Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Features

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

Routing Suggestions:

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- ☐ Chief Financial Officer
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Health Care Financing Administration

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

October/November 2000 Volume 2, Number 5

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

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

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

A PHYSICIAN'S FOCUS

Diagnosis and Procedure Coding

Traditional Medicare implementation of the Outpatient Prospective Payment System has re-emphasized the importance of diagnosis and procedure coding in the correct payment of claims. The Health Care Financing Administration (HCFA) developed a new classification system, ambulatory payment classifications (APCs), with definitions based on HCFA Common Procedure Coding System (HCPCS) codes. International Classification of Diseases, Clinical Modification (ICD-CM) diagnosis codes were used in the research and development. It is important to remember that traditional Medicare utilizes two claim processing systems, one administered by carriers (Part B) requiring a HCFA-1500 claim form, and another administered by intermediaries (Part A and Part B of A- claims to intermediaries paid out of B funds) requiring a HCFA-1450 (UB-92) claim form. Within these formats are diagnosis and procedure coding requirements for services depending on the type of provider, type of service, type of payment program, HCFA instructions, and carrier/intermediary instructions. Providers need to be alert to the details of these requirements and not assume a procedure code definition unique to a service on a HCFA-1500 claim line translates to a definition on a UB-92 outpatient claim line. The following is a brief overview of diagnosis and procedure coding sources used in Medicare.

There are two related classifications of diseases. The *International Classification of Diseases* (ICD) is the classification used to code and classify mortality data from death certificates. The *International Classification of Diseases, Clinical Modification* (ICD-CM) is used to code and classify morbidity data from the inpatient and outpatient records, physician and ancillary provider offices, and most National Center for Health Statistic (NCHS) surveys. The NCHS serves as the World Health Organization (WHO) Collaborating Center for the Classification of Diseases for North America and is responsible for coordination of all official disease classification activities in the United States relating to the ICD and its use, interpretation, and periodic revision. The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is the current official system of assigning codes to diagnoses associated with traditional Medicare claims and of assigning codes to procedures associated with Medicare part A inpatient claims only. The ICD-9-CM consists of a tabular list containing a numerical list of the disease code numbers; an alphabetical index to the disease entries; and a classification system for surgical, diagnostic, and therapeutic procedures (alphabetic index and tabular list). The NCHS and HCFA, through the ICD-9-CM Coordination and Maintenance Committee, oversee all changes and modifications to the ICD-9-CM. Suggestions for modifications come from both the public and private sectors. Interested parties are asked to submit recommendations for modification. The implementation date of ICD-10-CM has not been announced and will be based on the process for adoption of standards under the Health Insurance Portability Act of 1996 with a two year implementation window once the final notice has been published in the Federal Register.

HCFA developed HCPCS (HCFA Common Procedure Coding System) in 1983 as a three level coding system to provide a uniform method for health care providers and medical suppliers to report professional services, procedures, and supplies. Level I codes are the adopted American Medical Association CPT-4 (Current Procedural Terminology, 4th edition) that has been revised annually since 1983. Level II codes are published nationally by HCFA in order to augment CPT-4 and address non-physician services. Level III codes are established by local carriers/intermediaries and address new procedures and other nuances. HCFA is in the process of reducing and eliminating local codes.

The CPT Editorial Panel is authorized to revise, update, or modify CPT. It is comprised of 16 members- 11 nominated by the AMA's Board of Trustees and one each from the Blue Cross and Blue Shield Association, the Health Insurance Association of America, HCFA, the American Hospital Association, and

Diagnosis and Procedure Coding (continued)

the co-chair of the Health Care Professionals Advisory Committee (HCPAC). Medical specialty societies, individual physicians, hospitals, third-party payers and other interested parties may submit materials for consideration by the editorial panel. The CPT editorial panel meets quarterly to consider proposals. Level II HCPCS are the alpha-numeric codes for items not included in Level I (CPT). Recommendations from outside interested parties are reviewed at a regularly scheduled meeting of the HCFA HCPCS Workgroup and then referred to the Alpha-Numeric Editorial Panel, an interagency committee established for the purpose of making decisions pertaining to additions, deletions and changes to the Alpha-Numeric portion of HCPCS. The Panel, which meets three times a year, is comprised of representatives of the Blue Cross Blue Shield Association, the Health Insurance Association of America, and HCFA.

Information on the ICD-CM modification process for diagnosis coding can be explored at **www.cdc.gov/nchs** and for hospital inpatient procedure coding at **www.hcfa.gov**. CPT coding editorial process information can be searched at **www.ama-assn.org** and the HCPCS Level II code modification process can be reached from **www.hcfa.gov** also. Please contact customer service with specific claims coding questions. Keep up to date with FCSO Intermediary and Carrier Local Medical Review Policy and other new information at **www.floridamedicare.com**.

James J. Corcoran, MD, MPH
Medicare Medical Director

About *The Medicare A Bulletin*

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

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

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

Who Receives the *Bulletin*?

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

What Is in the *Bulletin*?

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

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

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

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

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

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

GENERAL INFORMATION

Changes to the Remittance Advice Notice

First Coast Service Options, Inc. (FCSO), one of the Florida Medicare fiscal intermediaries, will be implementing a new process for printing and mailing the Medicare Part A remittance advice notices.

The major changes in the process are:

- The remittance advice notice will be printed on a blue fade paper.
- The Medicare checks will be attached to the remittance advice notice; therefore, it is important that any address changes be made in a timely manner as the checks cannot be forwarded.
- There will be a watermark on the back of the checks for security purposes.
- The remittance advice notice will now be duplex printed (front and back) to reduce the amount of paper used in the mailing process.
- The implementation date for this initiative is targeted for October 15, 2000.
- There will not be a change to the printed format of the remittance.
- There will now be an area available on the remit to input any special messages that the fiscal intermediary may need to convey to the providers on an as needed basis. ❖

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 August 1, 2000, the interest rate applied to Medicare overpayments is **13.875** percent, based on the new revised PCR rate. The following table lists previous interest rates.

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

Update of Rates for Ambulatory Surgical Center (ASC) Payments

Florida Medicare fiscal intermediary is currently processing claims for hospital outpatient services paid under the ASC blended payment method for claims with dates of service on or after January 1, 2000, based on submitted charges. Once the system is updated to recognize these services as ASC procedures, the fiscal intermediary will perform adjustments to the hospital outpatient claims paid for services furnished on or after January 1, 2000, and processed prior to the installation of the updated list of HCPCS codes and their assigned rates. ❖

GENERAL COVERAGE

Ocular Photodynamic Therapy (OPT)

Coverage guidelines for ocular photodynamic therapy (OPT) were published in the August/September 2000 Medicare A Bulletin page 57. Verteporfin (Visudyne™), the first drug approved for OPC, has been approved for inclusion in the United States Pharmacopoeia (USP) **effective July 18, 2000.**

Since there is no national coverage policy concerning OPT; Florida Medicare will continue to make individual determinations based on medical necessity and reasonableness until a local medical review policy (LMRP) is developed.

Billing Guidelines

The following billing guidelines are effective based on the date of the services:

- **Effective for services furnished on July 1 through July 17, 2000,** claims for OPT must be reported using CPT code 67299 (unlisted procedure, posterior segment). Per section 1861 (t) of the Social Security Act, Medicare covers non-cancer drugs if the drug (a) is included, or approved for inclusion, in the USP; or (b) is approved by the pharmacy and drug therapeutic committee of the medical staff of the hospital furnishing the drug. Since Verteporfin (Visudyne™) does not meet the condition of (a) above prior to July 18, 2000, it is covered in a hospital inpatient or outpatient settings only if the condition in (b) is met. In this instance, the hospital must bill the fiscal intermediary for the cost of the drug. In determining payment, Florida Medicare will consider that CPT code 67299 includes verteporfin, the infusion of verteporfin, and all other services required to perform OPT. Florida Medicare will not pay separately for verteporfin or for the infusion of verteporfin.
- **Effective for services furnished on July 18 through July 31, 2000,** providers must report verteporfin using the unlisted drug HCPCS code J3490. The surgical procedure, the infusion of verteporfin, and all other services required to provide OPT must be billed using CPT code 67299.
- **Effective for services furnished on or after August 1, 2000 (**outpatient prospective payment system implementation), claims for OPT must be reported using HCPCS code C1360 and HCPCS code C1203 must be used to report verteporfin.

When claims are submitted for OPT performed on both eyes on the same day, a single payment will be made for verteporfin and the infusion of verteporfin, as a single infusion is adequate for treatment of both eyes.

The use if verteporfin with laser activation is the only form of OPT that is FDA approved. Other drugs for OPT and other procedures, such as transpupillary thermal therapy, destruction of mascular drusen by photocoagulation and feeder vessel technique (photocoagulation) remain experimental. These procedures must be reported using CPT 67999. ❖

Additional Coverage for Autologous Stem Cell Transplantation

Effective for services furnished **on or after October 1, 2000,** Medicare coverage for autologous stem cell transplantation has been revised to add the following covered and noncovered guidelines:

1. Multiple myeloma as a covered condition only for beneficiaries less than age 78 who have Durie-Salmon stage II or III newly diagnosed or responsive multiple myeloma and adequate cardiac, renal, pulmonary and hepatic function.
2. Nonprimary amyloidosis as a non-covered condition.
3. Primary amyloidosis as a non-covered condition for Medicare beneficiaries age 64 and older.
4. Coverage for primary amyloidosis for beneficiaries under the age of 64 is at the intermediary's discretion.

ICD-9-CM Reporting

The above conditions should be reported with the following ICD-9-CM diagnosis codes:

For multiple myeloma as a covered condition only for beneficiaries less than age 78 who have Durie-Salmon stage II or III newly diagnosed or responsive multiple myeloma and adequate cardiac, renal, pulmonary and hepatic function:

203.00 Multiple myeloma and immunoproliferative neoplasms; without mention of remission
238.6 Neoplasm of uncertain behavior of plasma cells

For the conditions of nonprimary amyloidosis and primary amyloidosis:

277.3 Amyloidosis. ❖

Medicare Beneficiaries Participating in Medicare Qualifying Clinical Trials

The following article has been developed by the Health Care Financing Administration to implement a national coverage determination addressing the routine costs of qualifying clinical trials.

"On June 7, 2000, the President of the United States issued an executive memorandum directing the Health Care Financing Administration (HCFA) to "explicitly authorize [Medicare] payment for routine patient care costs…and costs due to medical complications associated with participation in clinical trials." In keeping with the President's directive, this National Coverage Decision (NCD) serves to define the routine costs of clinical trials and identify the clinical trials for which payment for such routine costs should be made for eligible services furnished on or after September 19, 2000.

HCFA has developed a National Coverage Determination (NCD) which can be accessed and downloaded from the HCFA web page at www.hcfa.gov/quality/8d.htm. This NCD states that Medicare covers: 1) the routine costs of **qualifying** clinical trials as well as, 2) reasonable and necessary items and services used to diagnose and treat complications arising from participation in **all** clinical trials. This instruction addresses routine costs of qualifying clinical trials including complications resulting from qualifying clinical trials. All other Medicare rules apply.

Clinical Trial Services That Qualify for Coverage

Clinical trial services covered by Medicare must meet both the following requirements:

1. Qualifying Trial. In order to be covered, the service must be part of a trial that meets all of the following criteria in order to be considered a qualifying trial:

   a) **Evaluates a Medicare Benefit.** The subject or purpose of the trial must be the evaluation of an item or service that falls within a Medicare benefit category (e.g., physicians' service, durable medical equipment, diagnostic test) and is not statutorily excluded from coverage (e.g., cosmetic surgery, hearing aids).

   b) **Has a Therapeutic Intent.** The trial must have a therapeutic intent (i.e., is not designed exclusively to test toxicity or disease pathophysiology).

   c) **Enrolls Diagnosed Beneficiaries.** Trials of **therapeutic interventions** must enroll patients with diagnosed disease rather than healthy volunteers. Trials of **diagnostic interventions** may enroll healthy patients in order to have a proper control group.

   d) **Has Desirable Characteristics.** The desirable characteristics are listed in the NCD.

   - **Deemed Trials.** Some trials are considered automatically deemed as having desirable characteristics. They include:

     Effective September 19, 2000

     - Trials funded by the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Agency for Healthcare Resesarch and Quality (AHRQ), HCFA, Department of Defense (DOD), and Department of Veterans Affairs (VA);
     - Trials supported by centers or cooperative groups that are funded by the NIH, CDC, AHRQ, HCFA, DOD and VA;
     - Trials conducted under an investigational new drug application (IND) reviewed by the Food and Drugs Administration (FDA); and
     - Drug trials that are exempt from having an IND under 21 CFR 312.2(b)(1) are deemed until the qualifying criteria are developed and the certification process is in place. At that time the principal investigators of these trials must certify that the trials meet the qualifying criteria in order to maintain Medicare coverage of routine costs. This certification process will only affect the future status of the trial and will not be used to retroactively change the earlier deemed status.

Until the Medicare clinical trial registry is established, the sponsors of both IND trials and IND-exempt trials must identify themselves by e-mail to ***clinicaltrials@hcfa.gov*** for administration, payment and program integrity purposes.

- **Self-Certified Trials.** In the future, a multi-agency Federal panel (see NCD for further details) will develop qualifying criteria that will indicate a strong probability that a trial exhibits the desirable characteristics as stated in the NCD. ***No trials are covered based upon self-certification at this time.***

1. **Routine Costs.** Routine costs of a clinical trial include all items and services that are provided in either the experimental or the control arms of a trial except those listed below as not covered. Services provided to Medicare beneficiaries in both the experimental group and the control group are eligible for coverage provided that all other criteria in this instruction are met.

Routine costs do NOT include (and are therefore not covered):

- The investigational item or service, itself;
- Items and services:
  - For which there is no Medicare benefit category, or
  - Which are statutorily excluded, or
  - That fall under a national noncoverage policy.
- Items and services furnished solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; and
- Items and services provided solely to determine trial

Medicare Beneficiaries Participating in Medicare Qualifying Clinical Trials (continued)

eligibility.

Routine costs DO include (and are therefore covered):

- Items or services that are typically provided absent a clinical trial (e.g., medically necessary conventional care);
- Items and services required for the provision of the investigational item or service (e.g., administration of a non-covered chemotherapeutic agent);
- Items and services required for the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Items and services that are medically necessary for the diagnosis or treatment of complications arising from the provision of an investigational item or service.

This national coverage policy is based upon the authority found in section 1862(a)(1)(E) of the Social Security Act (Act). It is binding on all Medicare carriers, intermediaries, Peer Review Organizations, Health Maintenance Organizations, Competitive Medical Plans, Health Care Prepayment Plans, and Medicare+Choice organizations (section 1852 (a)(1)(A) of the Act)."

For claims with dates of service on or after September 19, 2000, submit claims for services that meet the requirements as outlined in the final National Coverage Decision for Medicare qualifying clinical trial services by reporting the ICD-9-CM diagnosis code of V70.5 (Health Examination of Defined Subpopulations). Report this code as the third or subsequent diagnosis code not as the principal diagnosis code on the claim. Continue to code the principal diagnosis code chiefly responsible for the service.

The ICD-9-CM code is used to identify services that constitute medically necessary routine patient care or treatment of complications arising from a Medicare beneficiary's participation in a Medicare covered clinical trial. Services that are provided solely to satisfy data collection and analysis needs and that are not used in the clinical management of the patient are not covered. In addition, services that are not covered by Medicare by virtue of a statutory exclusion or lack of a benefit category also may not be billed using this ICD-9 code. Finally, items and services customarily provided by the research sponsors free of charge for any enrollee in the trial may not be billed. ***This code will serve as your attestation that the service meets the Medicare coverage criteria (i.e., was furnished to a beneficiary who is participating in a Medicare qualifying clinical trial and represents routine patient care, including complications associated with qualifying trial participation.)***

When submitting claims with the V70.5 diagnosis code, you must include in the beneficiary's medical record the following information: trial name, sponsor, and sponsor-assigned protocol number. This information should not be submitted with the claim but must be provided if requested for medical review. A copy of the signed informed consent document must also be made readily available if requested for medical review activities.

Submit separate line items for clinical trial services when the claim includes other covered services not directly related to a Medicare qualifying clinical trial.

Payment Requirements

Payment for these Medicare qualifying clinical trial services furnished on or after September 19, 2000, will be paid under current payment methodologies specific to your provider type and the service being provided. All applicable deductible and coinsurance rules apply to clinical trial services with one exception. In the case of fee for service claims for managed care enrollees, the beneficiary will not be responsible for the Part A deductible.

Where the payment is bundled (e.g., DRG payments), Medicare will later adjust amounts paid for non-covered investigational items and services for which payment should not have been included as part of the bundled payment.

Billing Requirements

Bill on HCFA Form HCFA-1450 or electronic equivalent.

Applicable Bill Types

All institutional provider bill types (inpatient and outpatient) are applicable.

When utilizing the UB-92 flat file use record type 40 to report bill type. Record type (Field No. 1), sequence number (Field No. 2), patient control number (Field No. 3), and type of bill (Field No. 4) are required.

When utilizing the hard copy UB-92 (Form HCFA-1450) report the applicable bill type in Form Locator (FL) 4 "Type of Bill."

When utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the applicable bill type in 2-130-CLM01, CLM05-01, and CLM05-03.

ICD-9-CM Reporting

For claims with dates of service on or after September 19, 2000, report ICD-9 diagnosis code V70.5 (Health Examination of Defined Subpopulation) as the third or subsequent diagnosis code (not as the Principal Diagnosis) when billing for a Medicare qualifying clinical trial service.

When utilizing the UB-92 flat file use record type 70, Other Diagnoses Code (Field No. 6-12) to report the ICD-9 code.

When utilizing the hard copy UB-92 report the ICD-9 code in Form Locators (FLs) 69-75 (Other Diagnoses Codes).

When utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the ICD-9 in 2-225.A-HI04-02 through HI10-02.

When utilizing the Health Care Claim: Institutional 837 version 4010, report the ICD-9 in OTHER DIAGNOSIS INFORMATION HI02.

If a claim for a Medicare covered clinical trial service was erroneously denied for a date of service on or after September 19, 2000. The action you take to receive payment for this service depends on whether the claim was initially submitted with the clinical trial diagnosis code.

Initial Claim Did Not Include the Clinical Trial

Medicare Beneficiaries Participating in Medicare Qualifying Clinical Trials (continued)

Diagnosis Code

Submit an adjustment bill with the clinical trial ICD-9 diagnosis code. If the claim or any line item on the claim is denied, notify us [Medicare Part A Customer Services Department (904) 355-8899] that the denied service(s) on the claim was related to a Medicare covered clinical trial and, if appropriate, payment will be made.

Inadvertently Denied Claim Was Submitted With the Clinical Trail Diagnosis Code (As the Third or Subsequent Diagnosis)

Notify us that a denied service(s) on the claim was related to a Medicare covered clinical trial service and, if appropriate, payment will be made.

Payment of Clinical Trial Services for Managed Care Enrollees

Until Medicare capitation rates are adjusted to account for clinical trials, payment for clinical trial services furnished to beneficiaries enrolled in Medicare managed care plans will be made by the Medicare contractors that process fee for service claims. You will need to submit fee for service bills to those entities for covered clinical trial services furnished to Medicare managed care enrollees. Payment will be based on the current payment methodologies specific to your provider type and the service being provided. In addition, the Part A deductible is assumed to be met when billed on a fee for service basis for Medicare covered clinical trial services furnished to managed care enrollees.

Note: In order to receive reimbursement from a fee for service contractor, providers must apply with that contractor for a provider identification number (PIN) by completing Form HCFA-855C and forwarding it to the contractor (Form HCFA-855C may be found online at www.HCFA.gov/medicare/enrollment/forms/)

Claims submitted to the fee-for service contractor without an assigned PIN will be denied. ❖

OUTPATIENT HOSPITAL SERVICES

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

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

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

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

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

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

Proper Billing of Units for Intrathecal Baclofen under the Outpatient Prospective Payment System

For proper payment under outpatient prospective payment system (OPPS), hospitals must bill for intrathecal baclofen, an orphan drug entitled to pass-through payment under OPPS, using HCPCS code J0476 with the following units:

- 0.05 mg/ml (screening kit): bill 7 units
- 10 mg/20 ml, 20 ml ampule (refill kit): bill 20 units
- 10 mg/5ml, two 5 ml ampules (refill kit): bill 42 units
- 10mg/5ml, four 5 ml ampules (refill kit): bill 74 units

Effective October 1, 2000, unique codes will be available for each of the package/dosage combinations. A separate notification containing these codes will be issued at a later date. ❖

INPATIENT HOSPITAL SERVICES

Interim Process for Certain "Inpatient Only" Code Changes

The final rule for the outpatient prospective payment system (OPPS), which was published in the ***Federal Register*** on April 7, 2000, indicated certain procedures that will not be paid by Medicare if performed on an outpatient basis. A hospital will receive Medicare payment for these procedures only when they are furnished on an inpatient basis only. The HCPCS codes that are on the "inpatient only" list were published in Addendum E of the final rule. However, certain codes from the list were erroneously included as "inpatient only" procedures and as a result are being removed from the list.

The following is a list of HCPCS codes that will be removed from the inpatient only list. These codes will be assigned and paid under the appropriate ambulatory payment classification (APC).

HCPCS Code	Description	APC
74300	X-ray bile ducts/pancreas	0263
75945	Intravascular us	0267
75946	Intravascular us add on	0267
75960	Transcatheter intro, stent	0279
75961	Retrieval, broken catheter	0279
75962	Repair arterial blockage	0280
75964	Repair artery blockage, each	0279
75966	Repair arterial blockage	0280
75968	Repair artery blockage, each	0279
75970	Vascular biopsy	0279
75978	Repair venous blockage	0279
75992	Atherectomy	0279
75995	Atherectomy	0279
92977	Dissolve clot, heart vessel	0120
95920	Intraop nerve test add on	0216
95961	Electrode stimulation, brain	0216
95962	Electrode stim, brain add on	0216

Although these changes are effective for services furnished on or after August 1, 2000, the Outpatient Code Editor (OCE) will not be able to properly pay these services as outpatient services until the October OCE update. Therefore, hospital outpatient claims containing any of the above codes will result in rejection of the claim. The October update to the OCE will be revised to properly process these codes for hospital outpatient claims submitted to the fiscal intermediary on or after October 1, 2000, even if the date of service on the claim occurs during the period August 1, 2000 through September 30, 2000.

If a hospital has submitted a claim containing any of the above codes prior to October 1, 2000, and the claim has been rejected, the intermediary will reprocess those claims with any of the above codes that were rejected as "inpatient only" no later than November 30, 2000.

If a hospital has submitted a claim for all services furnished to a beneficiary (with the exception of the codes listed above), on or after October 1, 2000, the hospital must submit an adjustment claim containing all the services provided, including any of the above codes previously not billed. ❖

SKILLED NURSING FACILITY SERVICES

Skilled Nursing Facility Adjustment Billing: Adjustments to HIPPS Codes Resulting From MDS Corrections

Background

There is a new policy that allows corrections to MDS assessments. The instructions that explain the types of error that may be corrected and the procedures to be followed are available at **http://www.hcfa.gov/medicaid/mds20/whatsnew.htm.**

The web site does not include any instruction regarding billing changes that are required as a result of an MDS correction. Effective for services provided on and after June 1, 2000, providers must submit adjustment bills whenever a correction of an MDS results in a change in a billed HIPPS code. The adjustment bill is retroactive to the first day payment was made based on the original (but incorrect) MDS assessment or June 1, 2000, whichever is earlier.

Unlike the Significant Correction of a Prior Full Assessment that has been available to facilities for some time, an MDS correction is not a new assessment and can never be used as a replacement for any required MDS.

Facts about the Adjustment Bill Process

- Providers may start submitting adjustment bills on **November 6, 2000.**
- Providers must use condition code **D4** (Change in Grouper Code) for adjustment bills that result from corrections to an MDS. This code indicates that the reason for the adjustment is a HIPPS code change resulting from the correction of MDS data.
- Adjustment bills based on corrected MDS assessments are eligible for payment under this procedure effective June 1, 2000. This policy only refers to Medicare skilled services that were provided in the SNF on June 1, 2000 or later. HIPPS codes for dates of service (FL 45) prior to June 1, 2000 may not be adjusted based on a correction to the relevant MDS.
- After the initial period of this new adjustment bill policy, the beginning date of service, the "from" date, will have little significance. The "through" date will be used to calculate the period during which D4 type adjustment bills may be submitted based on corrected MDS assessments. The "through" date indicates the last day of the billing period for which the HIPPS code is billed. Providers are required to submit adjustment bills based on corrected MDS assessments within 120 days of the "through" date on the bill.
- Once the fiscal intermediary has medically reviewed a bill, no adjustment bill may be submitted. The MDS may be corrected, but no adjustment bill may be sent.
- The requirement that providers may not knowingly over bill the Medicare program remains in effect. SNFs that identify patterns of errors that result in overpayments must report them to the FI, and these overpayments must be recouped. A pattern of errors includes but is not limited to software errors in transmitting MDS files, misunderstandings of MDS instructions that result in consistent miscoding of one or more MDS files, misunderstandings of MDS instructions that result in consistent miscoding of one or more MDS items used in determining the RUG-III group, etc.
- The procedure you should use to report this type of overpayment is by submitting adjustment bills to reflect corrections to the MDS data that results in changes to the RUG-III code (i.e. the first three digits of the HIPPS code).

Examples

1. A Medicare 5-day assessment was completed timely and used to establish the RUG-III rate for days 1-14 of the Part A stay. The bill was paid before the provider found the error, on day 16. The facility corrected the 5-day assessment and submitted an adjustment bill for days 1 through 14 of the Part A stay.

2. On day 39 of the Part A stay, the facility identified an error in a 30-day Medicare MDS. Five days of service had already been billed and paid based on the HIPPS code generated from that 30-day Medicare assessment. The facility submitted an MDS correction that resulted in a change in the RUG-III group (and of course, the HIPPS code). Then, the correct RUG-III classification was used to generate the adjustment bill for the remaining covered days in the applicable payment period. ❖

Annual Update to the Prospective Payment System (PPS) Pricer and Health Insurance Prospective Payment System (HIPPS) Coding Changes

The following information has been provided by the Health Care Financing Administration (HCFA) to inform providers of the system changes required as part of the annual Skilled Nursing Facility (SNF) update. The Health Insurance Prospective Payment System (HIPPS) and the fiscal intermediary claim processing systems will be updated with the modifiers presented in this document. Additional instructions related to the use of these codes for billing will be issued separately as they become available.

Annual Pricer Update

Annual updates to the PPS rates are required by section 1888(e) of the Social Security Act, as amended by Medicare, Medicaid, and the Balanced Budget Refinement Act of 1999 (BBRA), related to Medicare payments and consolidated billing for SNFs. PPS rates for fiscal year 2001 were published in a final rule before July 31, 2000. The revised pricer program will be installed timely to ensure accurate payments for SNF services **on and after October 1, 2000.**

HIPPS Coding Changes

These changes will be reflected in an updated SNF PPS pricer. The Arkansas Part A Standard System (APASS), Fiscal Intermediary Standard System (FISS), and local intermediary systems must assure that the new HIPPS codes can be accepted into the data entry and claim processing systems, and can be processed appropriately throughout the system.

The 5-digit HIPPS code includes two components: the 3-digit classification code assigned to each resource utilization group (RUG), version 3 (RUG-III) group, and a 2-digit assessment indicator that specifies the type of Medicare-required assessment used to support billing. Front-end edits are currently in place to ensure that payment will only be made for SNF claims that are billed with valid HIPPS codes.

RUG-III Codes: For fiscal year 2001, there will be no changes to the 44-group RUG-III coding system.

Assessment Indicator Codes: Effective October 1, 2000, the number of allowable 2-digit assessment indicator codes will be expanded. The allowable codes are shown below. New codes are in **bold** type. The new codes are being added to facilitate the planned electronic generation of all assessment indicator codes discussed below.

Assessment Indicator	Descriptor
01	5-day Medicare-required assessment/not an initial admission assessment 30-day Medicare-required assessment
03	60-day Medicare-required assessment 90-day Medicare-required assessment
05	**Readmission/Return Medicare-required assessment**
07	14-day Medicare-required assessment/not an initial admission assessment
08	Off-cycle Other Medicare-required assessment (OMRA)
11	5-day (or readmission/return) Medicare-required assessment AND initial admission assessment
17	**14-day Medicare-required assessment AND initial admission assessment:** This code is being activated to facilitate the planned automated generation of all assessment indicator codes Currently, code 07 is used for all 14-day Medicare assessments, regardless of whether it is also a clinical initial admission assessment (i.e., an assessment mandated as part of the Medicare/Medicaid certification process).
18	**OMRA replacing 5-day Medicare-required assessment**
28	**OMRA replacing 30-day Medicare-required assessment**
30	**Off-cycle significant change assessment (outside assessment window)**
31	**Significant change assessment REPLACES 5-day Medicare-required assessment**
32	Significant change assessment **REPLACES** 30-day Medicare-required assessment
33	Significant change assessment **REPLACES** 60-day Medicare-required assessment
34	Significant change assessment **REPLACES** 90-day Medicare-required assessment

Annual Update to the PPS Pricer ... (continued)

Assessment Indicator	Descriptor
35	**Significant change assessment REPLACES a readmission/return Medicare-required assessment**
37	Significant change assessment **REPLACES** 14-day Medicare-required assessment
38	**OMRA replacing 60-day Medicare-required assessment**
40	**Off-cycle significant correction assessment of a prior assessment (outside assessment window)**
41	Significant correction of a prior assessment **REPLACES** a 5-day Medicare-required assessment
42	Significant correction of a prior assessment **REPLACES** 30-day Medicare-required assessment
43	Significant correction of a prior assessment **REPLACES** 60-day Medicare-required assessment
44	Significant correction of a prior assessment **REPLACES** 90-day Medicare-required assessment
45	**Significant correction of a prior assessment REPLACES a readmission/return assessment**
47	Significant correction of a prior assessment **REPLACES** 14-day Medicare-required assessment
48	**OMRA replacing 90-day Medicare-required assessment**
54	90-day Medicare assessment that is also a quarterly assessment
78	**OMRA replacing 14-day Medicare-required assessment**
00	Default code

Automating the HIPPS Codes

Currently, determining the correct assessment modifier code needed for billing is a manual process. It is clear that providers have experienced problems generating the proper codes. To eliminate this source of error, HCFA is planning to modify the Minimum Data Set validation reports to list the assessment indicator code as well as the RUG-III code. As a first step effective, October 1, 2000, HCFA will expand the number of assessment indicator codes to cover all the coding possibilities. Providers will assign the codes manually until the automation effort is completed. Specifications will be released in the future to allow providers to add this capability to their in-house software.

Provider Billing Instructions

The pricer program determines the proper payment amount using the "Service Through" date on the bill. In order to ensure accurate payment, providers must submit **separate bills** for services that span September 30, 2000 and October 1, 2000. Bills for services both before and after the October 1 annual rate update effective date cannot be accepted, regardless of the provider's regular monthly billing cycle.

This policy is the same one used for previous rate changes including the October 1999 annual update, and the April 1, 2000 update required under the BBRA. However; unlike previous transition procedures, the HIPPS code required for billing may change for services provided on and after October 1, 2000. ❖

Payment of Skilled Nursing Facility (SNF) Claims for Beneficiaries Disenrolling from Terminating Medicare+Choice (M+C) Plans Who Have Not Met the 3-Day Hospital Stay Requirement

Starting October 1, 2000, fiscal intermediaries are implementing a manual mechanism to pay for claims involving SNF care for beneficiaries **involuntarily** disenrolling from M+C plans as a result of a M+C plan termination when the beneficiary does not have a 3-day prospective payment system hospital stay before SNF admission. This manual mechanism will end December 31, 2000, with the implementation of the automatization of the systems changes indicated in this article.

Policy Overview

Medicare will cover SNF care for beneficiaries involuntarily disenrolling from M+C plans as a result of a M+C plan termination when the beneficiary does not have a 3-day prospective payment system hospital stay before SNF admission. If Medicare does not cover these claims, beneficiaries will be liable for payment. Beneficiaries in this situation have not been aware of their potential financial liability for their SNF care.

Fiscal intermediaries (FIs) will start counting the 100 days of SNF care with the SNF admission date (regardless of whether the beneficiary met the skilled level of care requirements on that date). All other original Medicare rules apply, such as the requirement that beneficiaries meet the skilled level of care requirement (for the period for which the original Medicare fee-for-service program is being billed).

To pay SNF claims for enrollees without a 3-day hospital stay and who are disenrolling from terminating M+C plans, the 3-day hospitalization met requirement will be deemed.

This policy is effective for services furnished on or after January 1, 2000.

Billing Instructions

To be reimbursed for these bills skilled nursing facilities must follow these billing instructions:

- Effective October 1, 2000, through December 31, 2000, SNFs may submit a hardcopy claim with a note indicating that condition code 58 applies to this claim. Condition code 58 will be used in the future when the beneficiary has been involuntarily disenrolled from a M+C organization while in a SNF stay and when the 3-day stay requirement has not been met.

Effective January 1, 2001,

- Providers must use ***condition code 58*** on the first fee-for-service (also known as "Original Medicare") claim for a beneficiary who was in a terminating M+C plan, and was an inpatient of a SNF at the time of termination.
- The beneficiary must be assigned to a ***resource utilization group (RUG)***. Original Medicare coverage rules regarding the skilled level of care requirements will be applied. Payment will be made only for claims submitted for beneficiaries in certified SNF beds.

Original Medicare fee-for-service rules regarding beneficiary cost sharing apply to these cases. That is, providers may only charge beneficiaries for SNF coinsurance amounts. ❖

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 **November 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**).*

44388: Colonoscopy

Policy Overview: The "ICD-9-CM Codes that Support Medical Necessity" section of the policy has been revised to include changes and additions affected by the implementation of the 2001 ICD-9-CM update.

Policy Number
44388

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Colonoscopy

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Section 35-59

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
07/13/1998

Revision Effective Date
10/01/2000

Revision Ending Effective Date
09/30/2000

Policy Ending Date
N/A

LMRP Description
Colonoscopy allows direct visual examination of the intestinal tract with a flexible tube containing light transmitting glass fibers that return a magnified image. Colonoscopy can act as both a diagnostic and therapeutic tool in the same procedure. Therapeutic indications include removal of polyps or foreign bodies, hemostasis by coagulation, and removal of tumors.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider a colonoscopy to be medically necessary under any of the following circumstances (see Covered ICD-9-CM Codes):

- Evaluation of an abnormality on barium enema which is likely to be clinically significant, such as a filling defect or stricture.
- Evaluation and excision of polyps detected by barium enema or flexible sigmoidoscopy.
- Evaluation of unexplained gastrointestinal bleeding; hematochezia not thought to be from rectum or perianal source, melena of unknown origin, or presence of fecal occult blood.
- Unexplained iron deficiency anemia.
- Examination to evaluate the entire colon for simultaneous cancer or neoplastic polyps in a patient with a treatable cancer or neoplastic polyp.
- Evaluation of a patient with carcinoma of the colon before bowel resection. Post surgical follow-up should be conducted annually for 2 years and every 2 years thereafter.
- Yearly evaluation with multiple biopsies for detection of cancer and dysplasia for patients with chronic ulcerative colitis who have had pancolitis of greater than seven years duration.
- Yearly evaluation with multiple biopsies for detection of cancer and dysplasia for patients with chronic ulcerative colitis who have had left-sided colitis of over 15 years duration (not indicated for disease limited to rectosigmoid).
- Chronic inflammatory bowel disease of the colon when more precise diagnosis or determination of the extent of activity of disease will influence immediate management.
- Clinically significant diarrhea of unexplained origin.
- Treatment of bleeding from such lesions as vascular anomalies, ulceration, neoplasia, and polypectomy site (e.g., electrocoagulation, heater probe, laser or injection therapy).
- Foreign body removal.
- Decompression of acute non-toxic megacolon.
- Balloon dilation of stenotic lesions (e.g., anastomotic strictures).
- Decompression of colonic volvulus.
- Examination and evaluation when a change in management is probable or is being suspected based on results of the colonoscopy.
- Evaluation within 6 months of the removal of sessile polyps to determine and document total excision. If evaluation indicates that residual polyp is present, excision should be done with repeat colonoscopy within 6 months. After evidence of total excision without return of the polyp, repeat colonoscopy yearly.
- If a total colonoscopy is unsuccessful preoperatively due to obstructive cancer, repeat colonoscopy 3-6 months post-operatively unless unresectable metastases are found at surgery.

44388: Colonoscopy (continued)

- Evaluation to differentiate between ulcerative and Crohn's colitis.
- Evaluation 3 years after resection of newly diagnosed small (< 5mm diameter) adenomatous polyps when only a single polyp was detected. After 1 negative 3-year follow-up examination subsequent surveillance intervals may be increased to 5 years.
- Evaluation at 1 and 4 year intervals after resection of multiple or large (> 10mm) adenomalous polyps. Subsequent surveillance intervals may then be increased to every 5 years.
- Evaluation of low to high grade dysplasia in flat mucosa by colonoscopy 6 months after undergoing aggressive medical therapy, especially when inflammatory changes were present.
- Evaluation in 1 year after the removal of multiple adenomas. If examination proves negative then repeat in 3 years. After 1 negative 3-year follow up examination, repeat exam every 5 years.
- Evaluation of a patient presenting with signs/symptoms (e.g., rectal bleeding, abdominal pain) of a disorder that appears to be related to the colon.

HCPCS Section & Benefit Category

Digestive System/Surgery

Type of Bill Code

Hospital – 12x, 13x
Skilled Nursing Facility – 21x, 22x

Revenue Code

750 Gastro-intestinal Services, General Classification

HCPCS Codes

44388	Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44389	with biopsy, single or multiple
44390	with removal of foreign body
44391	with control of bleeding, any method
44392	with removal of tumors(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
44393	with ablation of tumors(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
44394	with removal of tumors(s), polyp(s), or other lesion(s) by snare technique
45355	Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45379	with removal of foreign body
45380	with biopsy, single or multiple
45382	with control of bleeding, any method
45383	with ablation of tumor(s), polyp(s), or other lesions(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45384	with removal of tumor(s), polyp(s), or other lesions(s) by hot biopsy forceps or bipolar cautery
45385	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

009.0-009.1	Infectious colitis, enteritis, and gastroenteritis **and** colitis, enteritis, and gastroenteritis of presumed infectious origin
009.3	Diarrhea of presumed infectious origin
038.9	Unspecified septicemia
152.2	Malignant neoplasm of ileum
153.0-153.9	Malignant neoplasm of colon
154.0-154.8	Malignant neoplasm of rectum, rectosigmoid junction, and anus
155.2	Malignant neoplasm of liver, not specified as primary or secondary
176.3	Kaposi's sarcoma gastrointestinal sites
195.2	Malignant neoplasm of abdomen
197.0	Secondary malignant neoplasm of lung
197.5	Secondary malignant neoplasm of large intestine and rectum
197.6	Secondary malignant neoplasm of retroperitoneum and peritoneum
197.7	Secondary malignant neoplasm of liver, specified as secondary
198.3	Secondary malignant neoplasm of brain and spinal cord
198.89	Secondary malignant neoplasm of other specified sites
199.0	Disseminated malignant neoplasm without specification of site
199.1	Other malignant neoplasm without specification of site
201.90	Hodgkin's disease, unspecified; unspecified site, extranodal and solid organ sites
211.2	Benign neoplasm of duodenum, jejunum, and ileum
211.3	Benign neoplasm of colon
211.4	Benign neoplasm of rectum and anal canal
211.8	Benign neoplasm of retroperitonium and peritoneum
230.3	Carcinoma in situ of colon
230.4	Carcinoma in situ of rectum
230.5	Carcinoma in situ of anal canal
230.6	Carcinoma in situ of anus, unspecified
230.9	Carcinoma in situ of other and unspecified digestive organs
235.2	Neoplasm of uncertain behavior of stomach, intestines, and rectum
235.5	Neoplasm of uncertain behavior of other

44388: Colonoscopy (continued)

	and unspecified digestive organs
239.0	Neoplasm of unspecified nature of digestive system
280.0	Iron deficiency anemias secondary to blood loss (chronic)
280.9	Iron deficiency anemia, unspecified
281.9	Unspecified deficiency anemia
448.0	Hereditary hemorrhagic telangiectasia
555.0-555.9	Regional enteritis
556.0-556.9	Ulcerative colitis
557.0-557.9	Vascular insufficiency of intestine
558.1-558.9	Other noninfectious gastroenteritis and colitis
560.0	Intussusception
560.1	Paralytic ileus
560.2	Volvulus
560.30-560.39	Impaction of intestine
560.81-560.89	Other specified intestinal obstruction
560.9	Unspecified intestinal obstruction
562.11	Diverticulitis of colon (without mention of hemorrhage)
562.12	Diverticulosis of colon with hemorrhage
562.13	Diverticulitis of colon with hemorrhage
564.0	Constipation
564.1	Irritable bowel syndrome
564.4	Other postoperative functional digestive disorders
564.5	Functional diarrhea
564.7	Megacolon, other than Hirschsprung's
564.81-564.89	Other specified functional disorders of the intestine
569.0	Anal and rectal polyp
569.3	Hemorrhage or rectum and anus
569.41	Ulcer of anus and rectum
569.49	Other specified disorders of rectum and anus
569.5	Abscess of intestine
569.60-569.69	Colostomy and enterostomy complications
569.81-569.89	Other specified disorders of intestine
578.1	Blood in stool
578.9	Hemorrhage of gastrointestinal tract, unspecified
783.21	Loss of weight
787.3	Flatulence, eructation, and gas pain
787.6	Incontinence of feces
787.91-787.99	Other symptoms involving digestive system
789.00-789.09	Abdominal pain
789.30-789.39	Abdominal or pelvic swelling, mass, or lump
789.60-789.69	Abdominal tenderness
792.1	Nonspecific abnormal findings in stool contents
793.4	Nonspecific abnormal findings on radiological and other examination of the gastrointestinal tract
936	Foreign body in intestine or colon
V10.05	Personal history of malignant neoplasm of large intestine
V10.06	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus
V12.72	Personal history of colonic polyps

Diagnosis that Support Medical Necessity

N/A

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

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

For screening colonoscopies, refer to Florida Medicare's Medical Policy AG0104 (Colorectal Cancer Screening).

Documentation Requirements

Medical record documentation (office/progress notes) maintained by the ordering/referring physician must indicate the medical necessity of the colonoscopy procedure covered by the Medicare program. The procedure results/report and any associated pathology report must be included in the patient's medical record.

If the provider of the colonoscopy is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of procedure results/ report and pathology report along with copies of the ordering/referring physician's order for the procedure.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

Practice Parameters Committee of the American College of Gastroenterology
The American Journal of Gastroenterology
The New England Journal of Medicine
The U.S. Preventive Services Task Force, Washington, D.C.

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 Gastroenterology Society.

Start Date of Comment Period

N/A

44388: Colonoscopy (continued)

Start Date of Notice Period

10/01/2000

Revision History

Revision Number:	3	
Start Date of Comment Period:	N/A	
Start Date of Notice Period:	10/01/2000	Oct/Nov 2000 Bulletin
Revised Effective Date:	10/01/2000	
Explanation of Revision:	Annual ICD-9-CM Update. The procedure code to diagnosis application is effective 11/15/2000.	
Revision Number:	2	
Start Date of Comment Period:	N/A	
Start Date of Notice Period:	02/25/2000	Special Issue 2000 Bulletin
Revised Effective Date:	08/01/2000	
Explanation of Revision:	Outpatient PPS implementation. Since hospital TOBs are now included in this policy, the diagnosis application can be applied.	
Start Date of Comment Period:	N/A	
Start Date of Notice Period:		
Original Effective Date:	07/13/98	
Revision Date/Number:	10/01/98	1 1999 ICD-9-CM Update
Start Date of Comment Period:	02/27/98	
Start Date of Notice Period:	05/29/98	
Original Effective Date:	07/13/98 ❖	

78472: Cardiac Blood Pool Imaging

Policy Overview: The "Coding Guidelines" and the "ICD-9-CM Codes that Support Medical Necessity" sections of the policy has been revised to include additional guidelines affected by the implementation of the 2001 ICD-9-CM update.

Policy Number
78472

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Cardiac Blood Pool Imaging

AMA CPT Copyright Statement

HCFA National Coverage Policy
N/A

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
03/15/2000

Revision Effective Date
10/01/2000

Revision Ending Effective Date
09/30/2000

Policy Ending Date
N/A

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

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

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

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider cardiac blood pool imaging studies medically reasonable and necessary for the following indications:

- Evaluation of a patient with suspected or known Coronary Artery Disease (CAD). A radionuclide ventriculogram assists in stratifying patients into low and high risk, thereby providing prognostic value. However, perfusion imaging is superior to exercise radionuclide ventriculograms. Therefore, current practice is to perform stress myocardial perfusion imaging in patients with suspected CAD.
- Evaluation of a patient after a Myocardial Infarction (MI). Assessment of the impact of the MI on ventricular function, identification of the physiologic importance of coronary stenosis outside the infarct distribution (i.e., extent in which viable myocardium is jeopardized), and risk stratification for future cardiac events is determined. Normally, a resting study is recommended.
- Assessment of right ventricular function, especially in patients with cor pulmonale or an acute inferior MI caused by right ventricular infarction.
- Evaluation and monitoring of a patient with dilated or hypertrophic cardiomyopathy. Restrictive cardiomyopathy is normally diagnosed with other noninvasive methods, therefore, radionuclide studies do not have a role in the diagnosis of restrictive cardiomyopathy.
- Evaluation of a patient with suspected or known valvular heart disease to determine ventricular function and estimate the degree of valvular regurgitation. Serial evaluations may be necessary in patients with asymptomatic aortic regurgitation to determine surgical timing. In addition to obtaining a resting left ventricular ejection fraction (usually by the gated blood pool technique) in the timing of surgery, exercise duration is also a key indicator.
- Evaluation and management of a patient with congestive heart failure. The most important imaging procedure is two-dimensional echocardiography, which can evaluate ventricular chamber size, regional and global wall motion, left ventricular wall thickness, and valvular

78472: Cardiac Blood Pool Imaging (continued)

function. Radionuclide angiography provides assessment of left ventricular ejection fraction and is quantified easier by a radionuclide rather than an echocardiographic technique.

- Evaluation and management of a patient with a neoplastic disease who will be receiving an anthracycline like neoplastic drug. Doxorubicin (an example of an arthracycline) is associated with the development of irreversible cardiotoxicity when given in doses of 450 mg/m2 or greater. Therefore, a resting left ventricular ejection fraction is recommended before starting therapy and again after receiving cumulative doses of 300 mg/m2 and 450 mg/m2. Other anthracyclines include drugs such as Daunorubicin, Epirubicin, Idarubicin, Mitoxantrone, and Valrubicin.
- Detection and quantification of intracardiac shunts for patients with congenital heart disease. The first pass technique is better than the gated technique for this indication.
- Evaluation of ventricular function during exercise to determine cardiac reserve in patients with congenital heart disease.
- To distinguish systolic from diastolic dysfunction in a patient with exertional dyspnea thought to be cardiac in etiology.
- Evaluation of a patient after cardiac surgery (e.g., coronary artery bypass graft) to determine the effect of the intervention on left ventricular function and the results are being used in the management of the patient (i.e., changes to patient's medication regime or medical intervention will occur).

HCPCS Section & Benefit Category

Cardiovascular System/Radiology

Type of Bill Code

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

Revenue Code

34x Nuclear Medicine

HCPS Codes

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

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

410.00-410.92	Acute myocardial infarction
411.1	Intermediate coronary syndrome
411.81	Coronary occlusion without myocardial infarction
413.0-413.9	Angina pectoris
414.00-414.05	Coronary atherosclerosis
414.8	Other specified forms of chronic ischemic heart disease
414.9	Chronic ischemic disease, unspecified
416.9	Chronic pulmonary heart disease, unspecified
424.0	Mitral valve disorders
424.1	Aortic valve disorders
425.1	Hypertrophic obstructive cardiomyopathy
425.4	Other primary cardiomyopathies
428.0-428.9	Heart failure
745.0-745.9	Bulbus cordis anomalies and anomalies of cardiac septal closure
746.00-746.9	Other congenital anomalies of heart
786.05	Shortness of breath
E930.7	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antineoplastic antibiotics
E933.1	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antineoplastic and immunosuppressive drugs
V58.83	Encounter for therapeutic drug monitoring
V67.00	Follow-up examination following surgery, unspecified
V67.09	Follow-up examination following other surgery

Diagnosis that Support Medical Necessity

N/A

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

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

78472: Cardiac Blood Pool Imaging (continued)

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

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

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

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

Effective for services on or after 10/01/2000, diagnosis code V58.83 should be used when the imaging is being performed for the evaluation and management of a patient with a neoplastic disease who will be or is receiving an anthracycline like neoplastic drug. The E codes (E930.7 or E933.1) should be used when the patient is experiencing adverse events to the anthracycline like neoplastic drug.

Documentation Requirements

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

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

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

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

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

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

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 Chapter of the American College of Cardiology.

Start Date of Comment Period

N/A

Start Date of Notice Period

10/01/2000

Revision History

Revision Number:	2
Start Date of Comment Period:	N/A
Start Date of Notice Period:	10/01/2000 Oct/Nov 2000 Bulletin
Revised Effective Date:	10/01/2000
Explanation of Revision:	Numerous inquires have been received regarding the appropriate diagnosis to bill prior to beginning anthracycline like neoplastic drugs. A policy revision was needed to address this issue. Annual ICD-9-CM Update

Revision Number:	1
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/25/2000 Special Issue 2000
Revised Effective Date:	08/01/2000
Explanation of Revision:	Outpatient PPS implementation.
Start Date of Comment Period:	11/15/99
Start Date of Notice Period:	02/2000 Feb/Mar 2000 Bulletin
Original Effective Date:	03/15/2000 ❖

80100: Qualitative Drug Screen

Revision Overview—The "Coding Guidelines" section of the policy has been revised to provide information regarding the proper billing of CPT procedure codes 80100 and 80101.

Policy Number
80100

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Qualitative Drug Screen

AMA CPT Copyright Statement

HCFA National Coverage Policy
N/A

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
07/22/1999

Revision Effective Date
09/13/2000

Revision Ending Effective Date
09/12/2000

Policy Ending Date
N/A

LMRP Description
A qualitative drug screen is used to detect the presence of a drug in the body. A blood or urine sample may be used. However, urine is the best specimen for broad qualitative screening, as blood is relatively insensitive for many common drugs, including psychotropic agents, opioids, and stimulants.

Current methods of drug analysis include chromatography, immunoassay, chemical ("spot") tests, and spectrometry. Analysis is comparative, matching the properties or behavior of a substance with that of a valid reference compound (a laboratory must possess a valid reference agent for every substance that it identifies). Drugs or classes of drugs are commonly assayed by qualitative screen, followed by confirmation with a second method.

Examples of drugs or classes of drugs that are commonly assayed by qualitative screen, followed by confirmation with a second method, are: alcohols, amphetamines, barbiturates, benzodiazepines, cocaine and metabolites, methadones, methaqualones, opiates, phencyclidines, phenothiazines, propoxyphenes, tetrahydrocannabinoids, and tricyclic antidepressants.

A qualitative drug screen may be indicated when the history is unreliable, with a multiple-drug ingestion, with a patient in delirium or coma, for the identification of specific drugs, and to indicate when antagonists may be used.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider performance of a qualitative drug screen medically reasonable and necessary when a patient presents with suspected drug overdose and one or more of the following conditions:

- Unexplained coma;
- Unexplained altered mental status;
- Severe or unexplained cardiovascular instability (cardiotoxicity);
- Unexplained metabolic or respiratory acidosis;
- Unexplained head trauma with neurological signs and symptoms;
- Suspected history of substance abuse; and/or
- Seizures with an undetermined history.

Additionally, a qualitative drug screen will be considered medically reasonable and necessary for patients receiving active treatment for substance abuse when the patient presents with clinical signs and/or symptoms of noncompliance (e.g., feelings of euphoria, panic, mood swings). Providers must report ICD-9-CM code 304.90 for this coverage indication.

A qualitative drug screen is **not** medically reasonable or necessary under the following circumstances:

- In known overdose cases when the patient is asymptomatic (responsive to verbal stimuli, and has no seizures, hypoventilation, or cardiac abnormalities other than sinus tachycardia after several hours of observation);
- When the clinical picture is consistent with the reported history;
- To screen for the same drug with both a blood and a urine specimen simultaneously;
- To routinely monitor substance abuse compliance (i.e., the patient does not present with clinical signs and/or symptoms indicative of noncompliance);
- For medicolegal purposes (i.e., court-ordered drug screening); or
- For employment purposes (i.e., as a pre-requisite for employment or as a means for continuation of employment).

80100: Qualitative Drug Screen (continued)

HCPCS Section & Benefit Category

Pathology and Laboratory/Drug Testing

Type of Bill Code

Hospital – 12x, 13x, 14x
Rural Health Clinic – 71x

Revenue Code

301 Chemistry

HCPCS Codes

80100	Drug, screen; multiple drug classes, each procedure
80101	single drug class, each drug class
80102	Drug, confirmation, each procedure

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

276.2	Acidosis
304.90	Unspecified drug dependence
345.9	Epilepsy, unspecified
780.01	Coma
780.09	Alteration of consciousness, other
977.9	Poisoning by unspecified drug or medicinal substance

Diagnosis that Support Medical Necessity

N/A

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

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

The codes used to report qualitative drug testing distinguish between screening tests (80100 and 80101) and confirmatory testing (80102). The screening tests are further distinguished by the methods used to analyze **multiple drug classes** (80100) and those that test for **a single drug class** (80101).

The codes are intended to distinguish among analytical methods rather than the platform or instrumentation on which a particular method is run.

For example, chromatography, which can identify multiple drug classes, is coded using 80100 (when used in drug screening). For code 80100, each combination of stationary and mobile phase is to be counted as one procedure. For example, if screening for three drugs by chromatography requires one stationary phase with three mobile phases, report 80100 three times. However, if multiple drugs can be detected using a single analysis (e.g., one stationary phase with one mobile phase), report 80100 only once.

Immunoassays, which are used to identify single drug classes, should be coded using 80101 (when used in drug screening), whether the test is performed using a random access analyzer, a single analyte test kit, or a multiple analyte test kit. For procedure code 80101, each single drug class method tested and reported is to be counted as one drug class. For example, if a sample is aliquoted to five wells and separate class-specific immunoassays are run on each of the five wells and reported separately, report 80101 five times. Similarly, if a sample is run on a rapid assay kit comprising five class-specific immunoassays in a single kit, and the five classes are reported separately, code 80101 should be reported five times.

Use procedure code 80102 for each procedure necessary for confirmation. For example, if confirmation of three drugs by chromatography requires three stationary or mobile phases, bill 80102 three times. However, if multiple drugs can be confirmed using a single analysis, bill 80102 only once.

For **quantitation** of drugs screened, use the appropriate code (80150-80299 or 82000-84999).

Documentation Requirements

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

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

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

American Medical Association. (2000). Reporting drug testing codes. *CPT Assistant*, 10 (3), 1-3.

Ellenhorn, M.J., Schonwald, S., Ordog, G., et. al. (1997). *Ellenhorn's medical toxicology: diagnosis and treatment of human poisoning* (2nd ed.). Baltimore: Williams and Wilkins.

Fauci, A., Braunwald, E., Isselbacher, K. et. al. (1998).

80100: Qualitative Drug Screen (continued)

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Goldfrank, L.R., Flomenbaum, N.E., Lewin, N.H., et. al. (1998). *Goldfrank's toxological emergencies* (6th ed.). Stamford: Appleton and Lange.

Tierney, L.M., McPhee, S.J., and Papadakis, M.A. (Eds.). (1998). *Current medical diagnosis and treatment* (37th ed.). Stamford: Appleton and Lange.

Advisory Committee Notes

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

Start Date of Comment Period

N/A

Start Date of Notice Period

10/01/2000

Revision History

Revision Number:	1
Start Date of Comment Period:	N/A
Start Date of Notice Period:	10/01/2000 *Oct/Nov 2000 Bulletin*
Revised Effective Date:	09/13/2000
Explanation of Revision:	March 2000 *cpt Assistant* provided billing clarification regarding procedure code 80100 that has been incorporated into the policy.
Start Date of Comment Period:	02/08/99
Start Date of Notice Period:	06/01/1999 *June/July 1999 Bulletin*
Original Effective Date:	07/22/99 ❖

83540: Iron

Revision Overview—A new indication of coverage and additional information to two existing covered conditions were added to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy.

Policy Number
83540

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
83540

AMA CPT Copyright Statement

HCFA National Coverage Policy
N/A

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
03/26/1997

Revision Effective Date
08/03/2000

Revision Ending Effective Date
08/02/2000

Policy Ending Date
N/A

LMRP Description
Iron is essential to the formation and function of hemoglobin. Iron is contained in several components. Transferrin (also called siderophilio), regulates iron absorption. High levels of transferrin relate to the ability of the body to deal with infections. Total iron-binding capacity (TIBC) measures the amount of iron that would appear in plasma if all the transferrin were saturated with iron. Normally, transferrin is about 30% saturated, serum iron 70-150 mcg/dl and TIBC 300-450 mcg/dl.

Iron deficiency is the most common cause of anemia and is probably the most common dietary deficiency. Iron deficiency may develop from blood loss, decreased iron absorption, or increased iron supplements.

Iron excess in the body can also cause severe systemic diseases.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider iron, iron-binding capacity and transferrin tests medically reasonable and necessary for the following conditions:

- Diagnosis of hemochromatosis. Patients with this disease are often asymptomatic, however, may present with right upper quadrant abdominal pain, weakness, fatigue, joint pain, skin pigmentation, impotence, and loss of libido. The clinical findings associated with this disease include but are not limited to hepatomegaly, diabetes mellitus, bronze skin discoloration, inflammatory arthritis, and an increased suspectibility to infection.
- Distinguish between iron deficiency anemia and anemia of chronic disease.
- Evaluation of thalassemia. Thalassemias are inherited disorders characterized by hypochromic microcytic anemia caused by decreased synthesis of one of the globin chains. The symptoms and clinical findings associated with this disorder involve the hematologic system, skeletal abnormalities, hepatic changes, cardiopulmonary abnormalities, and other organs. The key signs and symptoms of thalassemias are pallor, fatigue, dark urine, anemia, jaundice, hepatosplenomegaly, Cooley's anemia facies (hypertrophy and expansion of erythroid marrow, maxilla is overgrown resulting in malocclusion of teeth), and cardiac failure/dilation.
- To determine response to iron therapy.
- Evaluate iron poisoning (toxicity) and overload in renal dialysis patients or patients with transfusion dependent anemias.

The ferritin level is normally performed in conjunction with iron to determine iron storage status.

HCPCS Section & Benefit Category
Pathology and Laboratory/Chemistry

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

Revenue Code
301 Laboratory Chemistry

HCPCS Codes
83540 Iron
83550 Iron binding capacity
84466 Transferrin

Not Otherwise Classified Codes (NOC)
N/A

83540: Iron (continued)

ICD-9-CM Codes that Support Medical Necessity

275.0	Disorders of iron metabolism
280.0-289.9	Diseases of the blood and blood-forming organs
571.5	Cirrhosis of liver without mention of alcohol
572.8	Other sequelae of chronic liver disease
585	Chronic renal failure
790.4	Nonspecific elevation of levels of transaminase or lactic acid dehydrogenase LDH
790.5	Other nonspecific abnormal serum enzyme levels

Diagnosis that Support Medical Necessity

N/A

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

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

N/A

Documentation Requirements

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

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

Utilization Guidelines

N/A

Other Comments

Terms Defined:

Anemia—a condition in which there is a reduction in number of circulating red blood cells or in hemoglobin, or in the volume of packed red cells per 100 ml. of blood or a combination of two or more of these factors.

Hemoglobin—the iron containing pigment of the red blood cells; its function is to carry oxygen from the lungs to the tissues.

Pernicious anemia—anemia due to Vitamin B-12 deficiency. Blood disease marked by progressive decrease in red blood corpuscles, muscular weakness, and gastrointestinal and neural disturbances.

Polycythemia—an excess of red blood cells.

Iron overload—excess iron storage in multiple organs. May be hereditary or acquired.

Hemochromatosi—a disease characterized pathologically by excess deposits of iron throughout the body (i.e., bronzed diabetes).

Thalassemia—a hereditary anemia due to a genetically-transmitted abnormality, with familial or racial incidence.

Sources of Information

Hurst, J. (1983). *Medicine for the Practicing Physician.* Boston: Butterworth Publishers.

Jacobs, D. (1996). *Laboratory Test Handbook* (4th ed.). Hudson: Lexi-Comp Inc.

Rakel, R. E. (2000). *Saunders Manual of Medical Practice* (2nd ed.). Philadelphia; W. B. Saunders Co.

Springhouse. (1994). *Illustrated Guide to Diagnostic Tests*. Springhouse: Springhouse Corporation.

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 Pathology, Hematology, and Oncology specialties.

Start Date of Comment Period

N/A

Start Date of Notice Period

10/01/2000

Revision History

Revision Number:	1
Start Date of Comment Period:	N/A
Start Date of Notice Period:	10/01/2000
	Oct/Nov 2000 Bulletin
Revised Effective Date:	08/03/2000
Explanation of Revision:	Upon the development of an internal working document for this policy, it was determined that an indication needed to be added.
Start Date of Comment Period:	None needed
Start Date of Notice Period:	02/25/97
Original Effective Date:	03/26/97 ❖

84484: Troponin

Revision Overview—Additions and clarifications to further identify when a Troponin test is medically necessary were added to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy.

Policy Number
84484

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Troponin

AMA CPT Copyright Statement

HCFA National Coverage Policy
Program Memorandum AB 98-42

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
11/02/1998

Revision Effective Date
08/10/2000

Revision Ending Effective Date
08/09/2000

Policy Ending Date
N/A

LMRP Description
Troponin is a muscle protein that attaches to both actin and tropomyosin. It is concerned with calcium binding and inhibiting cross-bridge formation. Troponin is a complex of three proteins: troponin C, troponin I, and troponin T. The distribution of these isoforms varies between cardiac muscle and slow- and fast-twitch skeletal muscle. Their importance lies in the fact that the isoforms troponin I and troponin T show a high degree of cardiac specificity, and therefore, have an important role in the diagnostic evaluation of a patient presenting with symptoms suggestive of a cardiac origin.

Cardiac Troponin I (cTnI) is highly specific for myocardial tissue, is thirteen times more abundant in the myocardium than CK-MB on a weight basis, is not detectable in the blood of healthy persons, shows a greater proportional increase above the upper limit of the reference interval in patients with myocardial infarction and remains elevated for seven to ten days after an episode of myocardial necrosis. In addition, measurements of cTnI is useful to clarify which increases in CK-MB are due to myocardial injury and which ones reflect acute or chronic skeletal muscle abnormalities.

Troponin T, the tropomyosin-binding protein of the regulatory complex located on the contractile apparatus of cardiac myocytes, is also a sensitive and specific marker for myocardial necrosis. Damaged heart muscle releases the protein, troponin T, which increases in the bloodstream as early as 3 hours after the onset of chest pain and remains at an elevated level for 2 to 7 days.

Indications and Limitations of Coverage and/or Medical Necessity
Troponin levels are considered medically reasonable and necessary to rule out myocardial injury only under the following conditions:

- patient presents with signs and symptoms of an acute myocardial infarction (prolonged chest pain often described as squeezing, choking, stabbing, etc., usually spreading across chest to the left arm; dyspnea, diaphoresis) which is confirmed by an electrocardiogram (EKG, ECG);
- patient presents with vague or atypical symptoms suggestive of a cardiac origin, which is not confirmed by an electrocardiogram;
- patient evaluation reveals a normal creatine kinase MB isoenzyme (CK-MB), however, the EKG demonstrates new changes consistent with ischemia (e.g., flipped T waves, ST-segment depression); or
- to distinguish patients with unstable angina from those with a non-Q wave myocardial infarction.

Initially, it is expected that a qualitative Troponin level (procedure code 84512) is performed on a patient with suspected myocardial injury. If the results of the qualitative Troponin level is positive, then the quantitative level of Troponin I or Troponin T (procedure code 84484) is performed, usually with the same blood specimen, to determine if the symptoms are cardiac in nature. The Troponin C isoform is not useful in the management of myocardial infarction and it is not necessary to monitor both the T and I isoform.

The quantitative test is normally performed every 8-12 hours the first 24 hours. Once the determination is made whether myocardial injury has occurred, it is expected that a Troponin level will be performed only when the results are to be used in the active treatment of the patient.

Also, it is not necessary to use Troponin in addition to Creatine Kinase (procedure codes 82550-82554) in the management of patients with myocardial infarction.

84484: Troponin (continued)

HCPCS Section & Benefit Category

Pathology and Laboratory/Chemistry

Type of Bill Code

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

Revenue Code

301 Chemistry

HCPCS Codes

84484	Troponin, quantitative
84512	Troponin, qualitative

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

410.00-410.92	Acute myocardial infarction
411.1	Intermediate coronary syndrome
413.0-413.9	Angina pectoris
427.0-427.9	Cardiac dysrhythmias
785.0	Tachycardia, unspecified
786.03-786.09	Dyspnea and respiratory abnormalities
786.50-786.59	Chest pain
794.31	Abnormal electrocardiogram [ECG][EKG]

Diagnosis that Support Medical Necessity

N/A

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

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

Troponin levels are not a covered service when performed as a routine screening procedure or in the absence of documentation of clinical findings in the patient's medical record indicating suspected myocardial injury.

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

One unit of troponin is equivalent to one order for 84484 or one order for 84512 regardless of the number or mix of isoforms provided. Therefore, regardless of the number of isoforms or mixture of isoforms provided, only one unit may be billed for each code.

Documentation Requirements

The medical records must document the medical necessity of the test including the test results. This information is usually found in the office/progress notes, emergency/hospital notes, and/or laboratory results.

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

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

Adams III, Schechtman, K., Landt, Y., Ladenson, J., & Jaffe, A. (1994). Comparable Detection of Acute Myocardial Infarction by Creatine Kinase MB Isoenzyme and Cardiac Troponin I. *Clinical Chemistry*, 40 (7), 1291-1295.

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Antman, E., Tanasijevic, M., Thompson, B., et al. (1996). Cardiac-specific Troponin I levels to predict the risk of mortality in patients with acute coronary syndromes. *The New England Journal of Medicine*, 335 (18), 1342-1349.

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Advisory Committee Notes

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

Start Date of Comment Period

N/A

Start Date of Notice Period

10/01/2000

Revision History

Revision Number:	3	
Start Date of Comment Period:	N/A	
Start Date of Notice Period:	10/01/2000 *Oct/Nov 2000 Bulletin*	
Revised Effective Date:	08/10/2000	
Explanation of Revision:	An evaluation in the use of both Troponin and CK-MB in the evaluation of patients warranted a revision to the indications section to better clarify the indications of coverage.	
Start Date of Comment Period:	N/A	
Start Date of Notice Period:	12/07/98	
Original Effective Date:	11/02/98	
Revision Date/Number:	11/02/98	2
Start Date of Comment Period:	N/A	
Start Date of Notice Period:		
Original Effective Date:	11/02/98	
Revision Date/Number:	10/01/98	1
1999 ICD-9-CM update		
Start Date of Comment Period:	10/31/97	
Start Date of Notice Period:	09/18/98	
Original Effective Date:	11/02/98 ❖	

93875: Noninvasive Extracranial Arterial Studies

Revision Overview—ICD-9-CM diagnosis codes 433.30 and 433.31 have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy for procedure codes 93875, 93880 and 93882 effective August 2, 2000. The same section of the policy has been revised to include changes and additions affected by the implementation of the 2001 ICD-9-CM update. The "Revenue Code" section of the policy has been revised to include additional revenue codes based on the outpatient prospective payment system (OPPS) initiative effective August 1, 2000.

Policy Number
93875

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Noninvasive Extracranial Arterial Studies

AMA CPT Copyright Statement

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

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
11/15/1999

Revision Effective Date
10/01/2000

Revision Ending Effective Date
09/30/2000

Policy Ending Date
N/A

LMRP Description
Non-invasive extracranial arterial studies involve the use of direct and occasionally indirect methods of ultrasound to evaluate and monitor the blood vessels that supply the brain. The direct methods of assessment are Doppler and duplex ultrasound, whereas the indirect methods include techniques such as oculoplethysmography.

Doppler ultrasonography is used to evaluate hemodynamic parameters, specifically the velocity of blood flow and the pattern or characteristics of flow. The Doppler ultrasound involves the evaluation of the supraorbital, common carotid, external carotid, internal carotid, and the vertebral arteries in the extracranial cerebrovascular assessment.

The second key component of vascular diagnostic ultrasound is the B-mode, or brightness-mode image. This real time imaging technique provides a two-dimensional gray-scale image of the soft tissues and vessels based on the acoustic properties of the tissues.

Duplex ultrasonography combines the direct visualization capabilities of B-mode ultrasonography and the blood-flow velocity measurements of Doppler ultrasonography.

In addition to the direct methods of Doppler and duplex ultrasonography to evaluate the cerebrovascular arterial system, indirect methods such as supraorbital Doppler ultrasonography and oculoplethysmography are used as an adjunct to assess the carotid artery. Supraorbital Doppler ultrasonography indirectly assesses blood flow from collateral branches of the internal carotid artery through the supraorbital vessels. This test is done by placing a directional Doppler probe over a supraorbital artery and observing the flow with and without compression of neighboring arteries. Oculoplethysmography indirectly measures blood flow in the ophthalmic artery by graphically recording ocular pulses obtained from corneal cups held in place by mild suction. Because the ophthalmic artery is the first major branch of the internal carotid artery, its blood flow accurately reflects carotid blood flow and ultimately that of cerebral circulation.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider non-invasive extracranial arterial studies medically reasonable and necessary under the following circumstances:

- To evaluate a patient with suspected occlusive cerebrovascular disease as demonstrated by the presence of transient ischemic attacks (TIA's), possible carotid bruit(s), diminished or absent pulses in the neck or arms, and/or a blood pressure difference in 2 arms of greater than 10mmHg.
- To evaluate a patient with signs/symptoms of subclavian steal syndrome. The symptoms usually associated with subclavian steal syndrome are a bruit in the supraclavicular fossa, unequal radial pulses, arm claudication following minimal exercise, and a difference of 20mmHg or more between the systolic blood pressures in the arms.
- To monitor a patient with known carotid stenosis. Patients demonstrating a diameter reduction of 30-50% are normally followed on an annual basis, whereas

93875: Noninvasive Extracranial Arterial Studies (continued)

patients with a diameter reduction greater than 50% are normally followed every six months. It is not necessary to monitor patients with a diameter reduction of less than 30%.

- To evaluate a patient with transient monocular blindness (amaurosis fugax). Normally a patient with this symptom is evaluated with an ocular pneumoplethysmography.
- To monitor patients who are post carotid endarterectomy. These patients are normally followed with duplex ultrasonography on the affected side at 6 weeks, 6 months, 1 year, and annually thereafter.
- To initially evaluate a patient presenting with an asymptomatic carotid bruit identified on physical examination. Routine monitoring of a patient with an asymptomatic carotid bruit without evidence of carotid stenosis is considered screening, and therefore, noncovered.
- To initially evaluate a patient who has had a recent stroke (recent is defined as less than six months) to determine the cause of the stroke.
- To evaluate a patient presenting with an injury to the carotid artery.
- To evaluate a patient with a suspected aneurysm of the carotid artery. This is suspected in patients with swelling of the neck particularly if occurring post carotid endarterectomy.
- To preoperatively validate the degree of carotid stenosis of a patient whose previous duplex scan revealed a greater than 70% diameter reduction. The duplex is only covered when the surgeon questions the validity of the previous study and the repeat test is being performed in lieu of a carotid arteriogram.

NOTE: The current medical literature contains inconclusive information regarding the evaluation and monitoring of patients with asymptomatic carotid bruits. Even though the presence of bruit increases the likelihood of finding disease of extracranial carotid arteries, it does not necessarily indicate severe stenosis. Also, the predictive value of a bruit is questioned when severe disease is found in patients without a bruit.

In addition, the literature supports that the test of choice for all the above indications is the duplex scan, which is represented by procedure code 93880 and 93882.

Since, the standard for the above indications is a color-duplex scan, portable equipment must be able to produce combined anatomic and spectral flow measurements.

HCPCS Section & Benefit Category

Non-invasive Vascular Diagnostic Studies/Medicine

Type of Bill Code

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

Revenue Code

920 General Classification, Other Diagnostic Services
921 Peripheral Vascular Lab
929 Other Diagnostic Services

HCPCS Codes

93875	Non-invasive physiologic studies of extracranial arteries, complete bilateral study (eg, periorbital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis)
93880	Duplex scan of extracranial arteries; complete bilateral study
93882	unilateral or limited study

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

362.34	Transient arterial occlusion
433.10	Occlusion and stenosis of carotid artery without mention of cerebral infarction
433.11	Occlusion and stenosis of carotid artery with cerebral infarction
433.30	Occlusion and stenosis of multiple and bilateral precerebral arteries without mention of cerebral infarction
433.31	Occlusion and stenosis of multiple and bilateral precerebral arteries with cerebral infarction
434.00-434.91	Occlusion of cerebral arteries
435.0	Basilar artery syndrome
435.1	Vertebral artery syndrome
435.2	Subclavian steal syndrome
435.3	Vertebrobasilar artery syndrome
435.8	Other specified transient cerebral ischemias
435.9	Unspecified transient cerebral ischemia
436	Acute, but ill-defined, cerebrovascular disease
442.81	Other aneurysm of artery of neck
785.9	Other symptoms involving cardiovascular system (carotid bruit)
900.00	Injury to carotid artery, unspecified
900.01	Injury to common carotid artery
900.02	Injury to external carotid artery
900.03	Injury to internal carotid artery
V67.00	Follow-up examination following surgery, unspecified
V67.09	Follow-up examination following other surgery

Diagnosis that Support Medical Necessity

N/A

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

N/A

93875: Noninvasive Extracranial Arterial Studies (continued)

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

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

The use of a single hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be part of the physical examination of the vascular system and is not separately reimbursed under procedure codes 93875, 93880, or 93882.

Since a duplex scan of the extracranial arteries includes the combined capabilities of the B-mode and Doppler ultrasonography, it is not expected that procedure code 93875 will be billed in addition to a duplex scan (93880 or 93882).

Documentation Requirements

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

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

Utilization Guidelines

N/A

Other Comments

Terms Defined:

Amaurosis fugax—a sudden and brief loss of vision in one eye.

Bruit—an adventitious sound of venous or arterial origin heard on auscultation.

Carotid bruit—a murmur heard in the cervical area that does not disappear with venous compression, is maximal over the carotid bifurcation, and are not due to transmitted cardiac murmurs. The presence of asymptomatic carotid bruits increases with advanced age, but is not associated with increased risk for stroke in elderly patients. In addition, carotid bruits may spontaneously disappear without sequelae.

Cerebrovascular accident (CVA)—a focal neurological abnormality confined to one cerebral hemisphere which persists for more than 24 hours.

Subclavian Steal Syndrome—a shunting of blood, which was destined for the brain, away from the cerebral circulation. This occurs when the subclavian artery is occluded. Blood then flows from the opposite vertebral artery across to and down the vertebral artery on the side of the occlusion.

Transient Ischemic Attacks (TIAs)—a temporary interference with blood supply to the brain. The symptoms of neurological deficit may last for only a few moments or several hours (usually less than 24 hours). After the attack no evidence of residual brain damage or neurological damage remains. The neurological deficits may include such symptoms as contralateral weakness, speech alterations, visual disturbances, etc.

Sources of Information

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93875: Noninvasive Extracranial Arterial Studies (continued)

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Advisory Committee Notes

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

Start Date of Comment Period

N/A

Start Date of Notice Period

10/01/2000

Revision History

Revision Number: 3
Start Date of Comment Period: N/A
Start Date of Notice Period: 10/01/2000
Oct/Nov 2000 Bulletin
Revised Effective Date: 10/01/2000
Explanation of Revision: Annual ICD-9-CM update

Revision Number: 2
Start Date of Comment Period: N/A
Start Date of Notice Period: 02/25/2000
Special Issue 2000
Revised Effective Date: 08/01/2000
Explanation of Revision: Outpatient PPS implementation

Revision Number: 1
Start Date of Comment Period: N/A
Start Date of Notice Period: 10/01/2000
Oct/Nov 2000 Bulletin
Revised Effective Date: 08/02/2000
Explanation of Revision: An evaluation was completed and it was determined to be appropriate to perform this study for diagnoses 433.30 and 433.31.

Start Date of Comment Period: 07/06/99
Start Date of Notice Period: 10/01/99
Oct/Nov 1999 Bulletin
Original Effective Date: 11/15/99 ❖

95004: Allergy Skin Tests

Revision Overview—CPT code 95004 has been deleted from the list of codes that are noncovered for food allergy testing in the "Noncovered ICD-9-CM Code(s)" and "Noncovered Diagnosis" sections of the policy.

Policy Number
95004

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Allergy Skin Tests

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual 50-53
Medicare Hospital Manual, Sections 442 and 443

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
07/17/2000

Revision Effective Date
08/31/2000

Revision Ending Effective Date
08/30/2000

Policy Ending Date
N/A

LMRP Description
Allergic or hypersensitivity disorders may be manifested by generalized systemic reactions as well as localized reactions in any part of the body. The reactions may be acute, subacute, or chronic, immediate or delayed, and may be caused by a variety of offending agents; pollen, molds, dust, feathers, fur, venoms, foods, drugs, etc.

Allergy testing is performed to determine a patient's sensitivity to particular allergens and is based on findings during a complete history and physical exam of the patient.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider allergy testing to be a covered service when medically necessary as evidenced by signs and symptoms or a diagnosis suggestive of allergies such as asthma, allergic rhinitis; or a history of hypersensitivity to animals, hay, pollen, dust, mold, grass, bee/wasp, etc.

The use of sublingual, intracutaneous, and subcutaneous provocative and neutralization testing and neutralization therapy for food allergies are not covered under the Medicare program because available evidence does not show that these tests and therapies are effective.

HCPCS Section & Benefit Category
Medicine/Allergy and Clinical Immunology

Type of Bill Code
Hospital – 13x

Revenue Code
924 Allergy Test

HCPCS Codes

95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, specify number of tests
95010	Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, specify number of tests
95015	Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, intermediate type reaction, specify number of tests
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, specify number of tests
95027	Skin end point titration
95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests
95078	Provocative testing (e.g., Rinkel test)

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
N/A

Diagnosis that Support Medical Necessity
N/A

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

Diagnosis that DO NOT Support Medical Necessity
N/A

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

95004: Allergy Skin Tests (continued)

Noncovered ICD-9-CM Code(s)

The following ICD-9-CM codes are noncovered for procedure codes 95010, 95015, 95024, 95027, 95028, and 95078:

692.5	Contact dermatitis and other eczema due to food in contact with skin
693.1	Dermatitis due to food
995.60-995.69	Anaphylactic shock due to adverse food reaction

Noncovered Diagnosis

Food allergies are noncovered for procedure codes 95010, 95015, 95024, 95027, 95028, and 95078.

Coding Guidelines

When coding for allergy skin tests indicate (1) unit for each test performed. For example, if 18 scratch tests are performed with allergenic extracts, bill procedure code 95004 indicating 18 units.

Documentation Requirements

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

Utilization Guidelines

N/A

Other Comments

Terms Defined:

Allergen—any substance that causes manifestations of allergy.

Allergy—an acquired, abnormal immune response to a substance (allergen) that does not normally cause a reaction.

Asthma—a disease caused by increased responsiveness of the tracheobronchial tree to various stimuli.

Sources of Information

N/A

Advisory Committee Notes

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

Start Date of Comment Period

N/A

Start Date of Notice Period

10/01/2000

Revision History

Revision Number:	1
Start Date of Comment Period:	N/A
Start Date of Notice Period:	10/01/2000
	Oct/Nov 2000 Bulletin
Revised Effective Date:	08/31/2000
Explanation of Revision:	Deletion of CPT code 95004 from the list of codes that are noncovered for food allergy testing.

Revision Number:	Original
Start Date of Comment Period:	02/21/2000
Start Date of Notice Period:	06/01/2000
	June/July 2000 Bulletin
Original Effective Date:	07/17/2000 ❖

95115: Allergen Immunotherapy

Policy Number
95115

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Allergen Immunotherapy

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Hospital Manual, Section 442

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
11/15/2000

Revision Effective Date
NA

Revision Ending Effective Date
N/A

Policy Ending Date
N/A

LMRP Description
Allergen immunotherapy (desensitization), also referred to as specific immunotherapy, is the subcutaneous introduction of increasing doses of allergens to which the patient is sensitive. Allergen immunotherapy is antigen-specific; thus the sensitivity of the patient must be known before formulating extracts for therapy. The antigenic cross-reactivity of extracts should be known by the physician to optimize use of the minimum number of separate extracts given per single injection. In this way, the maximum amount of protein antigen can be given.

This therapy is generally reserved for patients with significant relapsing, subacute to chronic symptoms, where the symptoms are likely caused by allergic pathology, and in situations where other means of conservative therapy (including avoidance) have failed to control the symptoms adequately, or avoidance of the relevant allergen (e.g., dust mites, pollen, mold) is impractical.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will provide coverage for allergen immunotherapy for patients with allergic rhinitis, allergic conjunctivitis, or asthma when **all four** of the following criteria are met:

1. the patient must have significant exposure to an allergen;
2. the patient must have demonstrated a significant level of sensitivity to the allergen;
3. the pattern of symptoms must conform to the pattern of exposure; and
4. other means of conservative therapy (including avoidance) have failed to control the symptoms, or avoidance of the relevant antigen (e.g., dust mites, pollen, mold) is impractical.

Generally, the course of allergen immunotherapy, if successful, should be continued until the patient has been symptom-free or has had substantially reduced symptoms for 1 to 2 years and in most cases from 3 to 5 years. If no response has occurred after 1 year at maintenance dose, the patient's sensitivities should be reviewed. All patients on immunotherapy should be encouraged to maintain environmental control and may have to use concomitant medication, such as antihistamines.

HCPCS Section & Benefit Category
Medicine/Allergy and Clinical Immunology

Type of Bill Code
Hospital – 13x

Revenue Code
924 Allergy Test

HCPCS Codes

95115	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection
95117	two or more injections
95165	Professional services for the supervision and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

372.05	Acute atopic conjunctivitis
372.14	Other chronic allergic conjunctivitis
477.0	Allergic rhinitis due to pollen
477.8	Allergic rhinitis due to other allergen
493.00-493.02	Extrinsic asthma (allergic asthma)
493.90-493.92	Asthma, unspecified (allergic bronchial asthma)

Diagnosis that Support Medical Necessity
N/A

95115: Allergen Immunotherapy (continued)

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

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

You may choose to use HCPCS code 95115 to report all allergy therapies provided during a visit, without regard to the type or number of antigens, or you may report each of the HCPCS codes in this policy separately.

Documentation Requirements

Medical record documentation maintained by the treating physician must clearly document the medical necessity to initiate allergen immunotherapy and the continued need thereof. The documentation should include:

- A history and physical that documents the following: a complete allergic history and physical examination, correlation of symptoms, occurrence of symptoms, exposure profile, documentation of allergic sensitization by accepted means and where attempts at avoidance have proven unsuccessful (or the impracticality of avoidance exists), and a copy of the sensitivity results.
- Progress notes that document physician management during the course of the allergic disease, anticipated length of treatment, and explanation of any deviations from normal treatment frequency.

Utilization Guidelines

N/A

Other Comments

Terms Defined:

Allergen—any substance that indicates a state of, or brings on manifestations of, allergy.

Allergy—an altered reaction of body tissues to a specific substance (allergen) which in nonsensitive persons will, in similar amounts, produce no effect.

Asthma—a reversible obstructive lung disorder characterized by increased responsiveness of the airways.

Immunotherapy—the production or enhancement of immunity.

Rhinitis—inflammation of the nasal mucosa.

Sources of Information

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Theodoropoulos, D.S. & Lockey, R.F. (2000). Allergen immunotherapy: Guidelines, update, and recommendations of the World Health Organization. *Allergy Asthma Proc. 2000, 21*(3), 159-166.

Advisory Committee Notes

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Start Date of Comment Period

06/12/2000

Start Date of Notice Period

10/01/2000

Revision History

Revision Number:	Original
Start Date of Comment Period:	06/01/2000
Start Date of Notice Period:	10/01/2000
	Oct/Nov 2000 Bulletin
Original Effective Date:	11/15/2000 ❖

95934: H-Reflex Study

Policy Number
95934

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
H-Reflex Study

AMA CPT Copyright Statement

HCFA National Coverage Policy
N/A

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
11/15/2000

Revision Effective Date
N/A

Revision Ending Effective Date
N/A

Policy Ending Date
N/A

LMRP Description
The H-reflex study is an electrodiagnostic nerve conduction study that provides information about the conduction of impulses through the proximal segments of a nerve. The study assesses sensory and motor nerve function and their connections in the spinal cord. This information is not obtainable by routine nerve conduction techniques.

The H-reflex represents the time required for a stimulus applied to a sensory nerve to travel to the spinal cord and return down the motor nerve (a type of late response). H-reflex studies usually involve assessment of the tibial motor nerve and the gastrocnemius/soleus muscle complex, although additional studies of other muscles are occasionally indicated. Generally, only one or two H-reflex studies are performed on a patient during a given encounter. The H-reflex is one of the few measures of afferent nerve conduction in proximal portions of sensory nerves and identifies dorsal root pathology when the H-reflex is prolonged in conjunction with normal F-wave response latency in the same nerve.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider the use of H-reflex studies to be medically reasonable and necessary when disease involving very proximal segments of a peripheral nerve is suspected (e.g., radiculopathies, neuropathies, and Guillain-Barre' syndrome).

H-reflexes are almost always recorded from the gastrocnemius/soleus muscles of the leg. Therefore, procedure code 95934 represents the most common H-reflex study performed. Occasionally, complex clinical conditions require H-reflex testing in other muscles. Procedure code 95936 represents testing in these nonstandard muscles. An example of this would be H-reflex testing in the upper limbs (flexor carpi radialis muscle) for conditions such as cervical radiculopathies or brachial plexopathies. Other muscles that rarely may be tested are the intrinsic small muscles of the hand and foot. Medical record documentation must support the use of testing in these other, nonstandard muscle groups.

HCPCS Section & Benefit Category
Medicine/Neurology and Neuromuscular Procedures

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

Revenue Code
92x Other Diagnostic Services

HCPCS Codes

95934	H-Reflex, amplitude and latency study; record gastrocnemius/soleus muscle
95936	record muscle other than gastrocnemius/soleus muscle

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

250.60-250.63	Diabetes with neurological manifestations
356.0-356.9	Hereditary and idiopathic peripheral neuropathy
357.0-357.9	Inflammatory and toxic neuropathy
722.80-722.83	Postlaminectomy syndrome
723.4	Brachial neuritis or radiculitis NOS
724.3	Sciatica
724.4	Thoracic or lumbosacral neuritis or radiculitis, unspecified

Diagnosis that Support Medical Necessity
N/A

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

Diagnosis that DO NOT Support

95934: H-Reflex Study (continued)

Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

Procedure codes 95934 and 95936 represent unilateral procedures and are reported per study. Documentation should support the bilateral study, if performed and should be billed with modifier –50 (Bilateral procedure).

Documentation Requirements

Medical record documentation maintained by the performing physician must clearly indicate the medical necessity of the service being billed. In addition, documentation that the service was performed must be included in the patient's medical record. This documentation should include a printed recording of the test results. This information is normally found in the office/ progress notes, hospital notes, and/or procedure notes.

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

For bilateral procedures, medical record documentation should support the rationale as addressed in the "Coding Guidelines" section of this policy.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

American Medical Association. (1996). New codes for H-reflex and F-wave studies. *cpt Assistant*, 6 (1), 1-4

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Advisory Committee Notes

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

Start Date of Comment Period

06/12/2000

Start Date of Notice Period

10/01/2000

Revision History

Revision Number:	Original
Start Date of Comment Period:	06/12/2000
Start Date of Notice Period:	10/01/2000
	Oct/Nov 2000 Bulletin
Original Effective Date:	11/15/2000 ❖

G0102: Prostate Cancer Screening

Revision Overview—"Type of Bill Code" and "Revenue Code" sections have been revised. New coding guidelines have been added to the "Coding Guidelines" section of the police.

Policy Number
G0102

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Prostate Cancer Screening

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Section 50-55
Medicare Intermediary Manual, Section 3616
Medicare Hospital Manual, Section 424

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
01/01/2000

Revision Effective Date
10/01/2000

Revision Ending Effective Date
09/30/2000

Policy Ending Date
N/A

LMRP Description
Cancer screening is a means of detecting disease early, in asymptomatic individuals, with the goal of decreasing morbidity and mortality. Generally, screening examinations, tests, or procedures are not diagnostic of cancer but instead indicate that a cancer may be present. The diagnosis is then made following a workup that generally includes a biopsy and pathologic confirmation. Prostate cancer screening involves the use **[of]** digital rectal examinations and prostate specific antigen blood test.

Section 4103 of the 1997 Balanced Budget Act (BBA) provides coverage for prostate cancer screening tests and procedures subject to certain coverage, frequency, and payment limitations. This policy documents the provisions listed in the BBA.

Indications and Limitations of Coverage and/or Medical Necessity
Effective for services furnished on or after January 1, 2000, Medicare will cover prostate cancer screening tests/procedures for the early detection of prostate cancer. The following are the coverage criteria for the new screening services:

Screening Digital Rectal Examinations

Screening digital rectal examinations are covered at a frequency of once every 12 months for men who attained age 50 (i.e., starting at least one day after they have attained age 50), if at least 11 months have passed following the month in which the last Medicare-covered screening digital rectal examination was performed . Screening digital rectal examination is a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate. This screening must be performed by a doctor of medicine or osteopathy, a physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife who is authorized under State law to perform the examination. In addition, the performing provider must be fully knowledgeable about the beneficiary's medical condition, and would be responsible for explaning the results of the examination to the beneficiary.

Screening Prostate Specific Antigen Tests

Screening prostate specific antigen (PSA) tests are covered at a frequency of once every 12 months for men who have attained age 50 (i.e., starting at least one day after they have attained age 50), if at least 11 months have passed following the month in which the last Medicare-covered screening prostate specific antigen test was performed . A screening PSA is a test that measures the level of PSA in an individual's blood. PSA is a reliable immunocytochemical marker for primary and metastatic adenocarcinoma of the prostate. This screening test must be ordered by the beneficiary's physician or by the beneficiary's physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife. In addition, the provider ordering the screening test must be fully knowledgeable about the beneficiary's medical condition, and would be responsible for explaining the results of the test to the beneficiary.

HCPCS Section & Benefit Category
Urology

Type of Bill Code
Hospital – 12x, 13x, 14x
Skilled Nursing Facility – 22x, 23x
Rural Health Clinic – 71x
Comprehensive Outpatient Rehabilitation Facility – 75x

Revenue Code
30x Laboratory
770 Preventative Care Services, General Classification

G0102: Prostate Cancer Screening (continued)

HCPCS Codes

G0102 Prostate cancer screening; digital rectal examination

G0103 Prostate cancer screening; prostate specific antigen test (PSA),-total

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

N/A

Diagnosis that Support Medical Necessity

N/A

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

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

N/A

Noncovered Diagnosis

N/A

Coding Guidelines

Prostate cancer screening; digital rectal exam should be billed with HCPCS G0102 and Revenue Code 770.

Prostate cancer screening; prostate specific antigen test (PSA), total should be billed with HCPCS G0103 and Revenue Code 30x.

When a PSA is being performed for diagnostic purposes, the applicable procedure code to bill is 84153 (Prostate specific antigen [PSA]; total) or 84154 (Prostate specific antigen [PSA]; free).

G0102 is an incidental service based on hospital outpatient prospective payment system. Incidental services are packaged into APC rates.

Documentation Requirements

Medical record documentation maintained in the patient's medical record must demonstrate that the service provided was screening in nature. In addition, documentation must support that the test/procedure was performed. This information is normally found in the office/ progress notes and/or laboratory results.

Utilization Guidelines

The screening digital rectal exams and screening prostate specific antigen tests are covered at a frequency of once every 12 months for men who attain the age of 50.

Other Comments

N/A

Sources of Information

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

Advisory Committee Notes

N/A

Start Date of Comment Period

N/A

Start Date of Notice Period

10/01/2000

Revision History

Revision Number:	3
Start Date of Comment Period:	N/A
Start Date of Notice Period:	10/01/2000 Oct/Nov 2000 Bulletin
Revised Effective Date:	10/01/2000
Explanation of Revision:	HCFA released Transmittals 758 and 1801 revised the language under the screening digital rectal exams and screening PSAs.
Revision Number:	2
Start Date of Comment Period:	N/A
Start Date of Notice Period:	10/01/2000 Oct/Nov 2000 Bulletin
Revised Effective Date:	10/01/2000
Explanation of Revision:	HCFA released Transmittals 758 and 1801 dated July 28, 2000, to modify the billing requirements for these services.
Start Date of Comment Period:	N/A
Start Date of Notice Period:	12/99 Dec/Jan 2000 Bulletin
Original Effective Date:	01/01/2000
Revised Date/Number:	01/01/2000

Change request 1006 dated 11/99 instructed providers to report HCPCS codes for prostate screening under revenue code 30x.

Start Date of Comment Period:	N/A
Start Date of Notice Period:	12/99 Dec/Jan 2000 Bulletin
Original Effective Date:	01/01/2000 ❖

J0001: Self-Administered Drugs

Policy Number
J0001

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Self-Administered Drugs

AMA CPT Copyright Statement

HCFA National Coverage Policy
Hospital Manual, Section 230.4B
Intermediary Manual, Sections 3112.4B, 3183.10
Rural Health Clinic Manual, Section 406.7

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
11/15/2000

Revision Effective Date
N/A

Revision Ending Effective Date
N/A

Policy Ending Date
N/A

LMRP Description
The Health Care Financing Administration (HCFA) received numerous inquiries about the coverage of self-administered drugs, as well as requests to add more self-administrable drugs to the list of covered benefits.

The Medicare statute does not provide for an overall outpatient drug benefit. As a result, self-administered drugs and biologicals (pill form) or those used for self injection are generally not covered by Medicare unless the statue includes a benefit that specifically provides for such coverage. Currently, Medicare allows for the coverage of the following self-administered drugs:

- Blood clotting factors;
- Drugs used in immunosuppressive therapy;
- Erythropoietin (EPO);
- Osteoporosis drugs for certain homebound patients;
- Certain oral anti-cancer drugs; and
- Certain oral anti-nausea drugs given in conjunction with oral or IV chemotherapy.

Indications and Limitations of Coverage and/or Medical Necessity
Based on national coverage guidelines, drugs and biologicals, which are self-administered by the patient, are not a benefit of Medicare. The drugs identified in the "HCPCS Codes" section of this policy have been determined to be self-administered drugs and therefore, are not covered.

HCPCS Section & Benefit Category
Drugs and Biologicals

Type of Bill Code
Hospital – 12x, 13x, 14x
Skilled Nursing Facility – 21x, 22x, 23x
Rural Health Clinic – 71x
End Stage Renal Disease – 72x
Comprehensive Outpatient Rehabilitation Facility – 75x
Community Mental Health Center – 76x

Revenue Code
636 Drugs requiring detailed coding

HCPCS Codes
J0275 Alprostadil urethral suppository (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)
J1438 Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) (Enbrel)
J1825 Injection, interferon beta-1a, 33 mcg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) (Avonex)
J1830 Injection interferon beta-1b, 0.25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) (Betaseron)
J3490 Unclassified drugs – Somatropin (Genotropin, Humatrope, Norditropin, Nutropin AQ, Saizen, Serostim)
J9218 Leuprolide acetate, per 1 mg

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
N/A

Diagnosis that Support Medical Necessity
N/A

J0001: Self-Administered Drugs (continued)

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

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

Drugs and biologicals that can be self-administered are not covered by Medicare unless the statute includes a benefit that specifically provides for such coverage.

Noncovered ICD-9-CM Code(s)

N/A

Noncovered Diagnosis

N/A

Coding Guidelines

N/A

Documentation Requirements

N/A

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

Drug Facts and Comparison
1998 Physicians' Desk Reference
1999 Physicians' Desk Reference

Advisory Committee Notes

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

Start Date of Comment Period

06/12/2000

Start Date of Notice Period

10/01/2000

Revision History

Revision Number:	Original
Start Date of Comment Period:	06/12/2000
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	Oct/Nov 2000 Bulletin
Original Effective Date:	11/15/2000 ❖

J1440: G-CSF (Filgrastim, Neupogen®)

Policy Number
J1440

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
G-CSF (Filgrastim, Neupogen®)

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Intermediary Manual, Sections 3101.1 and 3112.4

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
11/15/2000

Revision Effective Date
N/A

Revision Ending Effective Date
N/A

Policy Ending Date
N/A

LMRP Description
G-CSF is classified as a recombinant hematopoietic stimulant. This is not a cancer chemotherapy agent. It is a class II hematopoietic growth factor which acts on progenitor cells capable of forming a single differentiated cell type, the neutrophilic granulocyte, and is thus lineage-specific. Because Filgrastim acts only on progenitor cells that are already committed to one pathway, it increases only the neutrophil (e.g., granulocyte) count.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider G-CSF medically reasonable and necessary for the following FDA approved indications when it is not self/caregiver administered:

Cancer patients:
- Bone marrow transplant (BMT) - To reduce the severity of neutropenia in patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous BMT.
- Peripheral Blood Progenitor Cell (PBPC) Collection - For use in the mobilization of peripheral stem cells when the bone marrow transplant procedure itself is a covered benefit.
- Progenitor-cell transplantation - As an adjunct to allogeneic and autologous progenitor-cell transplantation, both for mobilization of PBPC and as a means to speed hematopoietic reconstitution following BMT or PBPC transplantation.
- Neutrophil engraftment failure - To assist in the recovery of patients who experience delayed or inadequate neutrophil engraftment following progenitor-cell transplantation.
- Myelosuppressive chemotherapy - To decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe febrile neutropenia.
- Acute myelogenous leukemia (AML) - To reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of adults with AML.

Severe chronic neutropenia (SCN) patients:
- Congenital, cyclic, or idiopathic neutropenia - To reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with SCN.

Florida Medicare will consider G-CSF medically reasonable and necessary for the following off-label indications when it is not self/caregiver administered:

- AIDS leukopenia in children
- Amelioration of leukopenia in AIDS patients on AZT
- Amelioration of leukopenia in AIDS patients with chorioretinitis on Ganciclovir.

Limitations
- A physician is not to bill Florida Medicare for a supply of G-CSF given to the patient for self administration at home.
- The following unlabeled uses of G-CSF have not been shown to be safe and effective and are noncovered by Florida Medicare: aplastic anemia, hairy cell leukemia, myelodysplastic disorders, myeloid malignancies (other than AML), drug-induced and congenital agranulocytosis, and alloimmune neonatal neutropenia.
- Therapeutic initiation of G-CSF does not add significantly to the antibiotic treatment outcome of established febrile neutropenia. Exceptions to this rule must be documented.
- There are inadequate data to support the use of G-CSF for patients with afebrile neutropenia.
- In general, for previously untreated patients receiving a chemotherapy regimen, primary administration of G-CSF is not considered medically necessary.

J1440: G-CSF (Filgrastim, Neupogen®) (continued)

- G-CSF should not be given within 24 hours before or after a dose of a chemotherapeutic agent, as rapidly dividing myeloid cells are potentially sensitive to these agents.
- There is no evidence of benefit from the use of G-CSF to increase chemotherapy dose-intensity.
- G-CSF should not be used concurrently with radiation therapy.

Dosage and Frequency

The package insert instructions for dosage and duration of treatment should not be exceeded.

The following is the recommended dosage and frequency when administering this drug:

BMT - Recommended dose following BMT is 10 mcg/kg/day given as an IV infusion of 4 or 24 hours or SC. The first dose should be administered at least 24 hours after chemotherapy and at least 24 hours after bone marrow infusion. The dose should be based on the neutrophil response. When the absolute neutrophil count (ANC) is >1000/mm³ for 3 consecutive days, reduce the G-CSF dosage to 5 mcg/kg/day. If the ANC remains >1000/mm³ for 3 more consecutive days, discontinue use.

PBPC - Recommended dose is 10 mcg/kg/day SC. G-CSF should be given for at least 4 days before the first leukapheresis procedure and continued until the last leukapheresis.

Myelosuppressive chemotherapy - Recommended starting dose is 5 mcg/kg/day SC or short IV infusion (15-30 minutes), or by continuous infusion. Doses may be increased in increments of 5 mcg/kg for each chemotherapy cycle, according to duration and severity of the ANC nadir. Administer no earlier than 24 hours after cytotoxic chemotherapy and not in the 24 hours before administration of chemotherapy. The drug should be discontinued when the absolute neutrophil count (ANC) reaches 10,000/mm³ and/or the patient becomes afebrile, or the patient has received the drug for a maximum of 14 days per treatment regimen.

AML - Recommended starting dose is 5mcg/kg/day SC until: ANC 1,000 cells/mm³ for 3 days or ANC >10,000 cells/mm³ for 1 day or for a maximum of 35 days.

SCN - Starting dose for congenital neutropenia is 6 mcg/kg twice daily SC every day. Idiopathic or cyclic neutropenia starting dose is 5 mcg/kg as a single injection SC every day. Chronic daily administration is required to maintain clinical benefit. Individually adjust the dose based on the patient's clinical course, as well as the ANC. Reduce the dose if the ANC is persistently >10,0000/mm³.

**The guidelines recommended for adults are generally applicable to the pediatric age group.

HCPCS Section & Benefit Category

Drugs and Biologicals

Type of Bill Code

Hospital – 13x
Skilled Nursing Facility – 21x
Rural Health Clinic – 72x

Revenue Code

636 Drugs Requiring Detailed Coding

HCPCS Codes

J1440	Injection, filgrastim (G-CSF), 300 mcg
J1441	Injection, filgrastim (G-CSF), 480 mcg

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

288.0	Agranulocytosis
V42.9	Organ or tissue replaced by unspecified organ or tissue
V58.1	Encounter for other and unspecified procedures and aftercare, chemotherapy
V58.69	Long-term (current) use of other medications
V59.8	Donors, other specified organ or tissue

** Please refer to coding guidelines for specific requirements regarding the billing of each of these ICD-9-CM codes.

Diagnosis that Support Medical Necessity

N/A

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

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

The use of G-CSF (Filgrastim, Neupogen®) for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

HCPCS code J1440 is subject to pass-through payment under the Outpatient Prospective Payment System (OPPS). Therefore, hospitals should use the units field to report multiples of the dosage identified in the code descriptor. Fractions of the dose specified in the code descriptor may be reported as 1 unit or one additional unit as appropriate.

HCPCS code J1441 is currently listed as a noncovered item and service according to OPPS. Therefore, hospital outpatient providers should bill for G-CSF using HCPCS code J1440 and adjust the units billed as appropriate.

Claims for G-CSF should be billed using the following diagnosis codes:

- 288.0 (Agranulocytosis) when G-CSF is used for patients with congenital, cyclic, or idiopathic neutropenia.
- V42.9 (Organ or tissue replaced by unspecified organ or

J1440: G-CSF (Filgrastim, Neupogen®) (continued)

tissue) when G-CSF is given to stem cell recipients (e.g., BMT).

- V58.1 (Encounter for other and unspecified procedures and aftercare, chemotherapy) when G-CSF is used for febrile neutropenia resulting from myelosuppressive chemotherapy or following induction or consolidation chemotherapy treatment of adults with AML.
- V58.69 (Long-term (current) use of other medications) when G-CSF is used for a patient with AZT or Ganciclovir neutropenia.
- V59.8 (Donors, other specified organ or tissue) when G-CSF is used in priming for autologous peripheral stem cells (e.g., PBPC), as an adjunct to allogeneic and autologous progenitor-cell transplantation, or for neutrophil engraftment failure.

Documentation Requirements

Medical record documentation maintained by the physician must clearly indicate:

- The patient's current absolute neutrophil count (ANC);
- The patient's weight in kilograms;
- The administration and dosage of the G-CSF;
- The actual indication for which the drug was given and accompanying symptomology (e.g., fever); and
- The patient's response to the treatment.

This information is usually found in the history and physical or the office/progress notes.

Utilization Guidelines

N/A

Other Comments

Terms Defined:

Absolute neutrophil count (ANC)—a lab test done on blood which counts the neutrophils within the blood specimen. It is represented by the total WBC x % segmented neutrophils and bands. Normal ANC is considered 3000-7000/mm³.
Congenital neutropenia/idiopathic chronic neutropenia—a heterogeneous group of congenital and acquired diseases of unknown cause. The disorders are thought to be due to reduced cellular responsiveness to G-CSF.
Cyclic neutropenia—characterized by cyclic 14 to 28 day fluctuations in the levels of platelets and myeloid and erythroid cell lines. The disorder is thought to result from a regulatory defect at the level of the stem cell.
Dose-intense chemotherapy—treatment given at higher doses or on a more frequent schedule than is conventional in an attempt to induce either more complete remissions or a greater cure rate.
Febrile neutropenia—generally designated as a temperature of approximately 38.5 C (~101 F) or greater, sustained for more than one hour, and developing concurrently with an ANC < 500/mm³.
G-CSF primary administration—the use of G-CSF before any occurrence of neutropenia or febrile neutropenia that may result from chemotherapy (i.e., beginning in the first cycle of treatment).

Myeloid—pertaining to, derived from or resembling bone marrow.
Neutropenia—an abnormally small number of neutrophil cells in the blood (an ANC of <1800/mm³).
Progenitor-cell support—refers to transplantation of hematopoietic cells derived from either bone marrow or the peripheral blood as a means to increase patient safety and tolerance of treatment when very high doses of chemotherapy are administered to increase remission rates and increase disease-free survival (DFS).
Severe chronic neutropenia—ANC less than 500/mm³.

Sources of Information

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Advisory Committee Notes

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

Start Date of Comment Period

11/15/1999

Start Date of Notice Period

10/01/2000

Revision History

Revision Number:	Original
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Start Date of Notice Period:	10/01/2000 Oct./Nov. 2000 Bulletin
Original Effective Date:	11/15/2000 ❖

Q0136: Non-ESRD Epoetin (Procrit)

Policy Number
Q0136

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Non-ESRD Epoetin (Procrit)

AMA CPT Copyright Statement

HCFA National Coverage Policy
Program transmittal AB-99-59
Hospital Manual – Sections 230.B4, E205C
Intermediary Manual – Section 3168D, 3922

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
11/15/2000

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N/A

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N/A

Policy Ending Date
N/A

LMRP Description
Erythropoietin is a glycoprotein which stimulates red blood cell production. It is produced in the kidneys and stimulates the division and differentiation of committed erythroid progenitors in the bone marrow.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare considers Epogen [EPO] to be medically necessary for the treatment of certain conditions including:

(1) Anemia induced by the drug Zidovudine (AZT)
- EPO is indicated in HIV infected patients to elevate or maintain the red blood cell level as manifested by an increase in the hemoglobin and/or hematocrit and to decrease the need for transfusions.
- EPO therapy is indicated for the patients with endogenous serum erythropoietin levels ≤ 500m units/ml **and** are receiving a dose of AZT ≤ 4200 mg/wk.
- The initial recommended starting dose is 100 u/kg as an IV or SC injection 3 times weekly for 8 weeks. If after 8 weeks of therapy, the patient's hematocrit has not increased or transfusion requirements have not decreased, then the dose of EPO can be increased by 50 to 100 u/kg 3 times weekly. If patients have not responded satisfactorily to a 300 u/kg dose 3 times weekly, it is unlikely that the patient will respond to higher doses, and therefore, the EPO should be discontinued.
- The maintenance dose is titrated to maintain the response based on factors such as zidovudine dose and presence of intercurrent infectious or inflammatory episodes.
- If the hematocrit exceeds 40%, the EPO should be stopped until the hematocrit drops to 36%. When resuming treatment, the EPO dose should be reduced by 25%, then titrate to maintain desired hematocrit.

*EPO is not indicated for patients with an endogenous serum erythropoietin level of >500 mu/ml or treatment of anemia in HIV-infected patients due to factors such as iron or folate deficiencies, hemolysis or gastrointestinal bleeding.

(2) Anemia in cancer patients receiving chemotherapy for nonmyeloid malignancies
- The use of EPO has been shown to be effective in treatment of anemia in patients with malignancies where anemia is due to the effect of **concomitantly** administered chemotherapy. EPO should be discontinued when the patient is no longer receiving chemotherapy.
- EPO is indicated to decrease the need for transfusions in patients who will be receiving concomitant chemotherapy for a **minimum of two months**.
- EPO is indicated for patients who had chemotherapy for a non-myeloid malignancy within the past year and presents post-chemo with anemia (i.e., permanent damage resulting from chemo). Documentation should support that the anemia was a result of a chemotherapy agent.
- EPO therapy is indicated for patients with a serum erythropoietin level of ≤ 500 mu/ml.
- The recommended starting dose is 150 units/kg 3 times weekly. If after 8 weeks the patient is not responding (increase HGB & HCT or decrease transfusion requirements), the dose may be increased up to 300 u/kg 3 times weekly. If patient has not responded satisfactorily to a 300 u/kg dose 3 times weekly, (defined as increase in HGB by 2g or decrease in transfusion requirements), it is unlikely that the patient will respond to higher doses. If the hematocrit exceeds 40%, the EPO should be stopped until the hematocrit drops to 36%. When resuming treatment, the EPO dose should be reduced by 25%, then titrate to maintain desired hematocrit.

(3) Anemia associated with myelodysplastic syndrome (MDS)
- EPO therapy is indicated for patients with a serum erythropoietin level below 500 mu/ml.
- Same dosage as cancer patients on chemotherapy.
- The patient presents with variable clinical features depending on the MDS classification and the degree of disordered hematopoiesis with anemia. Common

Q0136: Non-ESRD Epoetin (Procrit) (continued)

complaints or symptoms are fatigue, pallor, infection and bleeding or bruising. Diagnosis is usually confirmed by bone marrow aspiration and/or biopsy.

(4) Chronic anemia associated with Rheumatoid Arthritis (RA)
- The patient must have been previously diagnosed with RA using the American College of Rheumatology criteria.
- Usually these patients are on an antimetabolite (e.g., Methotrexate) which are causing the anemia.
- Same recommended dosages as cancer patients on chemotherapy and MDS patients.

(5) Reduction of allogeneic blood transfusion in surgery patients
- EPO is indicated in the treatment of anemic patients (hemoglobin > 10 to = 13 g/dl) scheduled to undergo major, elective orthopedic hip or knee surgery who are expected to require = 2 units of blood and who are not able or willing to participate in an autologous blood donation program.
- The recommended dose is 300 u/kg/day SC for 10 days before surgery, on the day of surgery, and for 4 days after surgery.
- An alternate dose schedule is 600 u/kg SC in once-weekly doses at 21, 14 and 7 days before surgery plus a fourth dose on the day of surgery.
- All patients should receive adequate iron supplementation throughout the course of therapy.
- Anemia is of chronic disease.

General indications and limitations for non-ESRD patients receiving EPO for indications 1-4:

- Prior to and during EPO therapy, the patient's iron status, including transferrin saturation and serum ferritin must be evaluated. Transferrin saturation should be at least 20% **and** ferritin should be at least 100 ng/ml. Virtually all patients will eventually require supplemental iron to increase or maintain transferrin saturation to levels which adequately support EPO stimulated erythropoiesis.
- To initiate EPO therapy, the patient must have a documented anemia as evidenced by symptoms and a hematocrit (HCT) of less than 30% or a hemoglobin (HGB) < 10g/dl unless there is medical documentation showing the need for EPO despite a HCT > 29.9 or a HGB > 9.9g/dl. It may be medically necessary for a patient to initiate EPO therapy when the hematocrit is greater than 29.9 percent or the hemoglobin is greater than 9.9 g/dl and the patient exhibits severe signs and symptoms such as: extreme weakness and fatigue, cold intolerance, tachycardia, severe pulmonary distress, severe hypotension, angina, congestive heart failure, etc., caused by the anemic condition.
- After reaching a target HCT & HGB of 36 or 12, the EPO should be tapered down to maintain the patient at this level. Normally, dosage is reduced by 25%. If the dosage is decreased to minimum dosages and the HCT & HGB continues to increase, the EPO should be discontinued. Documentation should support the medical necessity of continuing the same dosage. It may be necessary to initiate and/or maintain patients at higher HCT & HGB levels if the documented symptoms of anemia require the initiation or maintenance at a higher level.

NOTE: The standard of care regarding EPO dosing has changed from per kg to a standard starting total dose of 30000 u/wk (as divided doses three times a week or two times a week). If the EPO dose must be increased after 8 weeks, then it is not recommended to exceed the dosage indicated under the applicable indication.

HCPCS Section & Benefit Category
Drugs and Biologicals

Type of Bill Code
Hospital – 13x
Skilled Nursing Facility – 21x
Rural Health Clinic – 72x

Revenue Code
634 Erythropoietin (EPO) less than 10,000 units
635 Erythropoietin (EPO) 10,000 or more units
636 Drugs requiring detailing coding

HCPCS Codes
HCPC code not required on the UB-92 form

Q0136	Injection, epoetin alpha, (for non ESRD use), per 1,000 units

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

042	Human immunodeficiency virus [HIV] disease
238.7	Neoplasms of uncertain behavior, other lymphatic and hematopoietic (myelodysplastic) tissues
285.22*	Anemia in neoplastic disease
285.8 *	Other specified anemias
285.9 *	Anemia, unspecified
714.0	Rheumatoid arthritis
995.2	Unspecified adverse affect of drug, medicinal and biological substance
E878.1	Surgical operation with implant of artificial internal device
V58.1	Encounter for other and unspecified procedures and aftercare, chemotherapy

*The anemia diagnosis must be billed with the condition causing the anemia

Diagnosis that Support Medical Necessity
N/A

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

Diagnosis that DO NOT Support Medical Necessity
N/A

Reasons for Denial
When performed for indications other than those listed

Q0136: Non-ESRD Epoetin (Procrit) (continued)

in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

- To increase the amount of blood which can be drawn for auto-donation prior to surgery.
- For blood loss in patients who refuse transfusions for religious or other reasons.

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

- When billing for non-ESRD EPO, round up to the nearest 1,000 units.

When billing for non-ESRD EPO, the following dual diagnosis combination must be billed:

- For patients currently receiving chemotherapy, diagnosis code V58.1 must be coded as the secondary diagnosis to indicate that the anemic condition (diagnosis 285.22, 285.8, or 285.9) is chemotherapy-induced. These patients must currently be on a course of chemotherapy for a non-myeloid malignancy.
- For patients with post-chemo anemia, a secondary diagnosis of 995.2 must be coded with the diagnosis 285.8 or 285.9. These patients must have received chemotherapy within the last year.
- For patients with anemia related to Rheumatoid arthritis, a secondary diagnosis of 714.0 must be coded, with the diagnosis 285.8 or 285.9.
- For AZT-related service, a secondary diagnosis of AIDS (042) must be coded with the anemia diagnosis 285.8 or 285.9. These patients must have an endogenous serum erythropoietin level < 500 mg units/ml and receiving a dose of AZT < 4200 mg/week.
- A diagnosis of myelodysplastic syndrome (ICD-9-CM 238.7) must be coded as secondary for these patients, with the anemia diagnosis 285.8 or 285.9.
- For reduction of allogeneic blood transfusion in surgery patients, a secondary diagnosis of E878.1 must be coded with the anemia diagnosis 285.8 or 285.9.

On initial claims for Epogen, the provider must report the most recent hematocrit and/or hemoglobin prior to the initiation of EPO therapy. On subsequent claims, the provider must report the latest hematocrit or hemoglobin performed in the billing period. The hemoglobin (value code 48) or hematocrit (value code 49) and the total units of EPO administered during the billing period (value code 68) must be reported in form locators 39-41.

HCPCS code Q0136 is subject to pass-through payment under the Outpatient Payment System (OPPS) when billed with revenue code 636. Therefore, hospitals should bill revenue code 636 to receive pass-through payment.

Documentation Requirements

The physician must clearly document in the patient's medical record that all requirements have been met and support the medical necessity for the use of Procrit, including but not limited to covered diagnoses, appropriate laboratory studies (including date & results of most recent HCT/HGB levels within last month), dosage, route of administration, frequency and duration of the treatment and the patient's response to the therapy. This information is normally found in the office/progress and laboratory results.

Utilization Guidelines

N/A

Other Comments

Terms Defined:

AIDS (Acquired Immune Deficiency Syndrome): a deficiency in the immune system caused by the HIV virus

AZT (Azidothymidine): a drug used for the management of patients with HIV infections

End-Stage Renal Disease (ESRD): relates to kidney function; inability of the kidneys to carry out important functions in the body; removing poisonous wastes, maintaining the proper balance of chemicals, and removing excess fluid

Hematocrit (HCT): a measurement (in percent) of red blood cells in whole blood

Hemoglobin (HGB): a substance contained within the red blood cells; responsible for their color, composed of the pigment heme linked to the protein globin; unique property of combining reversibly with oxygen; medium by which oxygen is transported within the body

HIV (Human Immunodeficiency Virus): a virus causing a breakdown of the body's immune system resulting in infections, malignancies and neurologic disease

Myelodysplastic syndrome (MDS): includes a group of clonal hematopoietic diseases characterized by impaired maturation of hematopoietic precursors with the development of progressive peripheral cytopenias. MDS is characterized by erythroid, myeloid, and megabaryocytic forms on bone marrow. There are five distinct forms of MDS: Refractory anemia (RA), RA with sideroblasts, RA with excess blasts (RAEB), chronic myelomonocytic leukemia, and RAEB in transformation.

Sources of Information

2000 Facts and Comparisions

Stein, J. (1994). Internal Medicine. (4th ed.). Mosby-Year Book: St. Louis.

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 College of Oncology.

Start Date of Comment Period

06/12/2000

Start Date of Notice Period

10/01/2000

Revision History

Revision Number:	Original
Start Date of Comment Period:	06/12/2000
Start Date of Notice Period:	10/01/2000 Oct/Nov 2000 Bulletin
Original Effective Date:	11/15/2000 ❖

J9999: Antineoplastic Drugs–Addition to Policy

The complete local medical review policy (LMRP) for Antineoplastic Drugs was published in the June/July 2000 *Medicare Part A Bulletin* (pages 57-64). Another drug, Irinotecan (Camptosar®) has been added to policy.

Irinotecan (Camptosar®)

Irinotecan, also known as CPT-11, is an analog of camptothecin, a plant alkaloid. It inhibits the enzyme, topoisomerase I, which is necessary for DNA replication. Irinotecan is FDA approved for the treatment of colorectal carcinoma.

Florida Medicare will cover Irinotecan for its FDA approved use, as well as for the treatment of the following off-labeled indications:

- Small-cell lung carcinoma
- Cervical carcinoma

HCPCS CODES

J9206 Irinotecan, 20 mg

ICD-9-CM Codes That Support Medical Necessity

153.0-154.8 Malignant neoplasm of colon, rectum, rectosigmoid juction, and anus
162.2-162.9 Malignant neoplasm of lung (small-cell lung carcinoma)
180.0-180.9 Malignant neoplasm of cervix uteri

Documentation Requirements

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

Effective Date

The addition of Irinotecan will be effective for services processed on or after November 15, 2000. ❖

2001 ICD-9-CM Coding Changes

The 2001 update to the ICD-9-CM diagnosis coding structure is effective October 1, 2000. Providers are required to use the 2001 updated ICD-9-CM coding effective for all hospital discharges and outpatient services occurring **on or after October 1, 2000.** Due to the direct relationship between coding and reimbursement, it is particularly important that providers reimbursed under the prospective payment system (PPS) used the appropriate ICD-9-CM coding. Other providers that code diagnoses and procedures (non-OPPS providers) are also affected. In addition, the new diagnosis coding is used in hospital outpatient billing.

Florida Medicare has revised local medical review policies (LMRPs), for procedure codes with specific diagnosis criteria that are affected by the 2001 ICD-9-CM update. The following table lists the LMRPs affected, the publication in which diagnosis criteria appeared, and the specific conditions revised as a result of the 2001 ICD-9-CM update:

LMRP TITLE	PUBLISHED	2001 CHANGES
44388: Colonoscopy	*Bulletin* G-333, 5/19/1998	Change descriptor for 564.1 to read "irritable bowel syndrome"; Change 783.2 to 783.21 (Loss of weight)
52282: Urethral Stents	*Bulletin* G-346, 8/26/1998	Change 600 to 600.0-600.9
53850: Prostate Treatments	*Bulletin* G-354, 12/7/1998 Oct/Nov 1999 *Bulletin* (page 20) Jun/Jul 2000 *Bulletin* (page 18)	Change 600 to 600.0 Hypertrophy (bening) (benign) of prostate
70450: Computerized Tomography Scans	*Bulletin* G-354, 12/7/1998 *Bulletin* G-363, 2/8/1999 Aug/Sep 1999 *Bulletin* (page 15)	Change 781.0-781.9 to 781.0-781.8; Add 781.99 (Other symptoms involving nervous and musculoskeletal systems)
70551: Magnetic Resonance Imaging of the Brain	*Bulletin* G-354,12/7/1998	Change 781.0-781.9 to 781.0-781.8; Add 781.99 (Other symptoms involving nervous and musculoskeletal systems)
71010: Chest X-ray	*Bulletin* G-348, 9/18/1998 Aug/Sep 2000 *Bulletin* (page 24)	Change 493.00-493.91 to 493.00-493.92; Change 494 to 494.0-494.1; Change 783.2 to 783.21 (Loss of weight)
72141: Magnetic Resonance Imaging of the Spine	*Bulletin* G-360, 1/21/1999	Change 781.0-781.9 to 781.0-781.99

2001 ICD-9-CM Coding Changes (continued)

72192: Computed Tomography of the Pelvis	Jun/Jul 1999 *Bulletin* (page 37)	Change 996.89 to 996.87 (Complications of transplanted organ, intestines) Add V42.84 (Organ or tissue replaced by transplant, intestines
78460: Myocardial Perfusion Imaging	*Bulletin* G-360, 1/21/1999	Change V67.0 to V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery)
78472: Cardiac Blood Pool Imaging	Feb/Mar 2000 *Bulletin* (page 21)	Change V67.0 to V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery) Add V58.83 (Encounter for therapeutic drug monitoring)
82270: Fecal Occult Blood Testing	*Bulletin* G-291,7/2/1997 Jun/Jul 1999 *Bulletin* (page 47)	Change 783.2 to 783.21 (Loss of weight)
82607: Vitamin B-12 Assay	Feb/Mar 2000 *Bulletin* (page 24)	Add 558.3 (Allergic gastroenteritis and colitis)
82784: Gammaglobulin; IgA, IgD, IgG, IgM, each	*Bulletin* G-354, 12/7/1998	Change 600 to 600.0-600.9 (Hyperplasia of prostate)
83970: Parathormone	*Bulletin* G-354, 12/7/1998	Change V67.0 to V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery)
84436: Thyroid Function Tests	2000 HCPCS Dec 1999 Special *Bulletin* (page 29) Feb/Mar 2000 *Bulletin* (page 20) Apr/May 2000 *Bulletin* (page 21)	Change 783.2 to 783.21 (Loss of weight); Change descriptor for 783.4 (Lack of expected normal physiological development *in childhood*)
93015: Cardiovascular Stress Test	*Bulletin* G-367, 3/18/1999	Change V67.0 to V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery)
93350: Stress Echocardiography	*Bulletin* G-367, 3/18/1999	Change V67.0 to V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery)
93875: Non-Invasive Extracranial Arterial Studies	Oct/Nov 1999 *Bulletin* (page 29)	Change V67.0 to V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery)
93922: Non-Invasive Physiologic Studies of Upper or Lower Extremity Arteries	Apr/May 2000 *Bulletin* (page 22)	Change 707.1 to 707.10-707.19
93925: Duplex Scan of Lower Extremity Arteries	Feb/Mar 2000 *Bulletin* (page 30)	Change V67.0 to V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery)

2001 ICD-9-CM Coding Changes (continued)

93975: Duplex Scanning	*Bulletin* G-367, 3/18/1999 Jun/Jul 1999 *Bulletin* (page 95)	Change 783.2 to 783.21 (Loss of weight); Change V67.0 to V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery)
94010: Spirometry	*Bulletin* G-354, 12/7/1998 *Bulletin* G-360, 1/21/1999 Jun/Jul 2000 *Bulletin* (page 37)	Change 493.00-493.91 to 493.00-493.92; Change 494 to 494.0-494.1
94240: Functional Residual Capacity or Residual Volume	*Bulletin* G-354, 12/7/1998	Change 493.00-493.91 to 493.00-493.92; Change 494 to 494.0-494.1
94620: Pulmonary Stress Test	*Bulletin* G-354, 12/7/1998 *Bulletin* G-360, 1/21/1999	Change 493.00-493.91 to 493.00-493.92; Change 494 to 494.0-494.1
94642: Aerosolized Pentamidine Isethionate	*Bulletin* G-360, 1/21/1999 Aug/Sep 2000 *Bulletin* (page 41)	Change V42.0-V42.83 to V42.0-V42.84
94664: Diagnostic Aerosol or Vapor Inhalation	Dec '98/Jan '00 *Bulletin* (pg 26)	Change 493.00-493.91 to 493.00-93.92; Change 494 to 494.0-494.1
94760: Non-Invasive Ear or Pulse Oximetry for Oxygen Saturation	*Bulletin* G-354, 12/7/1998 2000 HCPCS Dec 1999 Special *Bulletin* (page 35) Feb/Mar 2000 *Bulletin* (page 35)	Change 493.00-493.01 to 493.00-493.02; Change 493.10-493.11 to 493.10-493.12; Change 493.20-493.21 to 493.20-493.22; Change 493.90-493.91 to 493.90-493.92; Change 494 to 494.0-494.1
94799: Pulmonary Rehabilitation Services	*Bulletin* G-318, 2/18/1998 *Bulletin* G-336, 6/12/1998	Change 494 to 494.0-494.1
95004: Allergy Skin Tests	Jun/Jul 2000 *Bulletin* (page 41)	Add 995.7 (Other adverse food reactions, not elsewhere classified)
A4644: Low Osmolar Contrast	*Bulletin* G-348, 9/18/1998 2000 HCPCS Dec 1999 Special *Bulletin* (page 35)	Add 493.02 (Extrinsic asthma with acute exacerbation) Add 493.12 (Intrinsic asthma with acute exacerbation) Add 493.22 (Chronic obstructive asthma with acute exacerbation) Add 493.92 (Asthma, unspecified with acute exacerbation) Change V15.0 to V15.01-V15.09

The latest versions of the ICD-9-CM manuals (as well as a variety of other coding materials) may be obtained from:

HealthCare Consultants of America (800) 253-4945	Medicode Publications (800) 999-4600	St. Anthony's Publishing (800) 632-0123

ICD-9-CM and other coding materials may also be obtained from local medical publishing and consulting firms. In addition, detailed information regarding the 2001 ICD-9-CM update is available by accessing the Florida Medicare Web site – **www.floridamedicare.com.** ❖

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Coding Information for Hospital Outpatient Prospective Payment System

The following article provides hospitals with coding information related to the Outpatient Prospective Payment System. Section I contains a list of HCFA Common Procedure Coding System (HCPCS) codes and long descriptors for drugs, biologicals, and devices eligible for transitional pass through payments, and for services and items classified in "new technology" ambulatory payment classifications (APCs). Section II contains a list of devices that are classified in "new technology" APCs. Section III contains a list of short descriptor changes. Section IV contains a list of blood/blood products and drugs that are **not** eligible for the transitional pass-through payment system but are classified in separate APCs. Section V provides information on the appropriate code for reporting stereotactic radiosurgery under the Outpatient Prospective Payment System. Section VI provides information on two additional "new technology" APCs and their payment rates. Sections I, III, IV, and V are effective August 1, 2000. Sections II and VI are effective October 1, 2000.

The listing of HCPCS codes contained in this instruction does not assure coverage of the specific item or service. To be eligible for payment, the items contained in this document must be considered reasonable and necessary.

I. Drugs, Biologics, Devices, and New Technology Services Effective August 1, 2000

[1] Other devices may be used for this code.
[2] Changed from the short descriptor list posted on HCFA's web site on May 12, 2000.
[3] New technology.

HCPCS CODE	LONG DESCRIPTORS
36550[3]	Declotting by thrombolytic agent of implanted vascular access device or catheter
53850[3]	Transurethral destruction of prostate tissue; by microwave thermotherapy
53852[3]	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy
77520[3]	Proton beam delivery to a single treatment area, single port, custom block, with or without compensation, with treatment set-up and verification images
77523[3]	Proton beam delivery to one or two treatment areas, two or more ports, two or more custom blocks, and two or more compensators, with treatment set-up and verification images
96570[3]	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes
96571[3]	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes
A4642	Supply of satumomab pendetide, radiopharmaceutical diagnostic imaging agent, per dose
A9500	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m sestamibi, per dose
A9502	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m tetrofosmin, per unit dose
A9503	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m medronate, up to 30 mCi
A9504	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m apcitide
A9505	Supply of radiopharmaceutical diagnostic imaging agent, thallous chloride TL 201, per mCi
A9507	Supply of radiopharmaceutical diagnostic imaging agent, IN 111 capromab pendetide, per dose
A9600	Supply of therapeutic radiopharmaceutical, strontium-89 chloride, per mCi
A9605	Supply of therapeutic radiopharmaceutical, samarium sm 153 lexidronamm, 50 mCi
C1000	Closure, arterial vascular device, Perclose Closer Arterial Vascular Closure Device, Prostar Arterial Vascular Closure Device
C1001	Catheter, diagnostic ultrasound, AcuNav Diagnostic Ultrasound Catheter
C1005[1]	Intraocular lens, Sensar Soft Acrylic Ultraviolet Light Absorbing Posterior Chamber Intraocular Lens
C1006	Intraocular lens, Array Multifocal Silicone Posterior Chamber Intraocular Lens
C1007[1]	Prosthesis, penile, AMS 700 Penile Prosthesis
C1008	Stent, urethral, permanent, UroLume
C1024	Quinopristin/dalfopristin, 10 ml, Synercid I.V.
C1025[1]	Catheter, diagnostic, electrophysiology, Marinr CS
C1026[1]	Catheter, ablation, RF Performr, 5F RF Marinr
C1027[1,2]	Stent, coronary, Magic Wallstent Extra Short or Short Coronary Self Expanding Stent with Delivery System, Radius 14mm Self Expanding Stent with Over the Wire Delivery System

Coding Information for Hospital Outpatient Prospective Payment System (continued)

HCPCS CODE	LONG DESCRIPTORS
C1028[1]	Sling fixation system for treatment of stress urinary incontinence, Precision Twist Transvaginal Anchor System , Precision Tack Transvaginal Anchor System, Vesica Press-In Anchor System, Capio CL (TVB/S) Transvaginal Suturing Device
C1029	Catheter, balloon dilatation, Controlled Radial Expansion Balloon Dilatation Catheter Wire-Guided and Fixed Wire
C1030[1]	Catheter, balloon dilatation, Marshal, Blue Max 20, Ultra-Thin Diamond
C1031	Electrode, needle, ablation, MR Compatible LeVeen, Modified LeVeen Needle Electrode
C1033[1]	Catheter, imaging, Sonicath Ultra Model 37-410 Ultrasound Imaging Catheter
C1034	Catheter,coronary angioplasty, SURPASS Superfusion Catheter, Long 30 SURPASS Superfusion Catheter
C1036[1]	Port/reservoir, venous access device, Vaxcel Implantable Vascular Access System, R Port Premier Kit
C1037	Catheter, dialysis, Vaxcel Chronic Dialysis Catheter
C1039[1,2]	Stent, tracheobronchial, Wallstent Tracheobronchial Endoprosthesis (covered), Wallstent Tracheobronchial Endoprosthesis with Permalume Covering and Unistep Plus Delivery System
C1040[1]	Stent, self-expandable for creation of intrahepatic shunts, Wallstent Transjugular Intrahepatic Portosystemic Shunt (TIPS) with Unistep Plus Delivery System (20/40/60 mm in length)
C1042[1,2]	Stent, biliary, Wallstent Biliary Endoprosthesis with Unistep Plus Delivery System, Wallstent Biliary Endoprosthesis with Unistep Delivery System (Biliary Stent and Catheter), Ultraflex Diamond Biliary Stent System, New Microvasive Biliary Stent and Delivery System
C1043[1,2]	Atherectomy system, coronary, RotablatorRotaLink Atherectomy Catheter and Burr, Rotablator RotaLink Rotational Atherectomy System Advancer and Guide Wire
C1045	Supply of radiopharmaceutical diagnostic imaging agent, I-131 MIBG [iobenguane sulfate I-131], per 0.5 mCi
C1047	Catheter, diagnostic, Navi-Star Diagnostic Deflectable Tip Catheter, NOGA-STAR Diagnostic Deflectable Tip Catheter
C1048	Generator, bipolar pulse, Cyberonics NeuroCybernetic Prosthesis Generator
C1050	Protein A immunoadsorption, PROSORBA Column
C1053	Catheter, diagnostic, EnSite 3000 Catheter
C1057	Tissue marker, 11-Gauge MicroMark II Tissue Marker
C1059	Autologous cultured chondrocytes, implantation, Carticel
C1060	Stent, coronary, ACS Multi-Link Tristar Coronary Stent System and Delivery System
C1061	Catheter, coronary guide, ACS Viking Guiding Catheter
C1063	Lead, defibrillator, Endotak Endurance EZ, Endotak Endurance RX
C1067	Stent, biliary, MEGALINK Biliary Stent
C1068	Pacemaker, dual chamber, Pulsar DDD
C1069[1]	Pacemaker, dual chamber, Discovery DR
C1071	Pacemaker, single chamber, Pulsar Max SR, Pulsar SR
C1072[2]	Catheter, balloon dilatation, coronary, RX Esprit, RX Gemini, RX Solaris, OTW Photon, OTW Solaris
C1073[2]	Morcellator, laparascopic, Gynecare X-tract Laparascopic Morcellator
C1074	Catheter, peripheral dilatation, RX Viatrac 14 Peripheral Dilatation Catheter, OTW Viatrac 18 Peripheral Dilatation Catheter
C1075	Lead, pacemaker, Selute Picotip, Selute, Sweet Picotip Rx, Sweet Tip Rx, FineLine, FineLine EZ, ThinLine, ThinLine EZ
C1076[2]	Defibrillator, single chamber, automatic, implantable, Ventak Mini IV, Ventak Mini III HE, Ventak Mini III
C1077[2]	Defibrillator, single chamber, automatic, implantable, Ventak Prizm VR, Ventak VR
C1078[1,2]	Defibrillator, dual chamber, automatic, implantable, Ventak Prizm, Ventak AV III DR
C1079	Supply of radiopharmaceutical diagnostic imaging agent, cyanocobalamin Co 58/57, kit, 0.5 mCi, Nycomed Cyanoco Co57/Cyanoco Co58
C1084	Denileukin diftitox, 300 mcg, Ontak IV
C1086	Temozolomide, 5 mg, Temodar
C1087	Supply of radiopharmaceutical imaging agent, sodium iodide I-123 (capsule), per uCi
C1088[3]	Laser optic treatment system, Indigo LaserOptic Treatment System
C1089	Supply of radiopharmaceutical diagnostic imaging agent, cyanocobalamin Co 57, 0.5 mCi, capsule
C1090	Supply of radiopharmaceutical diagnostic imaging agent, indium IN 111 chloride, per mCi
C1091	Supply of radiopharmaceutical diagnostic imaging agent, indium IN 111 oxyquinoline, per 5 mCi
C1092	Supply of radiopharmaceutical diagnostic imaging agent, indium IN 111 pentetate disodium, per 1.5 mCi
C1094	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m albumin aggregated, per vial
C1095	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m depreotide, per vial
C1096	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m exametazime,per dose
C1097	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m mebrofenin, per vial
C1098	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m pentetate, per vial
C1099	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m pyrophosphate, per vial

Coding Information for Hospital Outpatient Prospective Payment System (continued)

HCPCS CODE	LONG DESCRIPTORS
C1100[1]	Guide wire, percutaneous transluminal coronary angioplasty, Medtronic AVE GT1Guide Wire
C1101	Catheter, percutaneous transluminal coronary angioplasty guide, Medtronic AVE 5F, 6F, 7F, 8F, 9F Zuma Guide Catheter
C1102	Generator, pulse, neurostimulator, Medtronic Synergy Neurostimulator Generator and Extension
C1103	Defibrillator, implantable, Micro Jewel, Micro Jewel II
C1104[1]	Catheter, ablation, RF Conductr MC
C1105	Pacemaker, dual chamber, Sigma 300 VDD
C1106	Neurostimulator, patient programmer, Synergy EZ Patient Programmer
C1107	Catheter, diagnostic, electrophysiology, Torqr, Soloist
C1109	Anchor, implantable, Mitek GII Anchor, Mitek Knotless, Mitek TACIT, Mitek Rotator Cuff, Mitek GLS, Mitek Mini, Mitek FASTIN, Mitek Super, Mitek PANALOK, Mitek Micro, Mitek PANALOK RC, Mitek FASTIN RC, Innovasive ROC EZ, Innovasive MINIROC, Innovasive BIOROC, Innovasive ROC XS, Innovasive Contack
C1110	Catheter, diagnostic, electrophysiology, Stable Mapper
C1111	Stent graft system, AneuRx Aorto-Uni-Iliac-Stent Graft System
C1112[1]	Stent graft system, AneuRx Stent Graft System
C1113	Stent graft system, Talent Endoluminal Spring Stent Graft System
C1114	Stent graft system, Talent Spring Stent Graft System
C1115	Lead, pacemaker, 5038S, 5038, 5038L
C1116	Lead, pacemaker, CapSure SP Novus, CapSure SP, Capsure, Excellence +, S+, PS+, CapSure Z Novus, CapSure Z, Impulse
C1118	Pacemaker, dual chamber, Sigma 300 DR, Legacy II DR
C1119	Lead, defibrillator, Sprint 6932, Sprint 6943
C1120	Lead, defibrillator, Sprint 6942, Sprint 6945
C1121	Defibrillator, implantable, GEM
C1122	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m arcitumomab, per vial
C1123	Defibrillator, implantable, GEM II VR
C1124	Lead, neurostimulator, kit, InterStim Test Stimulation Lead Kit
C1125	Pacemaker, single chamber, Kappa 400 SR, Topaz II SR
C1126	Pacemaker, dual chamber, Kappa 700 DR (all models)
C1127	Pacemaker, single chamber, Kappa 700 SR
C1128	Pacemaker, dual chamber, Kappa 700 D, Ruby II D
C1129	Pacemaker, Kappa 700 VDD
C1130	Pacemaker, dual chamber, Sigma 200 D, Legacy II D
C1131	Pacemaker, dual chamber, Sigma 200 DR
C1132[1]	Pacemaker, single chamber, Sigma 200 SR, Legacy II SR
C1133	Pacemaker, single chamber, Sigma 300 SR, Vita SR
C1134	Pacemaker, dual chamber, Sigma 300 D
C1137	Septal defect implant system, CardioSEAL Septal Occlusion System, CardioSEAL Occluder Delivery Catheter
C1143	Pacemaker, dual chamber, AddVent 2060BL
C1144	Pacemaker, single chamber, rate-responsive, Affinity SR 5130L, Affinity 5130R, Integrity SR 5142
C1145[1,2]	Vascular closure device, Angio-Seal 6 French Vascular Closure Device 610091, Angio-Seal 8 French Vascular Closure Device 610089
C1146[2]	Endotracheal tube, VETT Endotracheal Tube
C1147	Lead, pacemaker, AV Plus DX 1368/52, AV Plus DX 1368/58
C1148	Defibrillator, single chamber, implantable, Contour MD V-175, Contour MD V-175A, Contour MD V-175AC, Contour MD V-175B, Contour MD V-175C, Contour MD V-175D
C1149	Pacemaker, dual chamber, Entity DC 5226R
C1151[2]	Lead, pacemaker, Passive Plus DX 1343K/46, Passive Plus DX 1343K/52, Passive Plus DX 1345K/52, Passive Plus DX 1345K/58, Passive Plus DX 1336T/52, Passive Plus DX 1336T/58, Passive Plus DX 1342T/46, Passive Plus DX 1342T/52, Passive Plus DX 1346T/52, Passive Plus DX 1346T/58
C1152[2]	Access system, dialysis, LifeSite Access System
C1153[1]	Pacemaker, single chamber, Regency SC+ 2402L
C1154	Lead, defibrillator, SPL SP01, SPL SP02, SPL SP04
C1155[1]	Repliform Tissue Regeneration Matrix, per 8 square centimeters
C1156	Pacemaker, single chamber, Affinity SR 5131M/S, Tempo VR 1102, Trilogy SR+ 2260L, Trilogy SR+ 2264L
C1157	Pacemaker, dual chamber, Trilogy DC+ 2318L
C1158	Lead, defibrillator, TVL SV01, TVL SV02, TVL SV04
C1159	Lead, defibrillator, TVL RV02, TVL06, TVL07
C1160	Lead, defibrillator, TVL-ADX 1559/65
C1161	Lead, pacemaker, Tendril DX 1388K/46, Tendril DX 1388K/52, Tendril DX 1388K/58, Tendril DX 1388T/46, Tendril DX 1388T/52, Tendril DX 1388T/58, Tendril DX 1388T/85, Tendril DX 1388T/100, Tendril DX 1388TC/46, Tendril DX 1388TC/52, Tendril DX 1388TC/58

Coding Information for Hospital Outpatient Prospective Payment System (continued)

HCPCS CODE	LONG DESCRIPTORS
C1162[1,2]	Pacemaker, dual-chamber, Affinity DR 5331 M/S, Tempo DR 2102, Trilogy DR+ 2360L, Trilogy DR + 2364L
C1163	Lead, pacemaker, Tendril SDX 1488T/46, Tendril SDX 1488T/52, Tendril SDX 1488T/58, Tendril SDX 1488TC/46, Tendril SDX 1488TC/52, Tendril SDX 1488TC/58
C1164	Brachytherapy seed, intracavity, I-125 seeds
C1166	Injection, cytarabine liposome, 10 mg, Depocyt/Liposomal Cytarabine
C1167	Injection, epirubicin hydrochloride, 2mg
C1170[1]	Biopsy device, breast, ABBI Device
C1171	Site marker device, disposable, Auto Suture SITE MARKER Device
C1172	Balloon, tissue dissector, Spacemaker Tissue Dissection Balloon
C1173[1]	Stent, coronary, S540 Over-the-Wire Coronary Stent System, S670 with Discrete Technology Over-the-Wire Coronary Stent System, S670 with Discrete Technology Rapid Exchange Coronary Stent System
C1174[1]	Needle, brachytherapy, Bard BrachyStar Brachytherapy Needle
C1178	Injection, Busulfan (Busulfex I.V.) per 6mg
C1188	Sodium iodide I-131, per uCi
C1200	Supply of radiological diagnostic imaging agent, technetium Tc 99m sodium glucoheptonate, per vial
C1201	Supply of radiological diagnostic imaging agent, technetium Tc 99m succimer, per vial
C1202	Supply of radiological diagnostic imaging agent, technetium Tc 99m sulfur colloid, per dose
C1203	Injection, Visudyne (verteporfin)
C1205	Supply of radiological diagnostic imaging agent, technetium Tc 99m disofenin, per vial
C1207	Octreotide acetate 1 mg
C1300[3]	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval
C1302[2]	Lead, defibrillator, TVL SQ01
C1304	Catheter, imaging, Sonicath Ultra Model 37-416 Ultrasound Imaging Catheter, Sonicath Ultra Model 37-418 Ultrasound Imaging Catheter
C1305[2]	Apligraf, per 44 square centimeters
C1306[1]	Lead, neurostimulator, Cyberonics NeuroCybernetic Prosthesis Lead
C1311	Pacemaker, dual chamber, Trilogy DR+/DAO
C1312	Stent, coronary, Magic Wallstent Mini Coronary Self Expanding Stent with Delivery System
C1313[2]	Stent, coronary, Magic Wallstent Medium Coronary Self Expanding Stent with Delivery System, Radius 31mm Self Expanding Stent with Over the Wire Delivery System
C1314	Stent, coronary, Magic Wallstent Long Coronary Self Expanding Stent with Delivery System
C1315	Pacemaker, dual chamber, Vigor DR, Meridian DR
C1316	Pacemaker, dual chamber, Meridian DDD
C1317	Pacemaker, single chamber, Discovery SR
C1318[1]	Pacemaker, single chamber, Meridian SR
C1319[1,2]	Stent, enteral, Wallstent Enteral Endoprosthesis and Unistep Delivery System (60mm in length)
C1320[2]	Stent, iliac, Wallstent Iliac Endoprosthesis with Unistep Plus Delivery System
C1324[1]	Electrode, disposable, LigaSure Disposable Electrode
C1325	Brachytherapy seed, intracavity, Palladium-103 seeds
C1326[1]	Catheter, thrombectomy, AngioJet Rheolytic Thrombectomy Catheter
C1328[1,2]	External transmitter, neurostimulation system, ANS Renew Spinal Cord Stimulator System
C1333	Stent, biliary, PALMAZ Corinthian Transhepatic Biliary Stent and Delivery System
C1334[2]	Stent, coronary, PALMAZ-Schatz Crown Stent, Mini-Crown Stent, CrossFlex LC Stent
C1335[1,2]	Mesh, hernia, PROLENE Polypropylene Hernia System
C1336[1,2]	Infusion pump, implantable, non-programmable, Constant Flow Implantable Pump Model 3000
C1348	Sodium iodide I-131, per mCi
C1350	Brachytherapy, per source, ProstaSeed I-125
C1351	Lead, pacemaker, CapSureFix, SureFix, Pirouet +, S+
C1352[1]	Defibrillator, dual chamber, implantable, Gem II DR
C1353	Neurostimulator, implantable, Itrel II/Soletra Implantable Neurostimulator and Extension, Itrel III Implantable Neurostimulator and Extension, InterStim Neurostimulator (implantable) and Extension
C1354	Pacemaker, dual chamber, Kappa 400 DR, Diamond II 820 DR
C1355	Pacemaker, dual chamber, Kappa 600 DR, Vita DR
C1356	Defibrillator, single chamber, implantable, Profile MD V-186HV3
C1357	Defibrillator, single chamber, implantable, Angstrom MD V-190HV3
C1358	Pacemaker, dual chamber, Affinity DC 5230R
C1359[1]	Pacemaker, dual chamber, Pulsar DR, Pulsar Max DR
C1360	Ocular photodynamic therapy
C1361	Recorder, cardiac event, implantable, Reveal, Reveal Plus
C1362	Stent, biliary, RX HERCULINK 14 Biliary Stent, OTW MEGALINK SDS Biliary Stent

Coding Information for Hospital Outpatient Prospective Payment System (continued)

HCPCS CODE	LONG DESCRIPTORS
G0125[3]	PET lung imaging of solitary pulmonary nodules, using 2-(fluorine-18)-fluoro-2-deoxy-d-glucose (FDG), following CT (71250/71260 or 71270)
G0126[3]	PET lung imaging of solitary pulmonary nodules, using 2-(fluorine-18)-fluoro-2-deoxy-d-glucose (FDG), following CT (71250/71260 or 71270); initial staging of pathologically diagnosed non-small cell lung cancer
G0160[3]	Cryosurgical ablation of localized prostate cancer, primary treatment only (post operative irrigations and aspiration of sloughing tissue included)
G0163[3]	Positron emission tomography (PET), whole body; for recurrence of colorectal metastatic cancer
G0164[3]	Positron emission tomography (PET), whole body; for staging and characterization of lymphoma
G0165[3]	Positron emission tomography (PET), whole body; for recurrence of melanoma or melanoma metastatic cancer
G0166[3]	External counterpulsation, per treatment session
G0168[3]	Wound closure by adhesive
J0130	Injection, abciximab, 10 mg
J0205	Injection, alglucerase, per 10 units
J0207	Injection, amifostine, 500 mg
J0256	Injection, alpha 1-proteinase inhibitor—human, 10 mg
J0286	Injection, amphotericin B, any lipid formulation, 50 mg
J0350	Injection, anistreplase, per 30 units
J0476	Baclofen intrathecal trial, 50 mcg
J0585	Botulinum toxin, type A, per unit
J0640	Injection, leucovorin calcium, per 50 mg
J0850	Injection, cytomegalovirus immune globulin intravenous (human), per vial
J1190	Injection, dexrazoxane hydrochloride, per 250 mg
J1260	Injection, dolasetron mesylate, 10 mg
J1325	Injection, epoprostenol, 0.5 mg
J1327	Injection, eptifibatide, 5 mg
J1436	Injection, etidronate disodium, per 300 mg
J1438	Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)
J1440	Injection, filgrastim (G-CSF), 300 mcg
J1561	Injection, immune globulin, intravenous, 500 mg
J1562	Injection, immune globulin, intravenous, 5 gms
J1565	Injection, respiratory syncytial virus immune globulin, intravenous, 50 mg
J1620	Gonadorelin hcl, 100 mcg
J1626	Injection, granisetron hydrochloride, 100 mcg
J1670	Injection, tetanus immune globulin, human, up to 250 units
J1745	Injection, infliximab, 10 mg
J1785	Injection, imiglucerase, per unit
J1825	Injection, interferon beta-1a, 33mcg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)
J1830	Injection, interferon beta-1b, 0.25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg
J2275	Injection, morphine sulfate (preservative-free sterile solution), per 10 mg
J2352	Injection, octreotide acetate, 1 mg
J2355	Injection, oprelvekin, 5 mg
J2405	Injection, ondansetron HCl, per 1 mg
J2430	Injection, pamidronate disodium, per 30 mg
J2765	Injection, metoclopramide HCl, up to 10 mg
J2790	Injection, Rho (D) immune globulin, human, one dose package
J2792	Injection, Rho (D) immune globulin, intravenous, human, solvent detergent, 100 I.U.
J2820	Injection, sargramostim (GM-CSF), 50 mcg
J3010	Injection, fentanyl citrate, up to 2 ml
J3240	Injection, thyrotropin alfa, 0.9 mg
J3245	Injection, tirofiban hydrochloride, 12.5 mg
J3280	Injection, thiethylperazine maleate, up to 10 mg
J3305	Injection, trimetrexate glucuronate, per 25 mg
J7190	Factor VIII (antihemophilic factor, human), per I.U.
J7191	Factor VIII (antihemophilic factor, (porcine)), per I.U.
J7192	Factor VIII (antihemophilic factor, recombinant), per I.U.
J7194	Factor IX, complex, per IU

Coding Information for Hospital Outpatient Prospective Payment System (continued)

HCPCS CODE	LONG DESCRIPTORS
J7197	Antithrombin III (human), per IU
J7198	Anti-inhibitor, per I.U.
J7310	Ganciclovir, 4.5 mg, long-acting implant
J7315	Sodium hyaluronate for intra articular injection, 20 mg
J7320	Hylan G-F 20, 16 mg, for intra articular-injection
J7500	Azathioprine, oral, 50 mg
J7501	Azathioprine, parenteral, 100 mg
J7502	Cyclosporine, oral, 100 mg
J7504	Lymphocyte immune globulin, antithymocyte globulin, parenteral, 250 mg
J7505	Muromonab-CD3, 5 mg
J7507	Tacrolimus oral per 1 mg
J7513	Daclizumab, parenteral, 25 mg
J7516	Cyclosporin, parenteral, 250 mg
J8510	Busulfan; oral, 2 mg
J8520	Capecitabine, oral, 150 mg
J8530	Cyclophosphamide, oral, 25 mg
J8560	Etoposide, oral, 50 mg
J8600	Melphalan, oral, 2 mg
J8610	Methotrexate, oral, 2.5 mg
J9000	Doxorubicin HCl, 10 mg
J9001	Doxorubicin hydrochloride, all lipid formulations, 10 mg
J9015	Aldesleukin, per single use vial
J9020	Asparaginase, 10,000 units
J9031	BCG (intravesical), per installation
J9040	Bleomycin sulfate, 15 units
J9045	Carboplatin, 50 mg
J9050	Carmustine, 100 mg
J9060	Cisplatin, powder or solution, per 10 mg
J9065	Injection, cladribine, per 1 mg
J9070	Cyclophosphamide, 100 mg
J9093	Cyclophosphamide, lyophilized, 100 mg
J9100	Cytarabine, 100 mg
J9120	Dactinomycin, 0.5 mg
J9130	Dacarbazine, injection, 100 mg
J9150	Daunorubicin HCl, 10 mg
J9151	Daunorubicin citrate, liposomal formulation, 10 mg
J9165	Diethylstilbestrol diphosphate, 250 mg
J9170	Docetaxel, 20 mg
J9181	Etoposide, 10 mg
J9185	Fludarabine phosphate, 50 mg
J9190	Fluorouracil, 500 mg
J9200	Floxuridine, 500 mg
J9201	Gemcitabine HCl, 200 mg
J9202	Goserelin acetate implant, per 3.6 mg
J9206	Irinotecan, 20 mg
J9208	Ifosfamide, 1 gm
J9209	Mesna, 200 mg
J9211	Idarubicin HCl, 5 mg
J9212	Injection, interferon Alfacon-1, recombinant, 1 mcg
J9213	Interferon, alfa-2A, recombinant, 3 million units
J9214	Interferon, alfa-2B, recombinant, 1 million units
J9215	Interferon, alfa-N3, (human leukocyte derived), 250,000 IU
J9216	Interferon, gamma 1-B, injection, 3 million units
J9218	Leuprolide acetate, per 1 mg
J9230	Mechlorethamine HCl (nitrogen mustard), 10 mg
J9245	Injection, melphalan HCl, 50 mg
J9250	Methotrexate sodium, 5 mg
J9265	Paclitaxel, 30 mg
J9266	Pegaspargase, per single dose vial
J9268	Pentostatin, per 10 mg

Coding Information for Hospital Outpatient Prospective Payment System (continued)

HCPCS CODE	LONG DESCRIPTORS
J9270	Plicamycin, 2.5 mg
J9280	Mitomycin, 5 mg
J9293	Injection, mitoxantrone HCl, per 5 mg
J9310	Rituximab, 100 mg
J9320	Streptozocin, injection, 1 g
J9340	Thiotepa, 15 mg
J9350	Topotecan, 4 mg
J9355	Trastuzumab, 10 mg
J9357	Valrubicin, intravesical, 200 mg
J9360	Vinblastine sulfate, 1 mg
J9370	Vincristine sulfate, 1 mg
J9390	Vinorelbine tartrate, per 10 mg
J9600	Porfimer sodium, 75 mg
L8614	Cochlear device/system
Q0136	Injection, epoetin alpha, (for non-ESRD use), per 1000 units
Q0160	Factor IX (antihemophic factor, purified, non-recombinant), per I.U.
Q0161	Factor IX (antihemophic factor, non-recombinant), per I.U.
Q0163	Diphenhydramine hydrochloride, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48-hour dosage regimen
Q0164	Prochlorperazine maleate, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48-hour dosage regimen
Q0166	Granisetron hydrochloride, 1 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48-hour dosage regimen
Q0167	Dronabinol, 2.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48-hour dosage regimen
Q0169	Promethazine hydrochloride, 12.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48-hour dosage regimen
Q0171	Chlorpromazine hydrochloride, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48-hour dosage regimen
Q0173	Trimethobenzamide hydrochloride, 250 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48-hour dosage regimen
Q0174	Thiethylperrazine maleate, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48-hour dosage regimen
Q0175	Perphenazine, 4 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48-hour dosage regimen
Q0177	Hydroxyzine pamoate, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48-hour dosage regimen
Q0179	Ondansetron hydrochloride, 8 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48-hour dosage regimen
Q0180	Dolasetron mesylate, 100 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48-hour dosage regimen
Q0181	Unspecified oral anti-emetic
Q0187	Factor VIIa (coagulation factor, recombinant) per 1.2 mg
Q2002	Injection, Elliot's B solution, per ml
Q2003	Injection, aprotinin, 10,000 kiu
Q2004	Irrigation solution for treatment of bladder calculi, for example renacidin, per 500 ml
Q2005	Injection, corticorelin ovine triflutate, per dose
Q2006	Injection, digoxin immune fab (ovine), per vial
Q2007	Injection, ethanolamine oleate, 100 mg
Q2008	Injection, fomepizole, 1.5 mg
Q2009	Injection, fosphenytoin, 50 mg
Q2010	Injection, glatiramer acetate, per dose
Q2011	Injection, hemin, per 1 mg
Q2012	Injection, pegademase bovine, 25 IU
Q2013	Injection, pentastarch, 10% solution, per 100 ml
Q2014	Injection, sermorelin acetate, 0.5 mg

Coding Information for Hospital Outpatient Prospective Payment System (continued)

HCPCS CODE	LONG DESCRIPTORS
Q2015	Injection, somatrem, 5 mg
Q2016	Injection, somatropin, 1 mg
Q2017	Injection, teniposide, 50 mg
Q2018	Injection, urofollitropin, 75 IU
Q2019	Injection, basiliximab, 20 mg
Q2020	Injection, histrelin acetate, 10 mg
Q2021	Injection, lepirudin, 50 mg
Q2022	Von Willebrand factor complex, human, per IU
Q3002	Supply of radiopharmaceutical diagnostic imaging agent, gallium Ga 67, per mCi
Q3003	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m bicisate, per unit dose
Q3004	Supply of radiopharmaceutical diagnostic imaging agent, xenon XE 133, per 10 mCi
Q3005	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m mertiatide, per vial
Q3006	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m D-gluco-heptonate complex
Q3007	Supply of radiopharmaceutical diagnostic imaging agent, sodium phosphate P 32, per mCi
Q3008	Supply of radiopharmaceutical diagnostic imaging agent, indium IN 111 pentetreotide, per 3 mCi
Q3009	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m oxidronate, per mCi
Q3010	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m labeled red blood cell, per mCi
Q3011	Supply of radiopharmaceutical diagnostic imaging agent, chromic phosphate P 32 suspension, per mCi

The **specific** devices shown below should be coded using the corresponding C-codes only. The C codes in the left column (see below) are temporary and should only be used from August 1, 2000 to September 30, 2000. The C-codes in the right column (see below) are to be used effective October 1, 2000.

The information contained within this article is for billing purposes only. The outpatient code editor (OCE) system will not be updated to reflect the changes below until the next OCE update is implemented on October 1, 2000.

HCPCS Code (Aug-Sep)	LONG DESCRIPTORS	HCPCS Code (as of 10/01/00)
C1005	Intraocular lens, STAAR Elastic Ultraviolet-Absorbing Silicone Posterior Chamber Intraocular Lens with Toric Optic Model AA-4203T, Model AA-4203TF, Model AA-4203TL	C3851
C1007	Prosthesis, penile, Mentor Alpha I Inflatable Penile Prosthesis	C3500
C1025	Fast-Cath, Swartz, SAFL, CSTA, SEPT, RAMP Guiding Introducer	C1004
C1026	Catheter, ablation, Gynecare Thermachoice II Catheter	C1056
C1027	Stent, coronary, Radius 20mm Self Expanding Stent with Over the Wire Delivery System	C5046
C1028	Single use device for treatment of female stress urinary incontinence, Tension-Free Vaginal Tape Single Use Device	C1370
C1028	Sling fixation system for treatment of stress urinary incontinence, Female In-Fast Sling Fixation System with Electric Inserter *with* Sling Material, Female In-Fast Sling Fixation System with Electric Inserter *without* Sling Material	C6050
C1028	Sling fixation system for treatment of stress urinary incontinence, Male Straight-In Fixation System with Electric Inserter *with* Sling Material and Disposable Pressure Sensor, Male Straight-In Fixation System with Electric Inserter *without* Sling Material and Disposable Pressure Sensor	C6080
C1030	Catheter, balloon dilatation, D114S Over-the-Wire Balloon Dilatation Catheter	C1108
C1033	Catheter, imaging, UltraCross 2.9 F 30 MHz Coronary Imaging Catheter, UltraCross 3.2 F MHz Coronary Imaging Catheter	C1038
C1033	Catheter, Transesophageal 210 Atrial Pacing Catheter, Transesophageal 210-S Atrial Pacing Catheter	C1055

Coding Information for Hospital Outpatient Prospective Payment System (continued)

HCPCS Code (Aug-Sep)	LONG DESCRIPTORS	HCPCS Code (as of 10/01/00)
C1034	Catheter, coronary angioplasty balloon, Adante, Bonnie, Bonnie 15mm, Bonnie Sliding Rail, Bypass Speedy, Chubby, Chubby Sliding Rail, Coyote 20mm, Coyote 9/15/25mm, Maxxum, NC Ranger, NC Ranger 9mm, NC Ranger 16/18mm, NC Ranger 22/25/30mm, NC Big Ranger, Quantum Ranger, Quantum Ranger 1/4 sizes, Quantum Ranger 9/16/18mm, Quantum Ranger 22/30mm, Quantum Ranger 25mm, Ranger LP 20/30/40, Viva/Long Viva	C1981
C1036	Infusion system, On-Q Pain Management System	C1368
C1039	Stent, tracheobronchial, UltraFlex Tracheobronchial Endoprothesis (covered and non-covered)	C5284
C1040	Stent, self-expandable for creation of intrahepatic shunts, Wallstent Transjugular Intrahepatic Portosystemic Shunt (TIPS) with Unistep Plus Delivery System (80 mm in length)	C5283
C1042	Stent, biliary, Symphony Nitinol Stent Transhepatic Biliary System	C1371
C1043	Atherectomy system, peripheral, Rotablator Rotational Angioplasty System with the RotaLink Exchangeable Catheter and Advancer	C1500
C1069	Pacemaker, dual chamber, rate-responsive, Entity DR 5326L, Entity DR 5326R	C1135
C1069	Pacemaker, dual chamber, rate-responsive, Affinity DR 5330L, Affinity DR 5330R	C1136
C1078	Defibrillator, dual chamber, Photon DR V-230HV3	C1364
C1100	Guide wire, peripheral, Hi-Torque SPARTACORE 14 Guide Wire, Hi-Torque MEMCORE FIRM 14 Guide Wire, Hi-Torque STEELCORE 18 Guide Wire, Hi-Torque SUPRA CORE 35 Guide Wire	C1365
C1100	Guide wire, percutaneous transluminal coronary angioplasty, Hi-Torque Iron man, Hi-Torque Balance Middleweight, Hi-Torque All Star, Hi-Torque Balance Heavyweight, Hi-Torque Balance Trek	C1366
C1100	Guide wire, percutaneous transluminal coronary angioplasty, Hi-Torque Cross It, Hi-Torque Cross-It 100XT, Hi-Torque Cross-It 200XT, Hi-Torque Cross-It 300 XT, Hi-Torque Wiggle	C1367
C1104	Catheter, ablation, Livewire TC Ablation Catheter 402132, 402133, 402134, 402135, 402136, 402137, 402145, 402146, 402147, 402148, 402149, 402150, 402151, 402152, 402153, 402154, 402155, 402156	C1003
C1104	Catheter, intracardiac echocardiography, Ultra ICE 6F, 12.5 MHz Catheter (with disposable sheath), Ultra ICE 9F, 9 MHz Catheter (with disposable sheath)	C1035
C1112	Endograft system, Ancure Endograft Delivery System	C1117
C1132	Pacemaker, single chamber, Meridian SSI	C1181
C1132	Pacemaker, single chamber, Pulsar SSI	C1182
C1145	Vascular Closure Device, VasoSeal ES (Extravascular Security) Device	C5600
C1153	Pacemaker, single chamber, Jade II S, Sigma 300 S	C1183
C1153	Pacemaker, single chamber, Sigma 200 S	C1184
C1155	Repliform Tissue Regeneration Matrix, per 14 or 21 square centimeters	C1600
C1155	Repliform Tissue Regeneration Matrix, per 24 or 28 square centimeters	C1601
C1158	Lead, defibrillator, CapSure Fix 6940, CapSure Fix 4068-110	C1303

Coding Information for Hospital Outpatient Prospective Payment System (continued)

HCPCS Code (Aug-Sep)	LONG DESCRIPTORS	HCPCS Code (as of 10/01/00)
C1162	Pacemaker, dual chamber, Affinity VDR 5430	C4302
C1170	Biopsy device, MIBB Device	C1175
C1170	Biopsy device, Mammotome HH Hand-Held Probe with Smartvac Vacuum System	C1176
C1170	Biopsy device, 11-Gauge Mammotome Probe with Vacuum Cannister	C1177
C1170	Biopsy device, 14-Gauge Mammotome Probe with Vacuum Cannister	C1179
C1173	Stent, coronary, NIR ON Ranger Stent Delivery System, NIR w/Sox Stent System, NIR Primo Premounted Stent System	C1375
C1173	Stent, coronary, S660 with Discrete Technology Over-the-Wire Coronary Stent System 9mm, 12mm S660 with Discrete Technology Rapid Exchange Coronary Stent System 9mm, 12mm	C5030
C1173	Stent, coronary, S660 with Discrete Technology Over-the-Wire Coronary Stent System 15mm, 18mm S60 with Discrete Technology Rapid Exchange Coronary Stent System 15mm, 18mm	C5031
C1173	Stent, coronary, S660 with Discrete Technology Over-the-Wire Coronary Stent System 24mm, 30mm, S660 with Discrete Technology Rapid Exchange Coronary Stent System 24mm, 30mm	C5032
C1174	Needle, brachytherapy, Authentic Mick TP Brachytherapy Needle	C1700
C1174	Needle, brachytherapy, Medtec MT-BT-5201-25 Brachytherapy Needle	C1701
C1174	Needle, brachytherapy, Mentor Prostate Brachytherapy Needle	C1703
C1174	Needle, brachytherapy, Medtec MT-BT-5001-25, MT-BT-5051-25	C1704
C1306	Lead, neurostimulator, ANS Renew Spinal Cord Stimulation System Lead	C1376
C1306	Lead, neurostimulator, Specify 3998 Lead	C1377
C1306	Lead, neurostimulator, InterStim Therapy 3080 Lead, InterStim Therapy 3886 Lead	C1378
C1306	Lead, neurostimulator, Pisces-Quad Compact 3887 Lead	C1379
C1318	Pacemaker, single chamber, Vigor SR	C1180
C1319	Stent, enteral, Wallstent Enteral Endoprosthesis and Unistep Delivery System (90mm in length)	C5134
C1324	Electrode, disposable, Gynecare VERSAPOINT Resectoscopic System Bipolar Electrode	C1329
C1324	Electrode, disposable, VAPR Electrode, VAPR T Thermal Electrode	C1323
C1324	Electrode, disposable, Palate Somnoplasty Coagulating Electrode, Base of Tongue Somnoplasty Coagulating Electrode	C1321
C1324	Electrode, disposable, Turbinate Somnoplasty Coagulating Electrode	C1322
C1326	Catheter, thrombectomy, Oasis Thrombectomy Catheter	C1051
C1326	Catheter, thrombectomy, Hydrolyser 6F Mechanical Thrombectomy Catheter, Hydrolyser 7F Mechanical Thrombectomy Catheter	C1054

Coding Information for Hospital Outpatient Prospective Payment System (continued)

HCPCS Code (Aug-Sep)	LONG DESCRIPTORS	HCPCS Code (as of 10/01/00)
C1328	Internal receiver, neurostimulation system, ANS Renew Spinal Cord Stimulator System	C1369
C1333	Stent, biliary, Smart Cordis Nitinol Stent and Delivery System	C1372
C1335	Gore-Tex DualMesh Biomaterial, per 75 or 96 square centimeters (1mm thick)	C6017
C1335	Gore-Tex DualMesh Biomaterial, per 150 square centimeters oval shaped (1mm thick)	C6018
C1335	Gore-Tex DualMesh Biomaterial, per 285 square centimeters oval shaped (1mm thick)	C6019
C1335	Gore-Tex DualMesh Biomaterial, per 432 square centimeters (1mm thick)	C6020
C1335	Gore-Tex DualMesh Biomaterial, per 600 square centimeters (1mm thick)	C6021
C1335	Gore-Tex DualMesh Biomaterial, per 884 square centimeters oval shaped (1mm thick)	C6022
C1335	Gore-Tex DualMesh *Plus* Biomaterial, per 75 or 96 square centimeters (1mm thick)	C6023
C1335	Gore-Tex DualMesh *Plus* Biomaterial, per 150 square centimeters oval shaped (1mm thick)	C6024
C1335	Gore-Tex DualMesh *Plus* Biomaterial, per 285 square centimeters oval shaped (1mm thick)	C6025
C1335	Gore-Tex DualMesh *Plus* Biomaterial, per 432 square centimeters (1mm thick)	C6026
C1335	Gore-Tex DualMesh *Plus* Biomaterial, per 600 square centimeters (1mm thick)	C6027
C1335	Gore-Tex DualMesh *Plus* Biomaterial, per 884 square centimeters oval shaped (1mm thick)	C6028
C1335	Gore-Tex DualMesh *Plus* Biomaterial, per 150 square centimeters oval shaped (2mm thick)	C6029
C1335	Gore-Tex DualMesh *Plus* Biomaterial, per 285 square centimeters oval shaped (2mm thick)	C6030
C1335	Gore-Tex DualMesh *Plus* Biomaterial, per 432 square centimeters (2mm thick)	C6031
C1335	Gore-Tex DualMesh *Plus* Biomaterial, per 600 square centimeters (2mm thick)	C6032
C1335	Gore-Tex DualMesh *Plus* Biomaterial, per 884 square centimeters (2mm thick)	C6033
C1336	Infusion pump, implantable, programmable, SynchroMed EL Infusion Pump	C3800
C1336	Infusion pump, implantable, non-programmable, IsoMed Infusion Pump Model 8472-20, 8472-35, 8472-60	C1337
C1352	Defibrillator, implantable, dual chamber**,** Gem DR	C1363
C1359	Pacemaker, dual chamber, Integrity AFx DR Model 5342	C4300
C1359	Pacemaker, dual chamber, Integrity AFx DR Model 5346	C4301

II. Devices Classified with "New Technology" APCs Effective October 1, 2000

The Health Care Financing Administration (HFCA) has received a large number of applications from pharmaceutical and device manufacturers, hospitals and other interested parties for transitional pass-through payments. Many of the items included in these applications were approved for pass-through status. However, a number of them did not meet the criteria for pass-through payment that were established by statute and in the outpatient prospective payment system final rule published in the *Federal Register* on April 7, 2000 (65 Fed Reg. 18478-18482). The statute permits transitional pass-through payments for a new item only where payment for the item was not being made as of December 31, 1996. HCFA has determined that many of the items that failed to meet the pass-through criteria were items that were in use prior to 1997. Therefore, HCFA has evaluated the items that failed to meet the pass-through criteria to determine their potential eligibility for recognition as new technology items.

Coding Information for Hospital Outpatient Prospective Payment System (continued)

HCFA stated in the final rule that an item or service must meet certain criteria to be considered eligible for assignment to a new technology payment group (see 65 FR 18478). The first criterion is that "the item or service is one that could not have been billed to the Medicare program in 1996 or, if it was available in 1996, the cost of the item or price could not have been adequately represented in 1996 data" (65 Fed Reg. 18478). In determining whether the cost of an item or service "could not have been adequately represented," HCFA used the methodology specified in section 201(g) of the Balanced Budget Refinement Act of 1999, which limits the variation of costs of services classified within a group. Using this methodology, if the cost of the device (as submitted by the manufacturer) plus the median cost for the procedure with which the device is associated would have exceeded the limits imposed by the "two times" rule set forth in the April 7, 2000 final rule for the relevant APC (65 FR 18439), HCFA has determined that the cost of the item could not have been adequately represented in the 1996 data used to construct the outpatient PPS. Therefore, HCFA has found such items eligible for payment as new technology items and assigned them to the appropriate new technology APCs. These new technology items are listed below.

HCPCS C-code	Long Descriptor	APC
C8500	Catheter, atherectomy, Atherocath-GTO Atherectomy Catheter	977
C8501	Pacemaker, single chamber, Vigor SSI	983
C8502	Catheter, diagnostic, electrophysiology, Livewire Steerable Electrophysiology Catheter	974
C8503	Catheter, Synchromed Vascular Catheter Model 8702	986
C8504	Closure device, VasoSeal Vascular Hemostasis Device	972
C8505	Infusion pump, implantable, programmable, SynchroMed Infusion Pump	985
C8506	Lead, pacemaker, 4057M, 4058M, 4557M, 4558M, 5058	976
C8507	Lead, defibrillator, 6721L, 6721M, 6721S, 6939 Oval Patch Lead	976
C8508	Lead, defibrillator, CapSure 4965	976
C8509	Lead, defibrillator, Transvene 6933, Transvene 6937	976
C8510	Lead, defibrillator, DP-3238	977
C8511	Lead, defibrillator, EndoTak DSP	985
C8512	Lead, neurostimulation, On-Point Model 3987, Pisces—Quad Plus Model 3888, Resume TL Model 3986	977
C8513	Lead, neurostimulation, Pisces—Quad Model 3487a, Resume II Model 3587a	977
C8514	Prosthesis, penile, Dura II Penile Prosthesis	981
C8515	Prosthesis, penile, Mentor Alpha I Narrow-Base Inflatable Penile Prosthesis	983
C8516	Prosthesis, penile, Mentor Acu-Form Malleable Penile Prosthesis, Mentor Malleable Penile Prosthesis	979
C8517	Prosthesis, penile, Ambicor Penile Prosthesis	983
C8518	Pacemaker, dual chamber, Vigor DDD	984
C8519	Pacemaker, dual chamber, Vista DDD	984
C8520	Pacemaker, single chamber, Legacy II S	983
C8521	Receiver/transmitter, neurostimulator, Medtronic Mattrix	986
C8522	Stent, biliary, PALMAZ Balloon Expandable Stent	976
C8523	Stent, biliary, Wallstent Transhepatic Biliary Endoprosthesis	977
C8524	Stent, esophageal, Wallstent Esophageal Prosthesis	978
C8525	Stent, esophageal, Wallstent Esophageal Prosthesis (Double)	979
C8532	Stent, esophageal, UltraFlex Esophageal Stent System	977
C8533	Catheter, Synchromed Vascular Catheter Model 8700A, 8700V	974
C8534	AMS Malleable 650 Penile Prosthesis	979

Coding Information for Hospital Outpatient Prospective Payment System (continued)

III. Short Descriptor Changes Effective August 1, 2000

The following short descriptors posted on HCFA's web page on May 12, 2000 have been revised. See changes below.

HCPCS code	Short Descriptor	Revised Short Descriptor
C1027	Magic WALLSTENTstent—Short	Magic x/short, Radius14mm
C1039	WALLSTENT: Esoph stent	Wallstent, tracheobronchial
C1042	WALLSTENT: Bil,Entrl,Ilc,1K	Wallstent, biliary
C1043	Rotablater ADVANCER w/Burr	Atherectomy sys, coronary
C1044	Bioz.Com: monitor	BioZ.com sensor
C1047	NOGA-STAR catheter	Noga/Navi-Star cath
C1072	RX Esprit-cor blln dil cath	Guidant: blln dil cath
C1073	Guidant: blln dil cath	Morcellator
C1076	Ventak mini sc pmkr	Ventak mini sc defib
C1077	Ventak VR Prizm VR, SC pmkr	Ventak VR Prizm VR, sc defib
C1078	Ventak: Prizm, AVIIIDR pmker	Ventak: Prizm, AVIIIDR defib
C1109	RF Performr ablatn cath	Implantable anchor: Ethicon
C1122	TC 99M arcitumomab per dose	TC 99M arcitumomab per vial
C1145	Angio-Seal 6fr vas mod#610091	Angio-Seal 6fr, 8fr
C1146	Angio-Seal 8fr vasc clos dev	VETT tube
C1151	Passiveplus DX lead, 4mdls	Passiveplus DX lead, 10mdls
C1152	Pasve+Dxlead 1346T,1342 1346	LifeSite Access System
C1155	SpyglassTM angiograph cath	Repliform 8 sq cm
C1302	SQ01, DP-3238: lead	SQ01: lead
C1305	WALLSTENT:UniPls dlvry sys	Apligraf
C1313	Magic WALLSTENTstent-Medium	Magic medium, Radius 31mm
C1319	WALLSTENT:Bil,Entrl,18C	WALLSTENT: enteral
C1320	WALLSTENT:Unistep-dlvry sys	WALLSTENT:iliac
C1328	Mattrix NS recvr/trnsmtr	ANS Renew NS trnsmtr
C1334	PALMAZ Schatz Crown stent	Crown,Mini-crown,CrossLC
C1335	PALMAZ SchatzMiniCrown stent	Mesh, Prolene
C1336	CrossFlex LC Stent	Constant Flow Imp Pump

Coding Information for Hospital Outpatient Prospective Payment System (continued)

IV. Blood/Blood Products and Drugs Classified in Separate APCs Effective AUGUST 1, 2000

The following list of blood/blood products and drugs are classified in separate APCs. Since these are classified in separate APCs, they are **not** eligible for the transitional pass-through payment system.

HCPCS Code	Long Description	APC
C1009	Plasma, cryoprecipitate reduced, each unit	1009
C1010	Blood, leukoreduced, CMV-negative, each unit	1010
C1011	Platelet, HLA-matched leukoreduced, apheresis/pheresis, each unit	1011
C1012	Platelet concentrate, leukoreduced, irradiated, each unit	1012
C1013	Platelet concentrate, leukoreduced, each unit	1013
C1014	Platelet, leukoreduced, apheresis/pheresis, each unit	1014
C1016	Blood, leukoreduced, frozen/deglycerol/washed, each unit	1016
C1017	Platelet, leukoreduced, CMV-negative, apheresis/pheresis, each unit	1017
C1018	Blood, leukoreduced, irradiated, each unit	1018
C1019	Platelet, leukoreduced, irradiated, apheresiss/pheresis, each unit	1019
J0150	Injection, adenosine 6mg (not to be used to report any adenosine phosphate compounds, instead use A9270)	0917
J1245	Injection, dipyridamole, per 10 mg	0917
J1570	Injection, ganciclovir sodium, 500 mg	0907
J2260	Injection, milrinone lactate, per 5 ml	7007
J2994	Injection, reteplase, 37.6 mg (two single use vials)	0914
J2995	Injection, streptokinase, per 250,000 I.U.	0911
J2996	Injection, alteplase recombinant, per 10 mg	0915
J3365	Injection, IV, urokinase, 250,000 I.U. vial	7036
P9010	Blood (whole), for transfusion, per unit	0950
P9012	Cryoprecipitate, each unit	0952
P9013	Fibrinogen unit	0953
P9016	Leukocyte poor blood, each unit	0954
P9017	Plasma, single donor, fresh frozen, each unit	0955
P9018	Plasma protein fraction, each unit	0956
P9019	Platelet concentrate, each unit	0957
P9020	Platelet rich plasma, each unit	0958
P9021	Red blood cells, each unit	0959

Coding Information for Hospital Outpatient Prospective Payment System (continued)

V. Stereotactic Radiosurgery Codes for Use in Hospitals Under the Outpatient Prospective Payment System Effective August 1, 2000

For reporting stereotactic radiosurgery in place of HCPCS code 61793*:

61793 Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions

Hospitals should use the following HCPCS code(s):

G0173 Stereotactic radiosurgery, complete course of therapy in one session
G0174 Stereotactic radiosurgery, requiring more than one session

VI. Two Additional "New Technology" APCs and Their Payment Rates Effective October 1, 2000

APC	Group Title	Payment Rate	Minimum Unadjusted Coinsurance
0985	New Technology—Level XVI ($6,000 - $7,000)	$ 6,500	$1,300
0986	New Technology—Level XVII ($7,000 - $7,500)	$7,500	$1,500

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

First Update to the Coding Information for Hospital Outpatient Prospective Payment System

The following article is the first update to the original coding information for hospital outpatient prospective payment system (OPPS). See pages 56-70.

The information in this article provides hospitals with a list of long descriptors for drugs, biologicals, and devices eligible for transitional pass through payments, and for items classified in "new technology" ambulatory payment classifications (APCs) under the Outpatient PPS.

- Section I lists items with specific C-codes that are effective October 1, 2000. Many of the items listed in this section were effective August 1, 2000 with temporary assigned C-codes for use from August 1, 2000 to September 30, 2000. (See pages 56-63).
- Section II contains a list of devices that are classified in "new technology" APCs.
- Section III contains a new set of APCs created specifically for new technology devices.
- Section IV contains a list of blood/blood products that are classified in separate APCs and are **not** eligible for transitional pass-through payments.
- Section V contains a list of clarifications and corrections to the original article on the coding information for hospital outpatient PPS. (See pages 56-70).
- Section VI contains an item that will be ineligible for pass-through payments effective October 1, 2000.

Unless otherwise indicated, the effective date for the items in this article is October 1, 2000.

The listing of HCPCS codes contained in this instruction does not assure coverage of the specific item or service in a given case. To be eligible for pass-through and new technology payments, the items contained in this document must be considered reasonable and necessary.

All of the C-codes included in this file are used exclusively for services paid under the Outpatient PPS and may **not** be used to bill services paid under other Medicare payment systems.

Coinsurance is not applied to the additional payment allowed under the transitional pass-through provision. Therefore, some codes included in this article are not subject to coinsurance payments. The PRICER system will calculate the deductible and coinsurance, if applicable, for billed services.

I. Drugs, Biologics, and Devices Effective October 1, 2000

HCPCS CODE	LONG DESCRIPTOR
C1003	Catheter, ablation, Livewire TC Ablation Catheter 402132, 402133, 402134, 402135, 402136, 402137, 402145, 402146, 402147, 402148, 402149, 402150, 402151, 402152, 402153, 402154, 402155, 402156
C1004	Fast-Cath, Swartz, SAFL, CSTA, SEPT, RAMP Guiding Introducer
C1007	Prosthesis, penile, AMS 700 Penile Prosthesis, AMS Ambicor Penile Prosthesis **Note:** Only the AMS Ambicor Penile Prosthesis is effective October 1, 2000. The AMS 700 Penile Prosthesis was effective August 1, 2000.
C1025	Catheter, Marinr CS, InDura Intraspinal Catheter **Note:** The Marinr CS and InDura Intraspinal Catheter were effective August 1, 2000. See Section V of this article for additional information.
C1035	Catheter, intracardiac echocardiography, Ultra ICE 6F, 12.5 MHz Catheter (with disposable sheath), Ultra ICE 9F, 9 MHz Catheter (with disposable sheath)
C1038	Catheter, imaging, UltraCross 2.9 F 30 MHz Coronary Imaging Catheter, UltraCross 3.2 F MHz Coronary Imaging Catheter
C1039	Stent, tracheobronchial, Wallstent Tracheobronchial Endoprosthesis (covered), Wallstent Tracheobronchial Endoprosthesis with Permalume Covering and Unistep Plus Delivery System, Wallstent **RP** Tracheobronchial Endoprosthesis with Unistep Plus Delivery System **Note:** Only the Wallstent **RP** Tracheobronchial Endoprosthesis with Unistep Plus Delivery System is effective October 1, 2000. The Wallstent Tracheobronchial was effective August 1, 2000.
C1040	Stent, self-expandable for creation of intrahepatic shunts, Wallstent Transjugular Intrahepatic Portosystemic Shunt (TIPS) with Unistep Plus Delivery System (20/40/60 mm in length), Wallstent **RP** TIPS Endoprosthesis with Unistep Plus Delivery System (20/40/60 mm in length) **Note:** Only the Wallstent **RP** TIPS Endoprosthesis with Unistep Plus Delivery System is effective October 1, 2000. The Wallstent TIPS Endoprosthesis with Unistep Plus Delivery System was effective August 1, 2000.
C1042	Stent, biliary, Wallstent Biliary Endoprosthesis with Unistep Plus Delivery System, Wallstent Biliary Endoprosthesis with Unistep Delivery System (Biliary Stent and Catheter), Wallstent **RP** Biliary Endoprosthesis with Unistep Plus Delivery System, Ultraflex Diamond Biliary Stent System, New Microvasive Biliary Stent and Delivery System **Note:** Only the Wallstent **RP** Biliary Endoprosthesis with Unistep Plus Delivery System is effective October 1, 2000. The Wallstent, UltraFlex Diamond, and Microvasive Biliary Stent Systems were effective August 1, 2000.
C1051	Catheter, thrombectomy, Oasis Thrombectomy

First Update to the Coding Information for Hospital Outpatient Prospective Payment System (continued)

	Catheter
C1054	Catheter, thrombectomy, Hydrolyser 6F Mechanical Thrombectomy Catheter, Hydrolyser 7F Mechanical Thrombectomy Catheter
C1055	Catheter, Transesophageal 210 Atrial Pacing Catheter, Transesophageal 210-S Atrial Pacing Catheter
C1056	Catheter, ablation, Gynecare Thermachoice II Catheter
C1101	Catheter, percutaneous transluminal coronary angioplasty guide, Medtronic AVE 5F, 6F, 7F, 8F, 9F Zuma Guide Catheter, Medtronic AVE **Z2** 5F, 6F, 7F, 8F, 9F Zuma Guide Catheter **Note:** Only the Medtronic AVE **Z2** Zuma Guide Catheters are effective October 1, 2000. The Medtronic AVE Zuma Guide Catheters were effective August 1, 2000.
C1117	Endograft system, Ancure Endograft Delivery System
C1135	Pacemaker, dual chamber, rate-responsive, Entity DR 5326L, Entity DR 5326R
C1136	Pacemaker, dual chamber, rate-responsive, Affinity DR 5330L, Affinity DR 5330R
C1175	Biopsy device, MIBB Device
C1176	Biopsy device, Mammotome HH Hand-Held Probe with Smartvac Vacuum System
C1177	Biopsy device, 11-Gauge Mammotome Probe with Vacuum Cannister
C1179	Biopsy device, 14-Gauge Mammotome Probe with Vacuum Cannister
C1180	Pacemaker, single chamber, Vigor SR
C1181	Pacemaker, single chamber, Meridian SSI
C1182	Pacemaker, single chamber, Pulsar SSI
C1183	Pacemaker, single chamber, Jade II S, Sigma 300 S
C1184	Pacemaker, single chamber, Sigma 200 S
C1303	Lead, defibrillator, CapSure Fix 6940, CapSure Fix 4068-110
C1319	Stent, enteral, Wallstent Enteral Wallstent Endoprosthesis and Unistep Delivery System (60mm in length), Enteral Wallstent Endoprosthesis and Unistep Plus Delivery System/Single-Use Colonic and Duodenal Endoprosthesis with Unistep Plus Delivery System (60mm in length) **Note:** Only the Enteral Wallstent Endoprosthesis with Unistep Plus Delivery System is effective October 1, 2000. The Wallstent Enteral Endoprosthesis and Unistep Delivery System was effective August 1, 2000.
C1320	Stent, iliac, Wallstent Iliac Endoprosthesis with Unistep Plus Delivery System, Wallstent **RP** Iliac Endoprosthesis with Unistep Plus Delivery System **Note:** Only the Wallstent **RP** Iliac Endoprosthesis with Unistep Plus Delivery System is effective October 1, 2000. The Wallstent Iliac Endoprosthesis with Unistep Plus Delivery System was effective August 1, 2000.
C1321	Electrode, disposable, Palate Somnoplasty Coagulating Electrode, Base of Tongue Somnoplasty Coagulating Electrode
C1322	Electrode, disposable, Turbinate Somnoplasty Coagulating Electrode
C1323	Electrode, disposable, VAPR Electrode, VAPR T Thermal Electrode
C1329	Electrode, disposable, Gynecare VERSAPOINT Resectoscopic System Bipolar Electrode
C1336	Infusion pump, implantable, non-programmable, Constant Flow Implantable Pump with Bolus Safety Valve Model 3000, Model 3000-16 (16ml), Model 3000-50 (50ml) **Note:** Constant Flow Implantable Pump Model 3000 was effective August 1, 2000. Models 3000-16 and 3000-50 are effective October 1, 2000.
C1337	Infusion pump, implantable, non-programmable, IsoMed Infusion Pump Model 8472-20, 8472-35, 8472-60
C1363	Defibrillator, implantable, dual chamber, Gem DR
C1364	Defibrillator, dual chamber, Photon DR V-230HV3
C1365	Guide wire, peripheral, Hi-Torque SPARTACORE 14 Guide Wire, Hi-Torque MEMCORE FIRM 14 Guide Wire, Hi-Torque STEELCORE 18 Guide Wire, Hi-Torque STEELCORE 18 **LT** Guide Wire, Hi-Torque SUPRA CORE 35 Guide Wire **Note:** Only the Hi-Torque STEELCORE 18 **LT** Guide Wire is effective October 1, 2000. The other guide wires were effective August 1, 2000.
C1366	Guide wire, percutaneous transluminal coronary angioplasty, Hi-Torque Iron man, Hi-Torque Balance Middleweight, Hi-Torque All Star, Hi-Torque Balance Heavyweight, Hi-Torque Balance Trek
C1367	Guide wire, percutaneous transluminal coronary angioplasty, Hi-Torque Cross It, Hi-Torque Cross-It 100XT, Hi-Torque Cross-It 200XT, Hi-Torque Cross-It 300 XT, Hi-Torque Wiggle
C1368	Infusion system, On-Q Pain Management System, On-Q Soaker Pain Management System, PainBuster Pain Management System **Note:** The On-Q Pain Management System, On-Q Soaker Pain Management System, and PainBuster Pain Management System are effective August 1, 2000. See Section V of this article for additional information.
C1369	Internal receiver, neurostimulation system, ANS Renew Spinal Cord Stimulator System
C1370	Single use device for treatment of female stress urinary incontinence, Tension-Free Vaginal Tape Single Use Device
C1371	Stent, biliary, Symphony Nitinol Stent Transhepatic Biliary System
C1372	Stent, biliary, Smart Cordis Nitinol Stent and Delivery System
C1375	Stent, coronary, NIR ON Ranger Stent Delivery System, NIR w/Sox Stent System, NIR Primo Premounted Stent System
C1376	Lead, neurostimulator, ANS Renew Spinal Cord

First Update to the Coding Information for Hospital Outpatient Prospective Payment System (continued)

	Stimulation System Lead
C1377	Lead, neurostimulator, Specify 3998 Lead
C1378	Lead, neurostimulator, InterStim Therapy 3080 Lead, InterStim Therapy 3886 Lead
C1379	Lead, neurostimulator, Pisces-Quad Compact 3887 Lead
C1500	Atherectomy system, peripheral, Rotablator Rotational Angioplasty System with the RotaLink Exchangeable Catheter, Advancer, and Guide Wire
C1700	Needle, brachytherapy, Authentic Mick TP Brachytherapy Needle
C1701	Needle, brachytherapy, Medtec MT-BT-5201-25 Brachytherapy Needle
C1702	Needle, brachytherapy, WWMT Brachytherapy Needle, MD Tech P.S.S. Prostate Seeding Set (needle), Imagyn Medical Technologies IsoStar Prostate Brachytherapy Needle
C1703	Needle, brachytherapy, Mentor Prostate Brachytherapy Needle
C1704	Needle, brachytherapy, Medtec MT-BT-5001-25, MT-BT-5051-25
C1705	Needle, brachytherapy, Best Industries Flexi Needle Brachytherapy Seed Implantation (13G, 14G, 15G, 16G, 17G, 18G), Best Industries Prostate Brachytherapy Needle
C1800	Brachytherapy seed, Mentor PdGold Pd-103
C1801	Brachytherapy seed, Mentor IoGold I-125
C1802	Brachytherapy seed, Best Industries Iridium 192
C1803	Brachytherapy seed, Best Industries Iodine 125
C1804	Brachytherapy seed, Best Industries Palladium 103
C1805	Brachytherapy seed, Imagyn Medical Technologies IsoStar Iodine-125 Interstitial Brachytherapy Seed
C1806	Brachytherapy seed, Best Industries Gold 198
C1810	Catheter, balloon dilatation, D114S Over-the-Wire Balloon Dilatation Catheter
C1811	Anchor, Surgical Dynamics Anchorsew, Surgical Dynamics S.D. sorb EZ TAC, Surgical Dynamics S.D. sorb Suture Anchor 2.0mm, Surgical Dynamics S.D. sorb Suture Anchor 3.0mm
C1850	Repliform Tissue Regeneration Matrix, per 14 or 21 square centimeters
C1851	Repliform Tissue Regeneration Matrix, per 24 or 28 square centimeters
C1852	TransCyte, per 247 square centimeters
C1853	Suspend Tutoplast Processed Fascia Lata, per 8 or 14 square centimeters
C1854	Suspend Tutoplast Processed Fascia Lata, per 24 or 28 square centimeters
C1855	Suspend Tutoplast Processed Fascia Lata, per 36 square centimeters
C1856	Suspend Tutoplast Processed Fascia Lata, per 48 square centimeters
C1857	Suspend Tutoplast Processed Fascia Lata, per 84 square centimeters
C1858	DuraDerm Acellular Allograft, per 8 or 14 square centimeters
C1859	DuraDerm Acellular Allograft, per 21, 24 or 28 square centimeters
C1860	DuraDerm Acellular Allograft, per 48 square centimeters
C1861	DuraDerm Acellular Allograft, per 36 square centimeters
C1862	DuraDerm Acellular Allograft, per 72 square centimeters
C1863	DuraDerm Acellular Allograft, per 84 square centimeters
C1864	Bard Sperma Tex Mesh, per 13.44 square centimeters
C1865	Bard FasLata Allograft Tissue, per 8 or 14 square centimeters
C1866	Bard FasLata Allograft Tissue, per 24 or 28 square centimeters
C1867	Bard FasLata Allograft Tissue, per 36 or 48 square centimeters
C1868	Bard FasLata Allograft Tissue, per 96 square centimeters
C1869	Gore Thyroplasty Device, per 8, 12, 30, or 37.5 square centimeters (0.6mm)
C1930	Catheter, percutaneous transluminal coronary angioplasty, Coyote Dilatation Catheter 20mm/ 30mm/40mm
C1931	Catheter, Talon Balloon Dilatation Catheter
C1932	Catheter, SciMed Remedy Coronary Balloon Dilatation Infusion Catheter (20mm)
C1933	Catheter, Opti-Plast Centurion 5.5F PTA Catheter, shaft length 50cm to 120cm, Opti-Plast XL 5.5F PTA Catheter, shaft length 75 cm to 120cm
C1934	Catheter, Ultraverse 3.5F Balloon Dilatation Catheter
C1935	Catheter, WorkHorse PTA Balloon Catheter
C1936	Catheter, Uromax Ultra High Pressure Balloon Dilatation Catheter with Hydroplus Coating
C1937	Catheter, Synergy Balloon Dilatation Catheter
C1938	Catheter, Bard UroForce Balloon Dilatation Catheter
C1939	Catheter, Ninja PTCA Dilatation Catheter, Raptor PTCA Dilatation Catheter
C1940	Catheter, Cordis PowerFlex Extreme PTA Balloon Catheter, Cordis PowerFlex Plus PTA Balloon Catheter, Cordis OPTA LP PTA Balloon Catheter, Cordis OPTA 5 PTA Balloon Catheter
C1941	Catheter, Jupiter PTA Balloon Dilatation Catheter
C1942	Catheter, Cordis Maxi LD PTA Balloon Catheter
C1943	Catheter, RX CrossSail Coronary Dilatation Catheter, OTW OpenSail Coronary Dilatation Catheter
C1981	Catheter, coronary angioplasty balloon, Adante, Bonnie, Bonnie 15mm, Bonnie Sliding Rail, Bypass Speedy, Chubby, Chubby Sliding Rail, Coyote 20mm, Coyote 9/15/25mm, Maxxum, NC Ranger, NC Ranger 9mm, NC Ranger 16/18mm, NC Ranger 22/25/30mm, NC Big Ranger, Quantum Ranger, Quantum Ranger 1/4 sizes, Quantum Ranger 9/16/18mm, Quantum Ranger 22/30mm, Quantum Ranger 25mm, Ranger LP 20/30/40, Viva/Long Viva
C2000	Catheter, Orbiter ST Steerable Electrode Catheter

First Update to the Coding Information for Hospital Outpatient Prospective Payment System (continued)

C2001 Catheter, Constellation Diagnostic Catheter

C2002 Catheter, Irvine Inquiry Steerable Electrophysiology 5F Catheter

C2003 Catheter, Irvine Inquiry Steerable Electrophysiology 6F Catheter

C2004 Catheter, electrophysiology, EP Deflectable Tip Catheter (Octapolar)

C2005 Catheter, electrophysiology, EP Deflectable Tip Catheter (Hexapolar)

C2006 Catheter, electrophysiology, EP Deflectable Tip Catheter (Decapolar)

C2007 Catheter, electrophysiology, Irvine Luma-Cath 6F Fixed Curve Electrophysiology Catheter

C2008 Catheter, electrophysiology, Irvine Luma-Cath 7F Steerable Electrophysiology Catheter Model 81910, Model 81915, Model 81912

C2009 Catheter, electrophysiology, Irvine Luma-Cath 7F Steerable Electrophysiology Catheter Model 81920

C2010 Catheter, electrophysiology, Cordis Fixed Curve Catheter (decapolar, hexapolar, octapolar, quadrapolar)

C2011 Catheter, electrophysiology, Cordis Deflectable Tip Catheter (quadrapolar)

C2012 Catheter, ablation, Biosense Webster Celsius Braided Tip Ablation Catheter, Biosense Webster Celsius 5mm Temperature Ablation Catheter, Biosense Webster Celsius II Temperature Sensing Diagnostic/Ablation Tip Catheter

C2013 Catheter, ablation, Biosense Webster Celsius Large Dome Ablation Catheter

C2014 Catheter, ablation, Biosense Webster Celsius II Asymmetrical Ablation Catheter

C2015 Catheter, ablation, Biosense Webster Celsius II Symmetrical Ablation Catheter

C2016 Catheter, ablation, Navi-Star *DS* Diagnostic/ Ablation Catheter, Navi-Star Thermo-Cool Temperature Diagnostic/Ablation Catheter

C2017 Catheter, ablation, Navi-Star Diagnostic/Ablation Deflectable Tip Catheter

C2018 Catheter, ablation, Polaris T Ablation Catheter

C2019 Catheter, EP Medsystems Deflectable Electrophysiology Catheter

C2020 Catheter, ablation, Blazer II XP

C2021 Catheter, EP Medsystems SilverFlex Electrophysiology Catheter, non-deflectable

C2151 Catheter, Veripath Peripheral Guiding Catheter

C2200 Catheter, Arrow-Trerotola Percutaneous Thrombolytic Device Catheter

C2597 Catheter, Clinicath Peripherally Inserted *Midline* Catheter (PICC) *Dual-Lumen* PolyFlow Polyurethane Catheter 18G/ 20G/24G (includes catheter and introducer), Clinicath Peripherally Inserted *Central* Catheter (PICC) *Dual-Lumen* PolyFlow Polyurethane 16/18G (includes catheter and introducer), Clinicath Peripherally Inserted *Central* Catheter (PICC) *Single-Lumen* PolyFlow Polyurethane 18G (includes catheter and introducer)

C2598 Catheter, Clinicath Peripherally Inserted *Central* Catheter (PICC) *Single-Lumen* PolyFlow Polyurethane Catheter 18G/ 20G/24G (catheter and introducer), Clinicath Peripherally Inserted *Midline* Catheter (PICC) *Single-Lumen* PolyFlow Polyurethane Catheter 20G/24G (catheter and introducer)

C2599 Catheter, Clinicath Peripherally Inserted *Central* Catheter (PICC) *Dual-Lumen* PolyFlow Polyurethane Catheter 16G/18G (catheter and introducer)

C2600 Catheter, Gold Probe Single-Use Electrohemostasis Catheter

C2601 Catheter, Bard 10F Dual Lumen Ureteral Catheter

C2602 Catheter, Spectranetics 1.4/1.7mm Vitesse C_{os} Concentric Laser Catheter

C2603 Catheter, Spectranetics 2.0mm Vitesse C_{os} Concentric Laser Catheter

C2604 Catheter, Spectranetics 2.0mm Vitesse E Eccentric Laser Catheter

C2605 Catheter, Spectranetics Extreme Laser Catheter

C2606 Catheter, Oratec SpineCath XL Intradiscal Catheter

C2607 Catheter, Oratec SpineCath Intradiscal Catheter

C2608 Catheter, Scimed 6F Wiseguide Guide Catheter

C2609 Catheter, Flexima Biliary Drainage Catheter with Locking Pigtail, Flexima Biliary Drainage Catheter with Twist Loc Hub

C2700 Defibrillator, single chamber, implantable, MycroPhylax Plus

C2701 Defibrillator, single chamber, implantable, Phylax XM

C2801 Defibrillator, dual chamber, implantable, ELA Medical Defender IV DR Model 612

C2802 Defibrillator, dual chamber, implantable, Phylax AV

C3001 Lead, defibrillator, implantable, Kainox SL, Kainox RV

C3400 Prosthesis, breast, Mentor Saline-Filled Contour Profile, Mentor Siltex Spectrum Mammary Prosthesis

C3401 Prosthesis, breast, Mentor Saline-Filled Spectrum

C3500 Prosthesis, Mentor Alpha I Inflatable Penile Prosthesis, Mentor Alpha I Narrow-Base Inflatable Penile Prosthesis, AMS Sphincter 800 Urinary Prosthesis
Note: The Mentor Alpha I Narrow-Base Inflatable Penile Prosthesis and the AMS Sphincter 800 Urinary Prosthesis are effective October 1, 2000. The Mentor Alpha I Inflatable Penile Prosthesis was effective August 1, 2000. See Section V of this article for additional information

C3551 Guide wire, percutaneous transluminal coronary angioplasty, Choice, Luge, Patriot, PT Graphix Intermediate, Trooper, Mailman 182/300 cm

C3552 Guide wire, coronary, Hi-Torque Whisper

C3800 Infusion pump, implantable, programmable, SynchroMed EL Infusion Pump

C3851 Intraocular lens, STAAR Elastic Ultraviolet-Absorbing Silicone Posterior Chamber

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	Intraocular Lens with Toric Optic Model AA-4203T, Model AA-4203TF, Model AA-4203TL
C4000	Pacemaker, single chamber, ELA Medical Opus G Model 4621, 4624
C4001	Pacemaker, single chamber, ELA Medical Opus S Model 4121, 4124
C4002	Pacemaker, single chamber, ELA Medical Talent Model 113
C4003	Pacemaker, single chamber, Kairos SR
C4004	Pacemaker, single chamber, Actros SR+, Actros SR-B+
C4005	Pacemaker, single chamber, Philos SR, Philos SR-B
C4300	Pacemaker, dual chamber, Integrity AFx DR Model 5342
C4301	Pacemaker, dual chamber, Integrity AFx DR Model 5346
C4302	Pacemaker, dual chamber, Affinity VDR 5430
C4303	Pacemaker, dual chamber, ELA Brio Model 112 Pacemaker System
C4304	Pacemaker, dual chamber, ELA Medical Brio Model 212, Talent Model 213, Talent Model 223
C4305	Pacemaker, dual chamber, ELA Medical Brio Model 222
C4306	Pacemaker, dual chamber, ELA Medical Brio Model 220
C4307	Pacemaker, dual chamber, Kairos DR
C4308	Pacemaker, dual chamber, Inos^{2,} Inos $^{2+}$
C4309	Pacemaker, dual chamber, Actros DR+, Actros D+, Actros DR-A+, Actros SLR+
C4310	Pacemaker, dual chamber, Actros DR-B+
C4311	Pacemaker, dual chamber, Philos DR, Philos DR-B, Philos SLR
C4600	Lead, pacemaker, Synox, Polyrox, Elox, Retrox, SL-BP, ELC
C5001	Stent, biliary, Bard Memotherm-Flex Biliary Stent, small or medium diameter
C5002	Stent, biliary, Bard Memotherm-Flex Biliary Stent, large diameter
C5003	Stent, biliary, Bard Memotherm-Flex Biliary Stent, x-large diameter
C5004	Stent, biliary, Cordis Palmaz Corinthian IQ Transhepatic Biliary Stent
C5005	Stent, biliary, Cordis Palmaz Corinthian IQ Transhepatic Biliary Stent and Delivery System
C5006	Stent, biliary, Cordis Medium Palmaz Transhepatic Biliary Stent and Delivery System
C5007	Stent, biliary, Cordis Palmaz XL Transhepatic Biliary Stent (40mm length)
C5008	Stent, biliary, Cordis Palmaz XL Transhepatic Biliary Stent (50mm length)
C5009	Stent, biliary, Biliary VistaFlex Stent
C5010	Stent, biliary, Rapid Exchange Single-Use Biliary Stent System
C5011	Stent, biliary, IntraStent, IntraStent LP
C5012	Stent, biliary, IntraStent DoubleStrut LD
C5013	Stent, biliary, IntraStent DoubleStrut, IntraStent DoubleStrut XS
C5014	Stent, biliary, Medtronic AVE Bridge Stent System—Biliary Indication (10mm, 17mm, 28mm)
C5015	Stent, biliary, Medtronic AVE Bridge Stent System—Biliary Indication (40mm-60mm, 80-100mm), Medtronic AVE Bridge X3 Biliary Stent System (17mm)
C5016	Stent, biliary, Wallstent Single-Use Covered Biliary Endoprosthesis with Unistep Plus Delivery System
C5017	Stent, biliary, Wallstent RP Biliary Endoprosthesis with Unistep Plus Delivery System (20, 40, 42, 60, 68 mm in length)
C5018	Stent, biliary, Wallstent RP Biliary Endoprosthesis with Unistep Plus Delivery System (80, 94 mm in length)
C5030	Stent, coronary, S660 with Discrete Technology Over-the-Wire Coronary Stent System (9mm, 12mm), S660 with Discrete Technology Rapid Exchange Coronary Stent System (9mm, 12mm)
C5031	Stent, coronary, S660 with Discrete Technology Over-the-Wire Coronary Stent System (15mm, 18mm), S660 with Discrete Technology Rapid Exchange Coronary Stent System (15mm, 18mm)
C5032	Stent, coronary, S660 with Discrete Technology Over-the-Wire Coronary Stent System (24mm, 30mm), S660 with Discrete Technology Rapid Exchange Coronary Stent System (24mm, 30mm)
C5033	Stent, coronary, Niroyal Advance Premounted Stent System (9mm)
C5034	Stent, coronary, Niroyal Advance Premounted Stent System (12mm and 15mm)
C5035	Stent, coronary, Niroyal Advance Premounted Stent System (18mm)
C5036	Stent, coronary, Niroyal Advance Premounted Stent System (25mm)
C5037	Stent, coronary, Niroyal Advance Premounted Stent System (31mm)
C5038	Stent, coronary, BX Velocity Balloon-Expandable Stent with Raptor Over-the-Wire Delivery System
C5039	Stent, peripheral, IntraCoil Peripheral Stent (40mm stent length)
C5040	Stent, peripheral, IntraCoil Peripheral Stent (60mm stent length)
C5041	Stent, coronary, Medtronic BeStent 2 Over-the-Wire Coronary Stent System (24mm, 30mm)
C5042	Stent, coronary, Medtronic BeStent 2 Over-the-Wire Coronary Stent System (18mm)
C5043	Stent, coronary, Medtronic BeStent 2 Over-the-Wire Coronary Stent System (15mm)
C5044	Stent, coronary, Medtronic BeStent 2 Over-the-Wire Coronary Stent System (9mm, 12mm)
C5045	Stent, coronary, Multilink Tetra Coronary Stent System
C5046	Stent, coronary, Radius 20mm Self Expanding Stent with Over the Wire Delivery System
C5130	Stent, colon, Wilson-Cook Colonic Z-Stent
C5131	Stent, colorectal, Bard Memotherm Colorectal Stent Model S30R060
C5132	Stent, colorectal, Bard Memotherm Colorectal

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	Stent Model S30R080
C5133	Stent, colorectal, Bard Memotherm Colorectal Stent Model S30R100
C5134	Stent, enteral, Wallstent Enteral Endoprosthesis and Unistep Delivery System (90mm in length), Enteral Wallstent Endoprosthesis with Unistep Plus Delivery System (90mm in length) **Note:** Only the Enteral Wallstent Endoprosthesis with Unistep Plus Delivery System is effective October 1, 2000. The Wallstent Enteral and Unistep Delivery System was effective August 1, 2000.
C5280	Stent, ureteral, Bard Inlay Double Pigtail Ureteral Stent
C5281	Stent, tracheobronchial, Wallgraft Tracheobronchial Endoprosthesis with Unistep Delivery System (70mm in length)
C5282	Stent, tracheobronchial, Wallgraft Tracheobronchial Endoprosthesis with Unistep Delivery System (20mm, 30mm, 50mm in length)
C5283	Stent, self-expandable for creation of intrahepatic shunts, Wallstent Transjugular Intrahepatic Portosystemic Shunt (TIPS) with Unistep Plus Delivery System (80 mm in length), Wallstent **RP** TIPS Endoprosthesis with Unistep Plus Delivery System (80 mm in length) **Note:** Only the Wallstent **RP** TIPS Endoprosthesis with Unistep Plus Delivery System is effective October 1, 2000. The Wallstent TIPS with Unistep Plus Delivery System was effective August 1, 2000.
C5284	Stent, tracheobronchial, UltraFlex Tracheobronchial Endoprosthesis (covered and non-covered)
C5600	Vascular Closure Device, VasoSeal ES (Extravascular Security) Device
C6001	Mesh, hernia, Bard Composix Mesh, per 8 or 18 inches
C6002	Mesh, hernia, Bard Composix Mesh, per 32 inches
C6003	Mesh, hernia, Bard Composix Mesh, per 48 inches
C6004	Mesh, hernia, Bard Composix Mesh, per 80 inches
C6005	Mesh, hernia, Bard Composix Mesh, per 140 inches
C6006	Mesh, hernia, Bard Composix Mesh, per 144 inches
C6012	Pelvicol Acellular Collagen Matrix, per 8 or 14 square centimeters
C6013	Pelvicol Acellular Collagen Matrix, per 21, 24, or 28 square centimeters
C6014	Pelvicol Acellular Collagen Matrix, per 40 square centimeters
C6015	Pelvicol Acellular Collagen Matrix, per 48 square centimeters
C6016	Pelvicol Acellular Collagen Matrix, per 96 square centimeters
C6017	Gore-Tex DualMesh Biomaterial, per 75 or 96 square centimeters (1mm thick)
C6018	Gore-Tex DualMesh Biomaterial, per 150 square centimeters oval shaped (1mm thick)
C6019	Gore-Tex DualMesh Biomaterial, per 285 square centimeters oval shaped (1mm thick)
C6020	Gore-Tex DualMesh Biomaterial, per 432 square centimeters (1mm thick)
C6021	Gore-Tex DualMesh Biomaterial, per 600 square centimeters (1mm thick)
C6022	Gore-Tex DualMesh Biomaterial, per 884 square centimeters oval shaped (1mm thick)
C6023	Gore-Tex DualMesh *Plus* Biomaterial, per 75 or 96 square centimeters (1mm thick)
C6024	Gore-Tex DualMesh *Plus* Biomaterial, per 150 square centimeters oval shaped (1mm thick)
C6025	Gore-Tex DualMesh *Plus* Biomaterial, per 285 square centimeters oval shaped (1mm thick)
C6026	Gore-Tex DualMesh *Plus* Biomaterial, per 432 square centimeters (1mm thick)
C6027	Gore-Tex DualMesh *Plus* Biomaterial, per 600 square centimeters (1mm thick)
C6028	Gore-Tex DualMesh *Plus* Biomaterial, per 884 square centimeters oval shaped (1mm thick)
C6029	Gore-Tex DualMesh *Plus* Biomaterial, per 150 square centimeters oval shaped (2mm thick)
C6030	Gore-Tex DualMesh *Plus* Biomaterial, per 285 square centimeters oval shaped (2mm thick)
C6031	Gore-Tex DualMesh *Plus* Biomaterial, per 432 square centimeters (2mm thick)
C6032	Gore-Tex DualMesh *Plus* Biomaterial, per 600 square centimeters (2mm thick)
C6033	Gore-Tex DualMesh *Plus* Biomaterial, per 884 square centimeters (2mm thick)
C6034	Bard Reconix ePTFE Reconstruction Patch 150 square centimeters (2mm thick)
C6035	Bard Reconix ePTFE Reconstruction Patch 150 square centimeters (1mm thick), 75 square centimeters (2mm thick)
C6036	Bard Reconix ePTFE Reconstruction Patch 50 or 75 square centimeters (1mm thick), 50 square centimeters (2mm thick)
C6037	Bard Reconix ePTFE Reconstruction Patch 300 square centimeters (1 mm thick)
C6038	Bard Reconix ePTFE Reconstruction Patch 600 square centimeters (1mm thick), 300 square centimeters (2mm thick)
C6039	Bard Reconix ePTFE Reconstruction Patch 884 square centimeters oval shaped (1mm thick)
C6040	Bard Reconix ePTFE Reconstruction Patch 600 square centimeters (2mm thick)
C6041	Bard Reconix ePTFE Reconstruction Patch 884 square centimeters oval shaped (2mm thick)
C6050	Sling fixation system for treatment of stress urinary incontinence, Female In-Fast Sling Fixation System with Electric Inserter *with* Sling Material, Female In-Fast Sling Fixation System with Electric Inserter *without* Sling Material
C6051	Stratasis Urethral Sling, 20/40 cm
C6052	Stratasis Urethral Sling, 60 cm
C6080	Sling fixation system for treatment of stress

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	urinary incontinence, Male Straight-In Fixation System with Electric Inserter *with* Sling Material and Disposable Pressure Sensor, Male Straight-In Fixation System with Electric Inserter *without* Sling Material and Disposable Pressure Sensor
C6500	Sheath, guiding, Preface Braided Guiding Sheath (anterior curve, multipurpose curve, posterior curve)
C6501	Sheath, Soft Tip Sheaths
C6600	Probe, Microvasive Swiss F/G Lithoclast Flexible Probe .89mm, Microvasive Swiss F/G Lithoclast Flexible Probe II .89mm
C8100	Adhesion barrier, ADCON-L
C9000	Injection, sodium chromate Cr51, per 0.25 mCi
C9001	Linezolid injection, per 200mg
C9002	Tenecteplase, per 50mg/vial
C9003	Palivizumab, per 50 mg
C9004	Injection, gemtuzumab ozogamicin, per 5mg
C9005	Injection, reteplase, 18.8 mg (one single-use vial)
C9006	Injection, tacrolimus, per 5 mg (1 amp)
C9007	Baclofen Intrathecal Screening Kit
C9008	Baclofen Intrathecal Refill Kit, per 500mcg
C9009	Baclofen Intrathecal Refill Kit, per 2000mcg
C9010	Baclofen Intrathecal Refill Kit, per 4000mcg
C9100	Supply of radiopharmaceutical diagnostic imaging agent, iodinated I-131 albumin, per mCi
C9102	Supply of radiopharmaceutical diagnostic imaging agent, 51 sodium chromate, per 50 mCi
C9103	Supply of radiopharmaceutical diagnostic imaging agent, sodium iothalamate I-125 Injection, Per 10 uCi
C9104	Ani-thymocyte globulin, per 25mg
C9105	Injection, hepatitis B immune globulin, per 1 ml
C9106	Sirolimus, per 1mg/ml
Q3001	Radioelements for brachytherapy, any type, each **Note:** This code was effective August 1, 2000. See Section V of this article for additional information.

II. Devices Eligible for New Technology Payments Effective October 1, 2000

See pages 66-67 for background on HCFA's evaluation of devices eligible for new technology payments.

Payments for these new technology devices are made prospectively based on the assigned APC payment rate rather than based on the hospital's billed charges for the device adjusted to cost using the individual hospital's average cost-to-charge ratio. An APC payment will be made for each of the new technology items in addition to the APC payment for the surgical procedure with which the device is associated. These new device technology items are listed below.

Please note many of the items listed below were published in the original article for coding information on hospital outpatient PPS. At the time these C-codes were assigned a new technology service APC. HCFA has now created separate new device technology APCs for these devices. See Section III of this article for clarification of these new APCs.

HCPCS C-code	Long Descriptor	APC
C8500	Catheter, atherectomy, Atherocath-GTO Atherectomy Catheter	991
C8501	Pacemaker, single chamber, Vigor SSI	995
C8502	Catheter, diagnostic, electrophysiology, Livewire Steerable Electrophysiology Catheter	988
C8503	Catheter, Synchromed Vascular Catheter Model 8702	988
C8504	Closure device, VasoSeal Vascular Hemostasis Device	987
C8505	Infusion pump, implantable, programmable, SynchroMed Infusion Pump	997
C8506	Lead, pacemaker, 4057M, 4058M, 4557M, 4558M, 5058	990
C8507	Lead, defibrillator, 6721L, 6721M, 6721S, 6939 Oval Patch Lead	990
C8508	Lead, defibrillator, CapSure 4965	990
C8509	Lead, defibrillator, Transvene 6933, Transvene 6937	990
C8510	Lead, defibrillator, DP-3238	990
C8511	Lead, defibrillator, EndoTak DSP	996
C8512	Lead, neurostimulation, On-Point Model 3987, Pisces—Quad Plus Model 3888, Resume TL Model 3986	991
C8513	Lead, neurostimulation, Pisces—Quad Model 3487a, Resume II Model 3587a	991
C8514	Prosthesis, penile, Dura II Penile Prosthesis	993

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HCPCS C-code	Long Descriptor	APC
C8516	Prosthesis, penile, Mentor Acu-Form Malleable Penile Prosthesis, Mentor Malleable Penile Prosthesis	992
C8518	Pacemaker, dual chamber, Vigor DDD	996
C8519	Pacemaker, dual chamber, Vista DDD	996
C8520	Pacemaker, single chamber, Legacy II S	995
C8521	Receiver/transmitter, neurostimulator, Medtronic Mattrix	997
C8522	Stent, biliary, PALMAZ Balloon Expandable Stent	990
C8523	Stent, biliary, Wallstent Transhepatic Biliary Endoprosthesis	991
C8524	Stent, esophageal, Wallstent Esophageal Prosthesis	991
C8525	Stent, esophageal, Wallstent Esophageal Prosthesis (Double)	992
C8526	OptiPlast XT 5F Percutaneous Transluminal Angioplasty Catheter (various sizes)	987
C8528	MS Classique Balloon Dilation Catheter	987
C8529	Crista Cath II Deflectable 20-Pole Catheter	990
C8530	Mentor Siltex Gel-filled Mammary Prosthesis, Smooth-Surface Gel-filled Mammary Prosthesis	989
C8531	Wilson-Cook Esophageal Z Metal Expandable Stent	989
C8532	Stent, esophageal, UltraFlex Esophageal Stent System	991
C8533	Catheter, Synchromed Vascular Catheter Model 8700A, 8700V	988
C8534	Prosthesis, penile, AMS Malleable 650 Penile Prosthesis	992

III. New Device Technology APCs Effective October 1, 2000

To differentiate between new technology services and new technology devices, HCFA has created eleven (11) new technology APCs (0987-0997) applicable only to new technology devices. Below is a list of new technology APCs for the new technology devices listed in Section II. These "new device technology" APCs will be reflected in the Outpatient Code Editor and PRICER systems for the October update.

APC	Group Title		Status Indicator
0987	New Device Technology—Level I	($0-$250)	X
0988	New Device Technology—Level II	($250-$500)	X
0989	New Device Technology—Level III	($500-$750)	X
0990	New Device Technology—Level IV	($750-$1000)	X
0991	New Device Technology—Level V	($1000-1500)	X
0992	New Device Technology—Level VI	($1500-$2000)	X
0993	New Device Technology—Level VII	($2000-$3000)	X
0994	New Device Technology—Level VIII	($3000-$4000)	X
0995	New Device Technology—Level IX	($4000-$5000)	X
0996	New Device Technology—Level X	($5000-$7000)	X
0997	New Device Technology—Level XI	($7000-$9000)	X

First Update to the Coding Information for Hospital Outpatient Prospective Payment System (continued)

IV. Blood/Blood Products Classified in Separate APCs Effective October 1, 2000

The following list of blood/blood products are classified in separate APCs. Since these are classified in separate APCs, they are **not** eligible for transitional pass-through payments.

HCPCS Code	Long Descriptor	APC
C9500	Platelets, irradiated, each unit	9500
C9501	Platelets, pheresis, each unit	9501
C9502	Platelets, pheresis, irradiated, each unit	9502
C9503	Fresh frozen plasma, donor retested, each unit	9503
C9504	Red blood cells, deglycerolized, each unit	9504
C9505	Red blood cells, irradiated, each unit	9505

V. Clarifications/Corrections

Below are clarifications and corrections from original article on the coding information for hospital outpatient PPS. Unless otherwise indicated, the effective date for the codes listed below is August 1, 2000 and the implementation date is August 14, 2000.

C1025 (Catheter, diagnostic, electrophysiology, Marinr CS):

The words "diagnostic" and "electrophysiology" have been deleted from the long descriptor for C1025. The device "InDura Intraspinal Catheter" should be added to the long descriptor for C1025. The correct long descriptor reads as follows:

C1025 Catheter, Marinr CS, InDura Intraspinal Catheter

C1164 (Brachytherapy seed, intracavity, I-125 seeds):

The word "intracavity" has been deleted from the long descriptor for C1164. The correct long descriptor reads as follows:

C1164 Brachytherapy seed, Iodine-125

C1325 (Brachytherapy seed, intracavity, Palladium 103 seeds):

The word "intracavity" has been deleted from the long descriptor for C1325. The correct long descriptor reads as follows:

C1325 Brachytherapy seed, Palladium-103

C1368 (Infusion System, On-Q Pain Management System):

The On-Q Pain Management System was assigned to C-code C1036 for use from August 1, 2000 to September 30, 2000. The long descriptor for C1036 should include the following: Infusion System, On-Q Pain Management System, On-Q Soaker Pain Management System, PainBuster Pain Management System. Effective October 1, 2000, the code for this device is C1368 and the long descriptor for this code reads as follows:

C1368 Infusion System, On-Q Pain Management System, On-Q Soaker Pain Management System, PainBuster Pain Management System,

C8515 (Prosthesis, penile, Mentor Alpha I Narrow-Base Inflatable Penile Prosthesis)

Effective October 1, 2000 the Mentor Alpha I Narrow-Base Inflatable Penile Prosthesis should be reported with C-code C3500. This device was assigned to C8515 in transmittal A-00-42. Since this device will now be reported using C3500, C8515 is no longer reportable under the Hospital OPPS.

C8517 (Prosthesis, penile, Ambicor Penile Prosthesis)

Effective October 1, 2000 the Ambicor Penile Prosthesis should be reported with C-code C1007. This device was assigned to C8517 in transmittal A-00-42. Since this device will now be reported using C1007, C8517 is no longer reportable under the Hospital OPPS.

C9007-C9010 (Baclofen):

The following C-codes will replace J0476 and should be used to report a Baclofen intrathecal screening kit as well as the intrathecal refill kits effective October 1, 2000. **J0476** should **NOT** be reported under the Hospital OPPS as of October 1, 2000.

First Update to the Coding Information for Hospital Outpatient Prospective Payment System (continued)

C9007 Baclofen Intrathecal Screening Kit

C9008 Baclofen Intrathecal Refill Kit, per 500 mcg

C9009 Baclofen Intrathecal Refill Kit, per 2000 mcg

C9010 Baclofen Intrathecal Refill Kit, per 4000 mcg

J0735 (Clonidine HCL):

Through error, this code was listed in Addendum K of the April 7, 2000 final rule (65 FR 18820) as eligible for pass-through payment. This code is **not eligible** for pass-through payments. Rather, J0735 is a drug that is not paid separately but packaged into the APC rate of the relevant procedure. This error has been corrected in the OCE and the code has a status indicator "N."

J2545 (Pentamidine isethionte/300mg):

Through error, this code was listed in Addendum K of the April 7, 2000 final rule (65 FR 18820) as eligible for pass-through payment. This code is not paid under the Outpatient PPS and therefore, is **not eligible** for pass-through payments. Rather, J2545 is a drug that is paid under a different fee schedule. This error has been corrected in the OCE and the code has a status indicator "A."

J7513 (Daclizumab, parenteral, 25mg):

This code was listed incorrectly in Addendum K of the April 7, 2000 final rule (65 FR 18820) as code J7913. The correct code is J7513 and this change is reflected in the OCE. This drug is **eligible** for pass-through payments.

Q3001 (Radioelements for brachytherapy, any type, each):

This code was effective August 1, 2000, however, it was inadvertently omitted from transmittal A-00-42. This code should be used to report brachytherapy seed(s) where there is not a more specific code indicated in transmittal A-00-42 or in this program memorandum.

Q3001 may be reported for dates of service up to March 31, 2001. Effective April 1, 2001, Q3001 will no longer be reportable under the Outpatient PPS. Only specific brachytherapy codes will be valid for filing brachytherapy seed claims for dates of service on or after April 1, 2001.

Brachytherapy seed manufacturers are urged to submit applications for their specific brachytherapy seed(s) for the transitional pass-through payments if they have not already submitted an application. The deadline to submit an application for the April 1, 2001 update is December 1, 2000.

Q3005 (Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m mertiatide, per vial):

The correct dosage/measurement for this radiopharmaceutical agent is "per mCi." The corrected long descriptor for this code reads as follows:

Q3005 Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m mertiatide, per mCi

Q0181 (Unspecified Oral Anti-Emetic):

This code will no longer be a valid code for reporting Outpatient PPS services as of October 1, 2000.

Devices with New C-codes:

The devices below were listed in Section I of Transmittal A-00-42. As a result of changes in our system, we have corrected the C-codes for these devices. The following are the correct C-codes and long descriptor for each:

Old C-code	Corrected C-code	Long Descriptor
C1108	C1810	Catheter, balloon, dilatation, D114S Over-the-Wire Balloon Dilatation Catheter
C1600	C1850	Repliform Tissue Regeneration Matrix, per 14 or 21 square centimeters
C1601	C1851	Repliform Tissue Regeneration Matrix, per 24 or 28 square centimeters

VI. Item No Longer Eligible for Pass-Through Payments

C1005 (Intraocular lens, Sensar Soft Acrylic Posterior Chamber IOL):

Code C1005 may be used to bill Outpatient PPS claims for pass-through payments for dates of service beginning August 1, 2000 through September 30, 2000 only. The intraocular lens (IOL) associated with this code was included erroneously on the pass-through list. Therefore, effective October 1, 2000, such IOL will no longer be eligible for pass-through payments and C1005 will not be recognized as a valid code for billing such IOL.

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

www.floridamedicare.com — Florida Medicare Provider Website

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

What's New

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

Part A

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

Part B

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

Shared (information shared by Part A and Part B)

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

EDI (Electronic Data Interchange)

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

Extra

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

Search

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

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Procedure Codes

CPT Codes

Anesthesia/Surgery, 00100-69979

Anesthesia/Surgery, 00100-69979 (continued)

Diagnostic Tests, 70010-89399

Medicine, 90281-99199

Medicine, 90281-99199 (continued)

HCPCS Codes

HCPCS Codes (continued)

* Special *Bulletins*

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

Addresses

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

APPEAL RECONSIDERATIONS

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

MEDICARE SECONDARY PAYER (MSP)

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

General MSP Information
Completion of UB-92 (MSP Related)
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Medicare Secondary Payer
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Jacksonville, FL 32231
(904) 355-8899

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

ELECTRONIC CLAIM FILING

"DDE Startup"
Direct Data Entry (DDE)
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Jacksonville, FL 32231
(904) 791-8131

FRAUD AND ABUSE

Medicare Fraud Branch
P. O. Box 45087
Jacksonville, FL 32231
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REVIEW REQUEST

Denied claims that may have been payable under the Medicare Part A program
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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
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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
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(904) 791-8430

Phone Numbers

PROVIDERS

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Customer Service Representatives:
904-355-8899

BENEFICIARY

904-355-8899

ELECTRONIC MEDIA CLAIMS

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904-791-8131

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904-791-6865

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

PC-ACE Support
904-355-0313

Testing:
904-791-6865

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

Medicare Websites

PROVIDERS

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

BENEFICIARIES

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