or home health patients) due to evacuation situations, what admitting diagnosis should be used by the acute care facility?

Billing for Services During the Time of Evacuations (continued)

A7: When a patient does not meet Medicare criteria for an inpatient admission, but was admitted due to a natural disaster, the hospital claim should display the actual diagnosis with a secondary diagnosis of E908 as well as all other factual information required on the UB-92 claim form. The patient medical record must reflect the admission was required because of the natural disaster. These instructions are only for natural disasters.
However, if the patient was admitted due to the natural disaster with a non-covered Medicare condition (e.g., Parkinson's disease), the hospital must display an admitting diagnosis of 799.9 with a secondary diagnosis in the E908 range. The patient medical record must reflect the admission was required because of the natural disaster. **Note:** The specificity of the E908 is:

0 = hurricane
1 = tornado
2 = floods
3 = blizzard
4 = dust storm
8 = other cataclysmic storms
9 = unspecified cataclysmic storms, and floods resulting from storms.

Coding the claims as described above would result in DRG 467 being assigned. The Peer Review Organization (PRO) will review individually these admissions to determine the medical necessity of such admissions. The reason for the admission should be shown as a natural disaster and will be reviewed on a case-by-case basis.

Q8: In some cases, a hospital is not only transferring the patient, but is also transferring personnel and equipment. How are the costs handled in this situation?

A8: These hospital costs would be reimbursed as an element of the DRG that is paid under PPS. If the provider were paid on a cost basis, these personnel and equipment costs would be allowable costs.

Q9: In some instances hospital "A" transferred a patient to hospital "B" but because of the disaster, hospital "B" had to transfer the patient again and hospital "A" is no longer aware of the location of the patient. What does a hospital do when the patient cannot be located?

A9: If the receiving hospital/health care facility transferred a patient to some other facility or even discharged the patient; the first hospital should bill Medicare indicating a discharge/transfer (using the appropriate patient status code as identified in answer #1, page 51). The second health care facility would reflect the patient admitted on the day of the transfer from the first facility. The second facility would show an appropriate discharge or transfer upon releasing the patient to an additional health care facility or even to home.

Q10: If an acute care hospital receives patients from a nursing home with no records or Medicare health insurance claim number (HIC), and the nursing home was so badly damaged it has not reopened, how will the hospital obtain the HIC numbers for billing purposes?

A10: If the Medicare identification number or health maintenance organization (HMO) enrollment status of the patient is unknown, it is suggested that the hospital contact its intermediary if the HIC number cannot be obtained from the prior medical facility or the patient's family members.

Q11: During a disaster, arrangements were made with a hospital to render dialysis services to our patients. The hospital utilized dialysis equipment intended for the inpatient setting even though our patients were never admitted. We have been unable to coordinate the billing of these services for our patients with the hospital. My facility has since reopened. Can I bill those services as though they were rendered in my facility and work out a subsequent financial arrangement with the other hospital for reimbursement?

A11: Yes, you may bill for the dialysis services rendered in the hospital and reimburse the hospital accordingly. Please document in your records the rationale for the change in location of the services. If you do not bill for the services rendered in the hospital, it is important that the claims billed by both the hospital and your facility do not have overlapping dates of services. In other words, your normal monthly claim for your patients would not be allowed from the 1st through the 30th (or 31st) if the hospital chooses to bill for the services separately and the date of the services will fall within the same time frame.

Q12: Will health care facilities have trouble obtaining payment from HMOs for their enrollees who were admitted as a result of the disaster without HMO authorization?

A12: The HMOs are required by law to pay claims for emergency services inside the service areas without pre-authorization by the HMO. Coordination will occur between HCFA and Medicare HMOs as a reminder of this requirement. Facility claims for HMO enrollees should indicate treatment was rendered without pre-authorization due to the disaster.

Billing for Services During the Time of Evacuations (continued)

Q13: Can the 14-day payment floor be temporarily suspended to improve the hospital's cash flow?

A13: Cash flow problems can better be resolved through accelerated payments to the health care facility rather than through suspension of the mandatory payment floor. Intermediaries have procedures in place to immediately process requests for accelerated payments or increases in PIP. The intermediaries are also authorized to increase the rate of the accelerated payment to 100 percent and extend the repayment period to 180 days on a case-by-case basis.

Q14: How will ambulance services be paid when patients are moved from hospital to hospital or other locations?

A14: Charges for ambulance transportation will be paid according to the usual reimbursement guidelines. Ambulance transportation charges for patients who were evacuated from and returned to the originating hospital should be included on the inpatient claims submitted by the originating hospital. Payment will be included in the DRG reimbursement amounts made to hospitals paid under the prospective payment system. Outpatient claims may be submitted for ambulance charges incurred by those patients who were transported from the originating hospital and subsequently discharged by the receiving hospital.

Q15: If a beneficiary living at home and using a stationary oxygen unit has to be transported to another location, can we pay for any portable oxygen necessary to transport the beneficiary?

A15: Yes, payment under Medicare Part B can be made.

Q16: If electrical power is lost at the home of a beneficiary using stationary oxygen, can portable oxygen be covered?

A16: Yes, the temporary use of portable oxygen can be covered under Medicare Part B.

Q17: If an item for which there is lifetime limit, such as cataract glasses, is destroyed or lost in a storm, can we waive the lifetime limit and pay for a replacement?

A17: No, the statutory requirements do not provide the authority to pay for a second pair of cataract contact lenses or glasses. However, the possibility of another program such as the Disaster Assistance Program or the Administration on Aging may be able to help with this issue. ❖

"Let's Talk with Medicare Part A Senior Leadership" Session Hosted by First Coast Service Options, Inc. May 24, 2000

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

This session will provide an opportunity to:

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

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

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

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

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

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

"LET'S TALK WITH MEDICARE PART A SENIOR LEADERSHIP" SESSION
FIRST COAST SERVICE OPTIONS, INC.
May 24, 2000

Registration Form for Medicare Part A Providers

Registrant's Name: _____

Registrant's Title/Position: _____

Provider's Name: _____

Medicare Billing Provider Number: _____

Address: _____

City, State, Zip Code: _____

Phone: ( ) _____ Fax: ( ) _____

Note: Please complete one form per person.

Mark your Calendar:
Date: Wednesday, May 24, 2000
Time: 12:00 p.m. - 4:00 p.m.
Cost: ***None - It's Free!!!***

Location:
Parkway Regional Medical Center
160 N.W. 170th Street
North Miami Beach, FL 32179
(305) 654-5010

Two New Computer Based Training Courses Available

In an effort to increase awareness of preventive health services that are covered by Medicare, the Health Care Financing Administration (HCFA) has made available via the Medicare Online Training Web site (**www.medicaretraining.com**), two new *free* computer based training (CBT) courses – *Adult Immunizations and Women's Health.*

Every year, pneumonia and influenza take the lives of 40,000 to 70,000 Americans. Ninety percent of these deaths are in the Medicare population. The goals of the *Adult Immunizations* course are to help providers better understand the importance of immunizations, and identify ways to increase immunization rates in the healthcare community. The *Women's Health* course describes Medicare's coverage criteria as they relate to mammograms, pap tests, pelvic exams, and colorectal screenings. The course also identifies how providers should bill for these services.

In an effort to reach larger audiences with their message in 1999, HCFA provided a series of satellite broadcasts for healthcare professionals throughout the United States. Broadcast attendees were given the opportunity to interact with a panel of medical and healthcare industry experts who discussed important healthcare issues in a national context. Free video tapes of these broadcasts may be ordered for a limited time via the Medicare Online Training Web site (***www.medicaretraining.com***).

The CBT courses offer the convenience of learning at one's own pace. In each course, users are given the opportunity to practice what they've learned through quizzes and tests. Users may take as long as they want to complete each course, and may take them as often as they like.

With the addition of *Women's Health* and *Adult Immunizations*, there are now 10 free CBT courses available. They include:

- *World of Medicare* - an introduction to the Medicare program
- *ICD-9-CM Coding* - instructs providers in the proper use of the ICD-9-CM manual for correct diagnosis coding
- *Medicare Fraud & Abuse* - emphasizes the prevention and early detection of fraud and abuse
- *Front Office Management* - provides essential knowledge needed for "checking in" Medicare patients
- *Medicare Secondary Payer (MSP)* - provides basic information about the MSP program
- *HCFA-1500* - provides essential information required to properly complete the HCFA-1500 claim form
- *HCFA-1450 (or UB-92)* - provides essential information required to properly complete the HCFA-1450 claim form.
- *Medicare Home Health Benefit* - emphasizes the guidelines that providers must follow when dealing with home health agencies

Two additional CBT courses on *Medicare Coverage and Payment* and *Medicare Appeals* are scheduled for release later in 2000.

Medicare Provider Web Site Replaces BBS

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

Information Available on *www.floridamedicare.com*

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

Features

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

Most Files on the Site are in PDF® Format

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

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

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

P (continued)

R

S

T

W

Y

Procedure Codes

HCPCS Codes

HCPCS Codes (continued)

CPT Codes

Anesthesia/Surgery, 00100-69979

Diagnostic Tests, 70010-89399

Medicine, 90281-99199

* Special *Bulletins*

Addresses

CLAIMS STATUS

Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231
(904) 355-8899

APPEAL RECONSIDERATIONS

Claim Denials (outpatient services only)
Medicare Fair Hearings (Part A)
P. O. Box 45203
Jacksonville, FL

REVIEW REQUEST

Denied claims that may have been payable under the Medicare Part A program
Medicare Part A Reconsiderations
P. O. Box 45053
Jacksonville, FL 32232

OVERPAYMENT COLLECTIONS

Repayment Plans for Part A Participating Providers
Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or Program)
Interim Rate Determinations
TEFRA Target Limit and Skilled Nursing Facility Routine Cost Limit Exceptions
Freedom of Information Act Requests (relative to cost reports and audits)
Provider Audit and Reimbursement Department (PARD)
P.O. Box 45268
Jacksonville, FL 32232-5268
(904) 791-8430

ELECTRONIC CLAIM FILING

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

FRAUD AND ABUSE

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

MEDICARE SECONDARY PAYER (MSP)

Information on Hospital Protocols
Admission Questionnaires
Audits
Medicare Secondary Payer
Hospital Review
P. O. Box 45267
Jacksonville, FL 32231

General MSP Information
Completion of UB-92 (MSP Related)
Conditional Payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231
(904) 355-8899

Automobile Accident Cases
Settlements/Lawsuits
Other Liabilities
Medicare Secondary Payer Subrogation
P. O. Box 44179
Jacksonville, FL 32231

Phone Numbers

PROVIDERS

Automated Response Unit
904-355-8899

Customer Service Representatives:
904-355-8899

MEDICARE ONLINE BBS

Access
800-838-8859
904-791-6991

Technical Problems
904-791-8384

BENEFICIARY

904-355-8899

ELECTRONIC MEDIA CLAIMS

EMC Start-Up:
904-791-8767

EMC Front-End Edits/Rejects:
904-791-8767

Electronic Remittance Advice
904-791-6895

Electronic Claim Status
904-791-6895

Electronic Eligibility
904-791-6895

PC-ACE Support
904-355-0313

Testing:
904-791-6865

Help Desk (Confirmation/ Transmission)
904-791-9880