Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Features

The *Medicare A Bulletin* should be shared with all health care practitioners and managerial members of the provider/supplier staff.

Publications issued after October 1, 1997, are available at no-cost from our provider Web site at ***www.floridamedicare.com.***

Routing Suggestions:

- ☐ Medicare Manager
- ☐ Reimbursement Director
- ☐ Chief Financial Officer
- ☐ Compliance Officer
- ☐ DRG Coordinator
- ☐ _____
- ☐ _____
- ☐ _____

Health Care Financing Administration

FIRST COAST SERVICE OPTIONS, INC.

A HCFA Contracted Carrier & Intermediary

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

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

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

A PHYSICIAN'S FOCUS

Medicare Coverage of Drugs and Biologicals, Payment Methodologies, and Ethical Obligations of Health Care Professionals

Though the Medicare Program insures nearly one in seven Americans, its current benefit package is not as comprehensive as most private insurance plans. Drug coverage, especially prescription drugs, and the expenses of co-payments and deductibles put many Medicare beneficiaries at financial risk. Many beneficiaries have some type of Medicare supplemental insurance to fill the benefit and payment gaps. The supplement is an additional expense unless sponsored by a previous employer as a retirement benefit.

The Medicare statute does not provide an overall drug benefit. For Part A, drugs provided during acute inpatient stays and qualified skilled nursing facility stays are generally covered if requirements are met. For Part B, drugs and biologicals coverage is *generally* limited to the type of drugs that cannot be self-administered, are medically necessary and reasonable, are FDA approved, and meet all the requirements of items incident to physician services. The Medicare definition of the type of drugs that *cannot be self-administered* is based on the usual method of administration of the form of that drug or biological as furnished by the physician. The statute was recently redefined by Congress to *usually not self-administered* effective July 2001. As a result of this benefit structure, self-administered drugs and biologicals (pill form or injection form) are usually not covered unless Congress adds language to specifically provide new coverage. Examples of such additional coverage include:

- Blood clotting factors
- Drugs used in immunosuppressive therapy
- Erythropoietin
- Osteoporosis drugs for certain homebound patients
- Some oral anti-cancer drugs
- Some anti-nausea drugs given in conjunction with oral or IV chemotherapy.

Under the Medicare benefit structure there is also some carrier and intermediary latitude to allow off-label indications of covered drugs (usually anti-cancer drugs) if medical necessity can be supported.

Medicare payment of drugs and biologicals reflects the evolution of the program since its inception in 1966, with varied payment methodologies instituted over the decades in the face of a changing health care system. For example, currently, acute care hospitals and qualified skilled nursing facilities include most drugs and biological payments in the prospective payment system reimbursement. Acute care hospital outpatient has recently moved from a cost based reimbursement to a prospective payment system utilizing one or multiple classifications for an episode of care. Covered drugs and biologicals may be included in a classification or receive a separate classification based on estimated cost if 'new.' ESRD facilities are reimbursed on the composite rate system with some drugs paid outside the composite rate. Pricing is another issue. Currently, most covered drugs and biologicals not reimbursed by prospective payment systems are paid by fee schedule. By current law these fees are generally 95 percent of the average wholesale price of the drug. In recent years, the pricing of covered drugs and biologicals has come into question with concerns of over payment in some situations. This can be particularly troublesome if the over payment of drugs reinforces questionable treatment decisions by physicians. After some study, the Office of Inspector General, the Congress, and others have raised the pricing issue to the Health Care Financing Administration.

The complexity of our current health care system precludes one from overreacting to the drug over payment reports. However, the issues raised by these reports do serve as a reminder to all health care professionals such as physicians, nurses, administrators, executives, and others to understand the distinctions among legal, ethical, and business obligations in the delivery of health care. Within the framework of distinct benefits and varied payment methodologies, health care providers should engage in care programs that are beneficial to the Medicare patient and fair to the Medicare program.

Sincerely,

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

About *The Medicare A Bulletin*

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

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

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

Who Receives the *Bulletin*?

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

What Is in the *Bulletin*?

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

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

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

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

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

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

New Toll-Free Telephone Numbers Available

To better serve the Medicare Part A provider and beneficiary community, First Coast Service Options, Inc. has implemented two new toll free telephone numbers replacing the previous automated response unit and customer service representatives toll telephone number (904) 355-8899.

To speak with a Medicare customer representative, providers may dial the toll free number:
1-877-602-8816

To speak with a Medicare customer representative, beneficiaries may dial the toll free number:
1-800-333-7586

GENERAL INFORMATION

Payment Revisions for Diagnostic and Screening Mammograms Performed with New Technologies

Section 104 of the Benefits Improvement and Protection Act 2000, entitled "Modernization of Screening Mammography Benefit," provides for new payment methodologies for both diagnostic and screening mammograms that utilize advanced new technology for the period April 1, 2001, to December 31, 2001. Under this provision, payment for technologies that directly take digital images would equal 150 percent of the amount that would otherwise be paid for a bilateral diagnostic mammography. For technologies that convert standard film images to digital form, payment will be derived from the statutory screening mammography limit plus an additional payment of $15.00. All coinsurance, deductible, and payment policy rules that currently apply to both diagnostic and screening mammographies also apply to the new diagnostic and screening mammography codes respectively.

Payment Requirements for Intermediary Processed Claims

Effective for services furnished on or after April 1, 2001, providers that bill intermediaries for the technical component of screening and diagnostic mammographies that utilize advanced technologies will use the six new HCPCS codes, G0202 – G0207.

Screening HCPCS Codes

G0202 Screening mammography producing direct digital image, bilateral, all views.

G0203 Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views.

Diagnostic HCPCS Codes

G0204 Diagnostic mammography, direct digital image, bilateral, all views.

G0205 Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views.

G0206 Diagnostic mammography, direct digital image, unilateral, all views.

G0207 Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all view.

The following payments based on localities have been established for the period of April 1, 2001 through December 31, 2001

HCPCS Codes	Loc 01/02	Loc 03	Loc 04
G0202TC	75.66	83.13	88.38
G0203TC	58.72	63.38	66.86
G0204TC	75.66	83.13	88.38
G0205TC	58.72	63.38	66.84
G0206TC	47.81	44.95	47.81
G0207TC	40.88	44.95	47.81

Billing Requirements for Institutional Providers That Bill the Intermediary

Providers (see below for RHC/FQHCs) bill for the technical portion of screening and diagnostic mammograms on Form HCFA-1450 under bill type 14x, 22x, 23x, or 85x**.** The professional component is billed to the carrier on Form HCFA-1500 **(or electronic equivalent**).

Screening and diagnostic mammography services are not within the scope of RHC/FQHC services. Providers sometimes operate multi-purpose outpatient facilities based in the provider, all or part of which may be certified by Medicare as an RHC/FQHC. If the multi-purpose outpatient facility is certified to provide screening and diagnostic mammography services, it should bill the intermediary for the technical component and the practitioner may bill for the professional component of the screening or diagnostic mammography using their own Part B billing number. These multi-purpose outpatient facilities utilize bill type 14x, 22x, 23x, or 85x along with their outpatient provider number (not the RHC/FQHC billing number since these services are not covered as RHC/FQHC services) when billing their intermediary for this service.

Practitioners operating in independent multi-purpose facilities with designated parts certified as independent RHCs or freestanding FQHCs may bill their carrier, under their own Part B billing number, for both the technical and professional components of screening or diagnostic mammography services.

When billing for screening mammographies on Form HCFA-1450, the appropriate revenue code is 403 and the appropriate HCPCS are G0202 and G0203.

When billing for diagnostic mammographies on Form HCFA-1450, the appropriate revenue code is 401 and the appropriate HCPCS are G0204, G0205, G0206, and G0207.

Place of Service Restrictions for Performance of Diagnostic and Screening Mammograms

Payment restrictions for screening and diagnostic mammography apply to those facilities that meet all FDA certifications as provided under the Mammography Quality Standards Act (MQSA). (Refer to Intermediary Manual section 3660.10.)

Suspension of Requirement to Register for Receiving Contractor's Notifications

On the front page of the Second Quarter 2001 Medicare A *Bulletin* we published a short notice regarding an oncoming initiative requiring providers/suppliers to register with the fiscal intermediary in order to receive hard copy of the bulletins and newsletters. Since then, the Health Care Financing Administration has temporarily suspended this initiative. Medicare active providers and suppliers will continued to receive hard copies of all bulletin and newsletters issued by the Medicare contractor.

Elimination of Time Limit on Medicare Benefits for Immunosuppressive Drugs

Effective with immunosuppressive drugs furnished on or after December 21, 2000, the time limit on Medicare benefits for immunosuppressive drugs has been eliminated. This instruction supersedes HCFA Program Memorandum AB-99-98, which described the method for determining the former time limit for this benefit that applied to drugs furnished prior to December 21, 2000.

This policy applies to all Medicare entitled beneficiaries who meet all of the other program requirements for coverage under this benefit. Therefore, currently entitled beneficiaries who had been receiving benefits for immunosuppressive drugs in the past, but whose immunosuppressive drug benefit was terminated solely because of the time limit described in PM AB-99-98, would now resume receiving that benefit for immunosuppressive drugs furnished on or after December 21, 2000.

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 April 26, 2001, the interest rate applied to Medicare overpayments is **13.75 percent**, based on the revised PCR. The following table lists previous interest rates.

Period	Interest Rate
February 7, 2001 – April 25, 2001	14.125%
August 1, 2000 – February 6, 2001	13.875%
May 3, 2000 – July 31, 2000	13.75%
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%

Questions and Answers Regarding Payment for the Services of Therapy Students under Part B of Medicare

The following questions and answers have been provided by the Health Care Financing Administration (HCFA) in response to inquiries regarding payment for the services of therapy students under Part B of the Medicare program.

1. Q. Can services provided by a student be reimbursed under Medicare Part B?

A. No, services performed by a student are not reimbursed under Medicare Part B. Medicare pays for services of physicians and practitioners authorized by statute. ***Students do not meet the definition of practitioners listed in section1861 of the statute.***

2. Q. Can a physical or occupational therapist assistant serve as a clinical instructor (CI) for a physical therapist or occupational therapy assistant student while providing services to a Medicare patient that is within their scope of work, and performed under the direction and supervision of the licensed physical or occupational therapist?

A. Physical therapist assistants and occupational therapy assistants are not precluded from serving as CIs for therapy students while providing services within their scope of work, and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.

3. Q. Can services provided by a student with the supervising therapist "in the room" be reimbursed?

A. Only the services of the therapist can be billed to Medicare and paid. However, the fact that the student is "in the room" would not make the service unbillable. Medicare would pay for the services of the therapist.

4. Q. The Current Procedural Terminology (CPT) codes for therapeutic procedure state, "Physician or therapist are required to have direct (one-to-one) patient contact." What if the provider has some contact with the patient (e.g., 5 minutes direct patient contact time) and then the student assumes responsibility for treatment under supervision?

A. The therapist can bill for the direct services he/she provides to patients under Medicare Part B. ***Services performed by the therapy student are not payable under Medicare Part B.***

5. Q. Under the Part A Skilled Nursing Facility (SNF) benefit, the SNF prospective payment system allows therapy student services to be counted toward rehabilitation minutes if provided under "line of sight" supervision of the therapist. *Does "line of sight" supervision allow Medicare Part B services to be billed for student services?

Questions and Answers Regarding Payment for the Services of Therapy Students (continued)

A. No. "Line of sight" supervision by a therapist does not allow student services to be billed. ***Services of students are not billable under Medicare Part B.***

*Under the SNF prospective payment system, payments are based upon the case mix or resource utilization group (RUG) category that describes the patient. In the rehabilitation groups, the number of therapy minutes delivered to the patient determine the RUG category. Payment levels for each category are based upon the costs of caring for patients in each group rather than providing specific payment for each therapy service as is done in Medicare Part B.

6. Q. Can student supervision be provided under Medicare as "direct supervision" (e.g., on premises and immediately available) rather than "line of sight," after determining student's readiness by the therapist? This determination is based on the supervisor's evaluation of student competence and safety, patient acuity, patient complexity, patient's functional status and outcomes, and number of visits?

A. No. ***Services provided by students are not billable under Part B.***

7. Q. How can learning experiences be adequately provided for therapy students under Medicare if they must always be "in line of sight" even when:

- The student has been deemed competent in providing therapy or components of care delivery;
- The student is nearing the completion of a clinical experience; and,
- The student is nearing completion of the program and is evaluated as competent as an entry-level clinician.

A. As previously stated, ***services of students are not billable under Medicare Part B.*** The Medicare statute does not include a benefit category for students. This policy applies to all physician and practitioner groups under Medicare. You may wish to consult with physician groups about how they structure their training programs.

8. Q. What if a student who is supervised under "line of sight" by the supervising therapist is treating a patient who is under Medicare Part A on Friday. On Monday, the patient's coverage changes to Medicare Part B. How does this affect care provided by the student on Monday?

A. The payment methodologies for Part A and B therapy services rendered by a student are different. Under the physician fee schedule (Medicare Part B), Medicare pays for services provided by physicians and practitioners that are specifically authorized by statute. ***Students do not meet the definition of practitioners under Medicare Part B.***

BIPA Changes to the 2001 Payment Amounts for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

In accordance with the Benefits Improvement and Protection Act (BIPA) of 2000, the fee schedule update factors for 2001 for both DME (BIPA section 425) and prosthetics and orthotics (BIPA section 426) are equal to 3.7 percent (the percentage increase in the consumer price index for all urban consumers for the 12-month period ending with June 2000). Sections 425 and 426 specify that these update factors are to be implemented on July 1, 2001. To account for the timing of the implementation of the 3.7 percent update factors (i.e., July rather than January), BIPA of 2000 provides for temporary increases in the fee schedule amounts for items furnished on or after July 1, 2001, but before January 1, 2002. The temporary increases are 3.28 percent for DME and 2.6 percent for prosthetics and orthotics. For services furnished before July 1, 2001, payment will be based on the 2001 fee schedule amounts in effect prior to enactment of BIPA of 2000.

Based on changes made by BIPA of 2000, the Balanced Budget Refinement Act of 1999, and the Balanced Budget Act of 1997, the DMEPOS pricing updates (percentage increases) for the pricing periods beginning January 2001, July 2001 (where applicable), and January 2002 are as follows:

Category	January 1, 2001	July 1, 2001	January 1, 2002
DME (other than oxygen)	0.3*	3.7 + 3.28*	0.6*
Oxygen and Oxygen Equipment	0.3*	see below *	0.6*
Prosthetics & Orthotics	1.0*	3.7 + 2.6*	1.0
Ostomy/Tracheostomy/Urologicals	0.0	3.7 + 3.28*	0.0
Surgical Dressings	0.0	3.7 + 3.28*	0.0
Therapeutic Shoes	0.3*	3.7 + 3.28*	0.6*
Parenteral & Enteral Nutrition	0.0	n/a	0.0
Reasonable Charge (other than ambulance)	3.7	n/a	CPI-U

* Temporary increase not to be carried over into future periods, except in the case of oxygen and oxygen equipment, where the 0.3 percent increase applies to items furnished on or after January 1, 2001, and before January 1, 2002.

July 2001 DMEPOS Fee Schedule Update

The July 2001 fee schedules for DME, prosthetics and orthotics, and surgical dressings will be released to contractors on May 4, 2001. Fees for these codes will be posted to the provider Web site (*www.FloridaMedicare.com*) as soon as they become available, and published in a future issue of the *Medicare A Bulletin.*

Cervical Cancer Awareness and the Benefit of Pap Tests

Pap test is the most effective way to screen for cervical cancer. Medicare helps pay for screening Pap tests every three years. Beneficiaries do not pay co-insurance or deductible for a Pap test; however, they are liable for the twenty percent co-payment for a pelvic exam.

The National Cancer Institute (NCI) estimates that about 12,800 cases of newly diagnosed invasive cervical cancer will occur in the United States each year and that about 4,600 of the women affected will die. Research has shown that many women aged 65 and older have not had a Pap test or pelvic exam in the past 3 years because they vastly underestimate their risk for cervical cancer, or their providers do not recommend them. The fact is that women aged 65 and older account for 25 percent of all cervical cancer cases, and for 41 percent of all deaths from cervical cancer. Pap tests can detect abnormal cervical cell changes before they become cancerous. It is one of the stated goals of Healthy People 2010 to increase to 90 percent the number of women who receive screening Pap tests and to further reduce cervical cancer deaths. The following article provided by HCFA alerts readers to the significance of Pap tests, discusses some of the medical myths surrounding Pap tests and women over age 65, and provides mortality and morbidity rate information.

Pap Tests for Women Ages 65 and Older: Dispelling the Myths

While controlling blood pressure and preventing bone loss are common health concerns for women ages 65 and older, getting Pap tests is not. However, statistics show that regularly scheduled cervical cancer screening also should be a priority for older women: Women ages 65 and older have the highest incidence and mortality rates for cervical cancer. They also have the lowest screening rates. The National Cancer Institute (NCI) conducted in-depth interviews with general and family practitioners at the 1997 American Academy of Family Physicians (AAFP) Conference. The purpose of these interviews was to identify what prevents family and general practitioners from performing Pap tests on women ages 65 and older, and to create and test effective messages and communication channels to encourage physicians interest in Pap tests for women ages 65 and older. Comments made during the interviews uncovered some "myths" that physicians believe to be true, or claim that their patients believe to be true. The following quotes are actual comments expressed during the interviews.

Myth:

"Cancer of the cervix is mostly a disease of young women."

Facts:

According to the 1996 National Institutes of Health Consensus Panel on Cervical Cancer, women ages 65 and older account for nearly 25 percent of all diagnosed cervical cancer cases and 41 percent of cervical cancer deaths in the United States. In addition, more than one-half of all women ages 65 and older have not had a Pap test in the past 3 years. Frequently, post-menopausal women may still need to get a Pap test. It is also important to note that Pap tests should be done in conjunction with pelvic exams. Pelvic exams aid in the detection of abnormalities such as cancer of the endometrial lining of the uterus and ovarian cancer. Since very few older women visit gynecologists, their general practitioners or internists may need to perform Pap tests or refer women to an appropriate health care provider.

Myth:

"For women 65 and older who are not sexually active and have never had an abnormal Pap test, I tell them that…they do not have to have a Pap test."

Facts:

Some women who are not now sexually active may still need Pap tests. Cervical cancer is caused by the human papillomavirus (HPV)—a sexually transmitted virus—which is why it is so important to screen women who are or have *ever* been sexually active. Keep in mind that older women who are not currently sexually active may have been infected years before. HPV can live in the body for years, even a lifetime, without any indication.

Myth:

"By the time women reach age 65, a lot of them have had hysterectomies, and therefore a Pap test would actually not be very important."

Facts:

Many women ages 65 and older have had hysterectomies. Some women who have had hysterectomies still need to get Pap tests. When determining whether a woman who has had a total hysterectomy should have a Pap test, the reason for the hysterectomy must be considered. If the woman had a hysterectomy because of benign problems such as endometrial bleeding or benign fibroids, then she does not need to have regular Pap tests. However, if the hysterectomy was performed because of cervical abnormalities such as cervical neoplasia, then regularly scheduled Pap tests are recommended. For women who have had supracervical hysterectomies, and therefore still have cervixes, regularly scheduled Pap tests are appropriate.***"From the personal [side], I think if you could save one life, think of the opportunity as a physician to make a difference."***

For many older women, lack of information and cost stop them from having Pap tests. Educating women about the purpose of the Pap test and why it is important to have regularly scheduled Pap tests is crucial. Medicare helps pay for a screening Pap test once every 3 years. Medicare may pay more often if necessary. For Medicare information, call 1-800-MEDICARE (1- 800-633-4227) or visit Medicare's Web site at **www.medicare.gov.** NCI's Cancer Information Service (CIS) offers free cervical cancer information packages for health care providers. For the latest, most accurate information about cervical cancer and Pap tests, both women and health care providers can call the CIS at 1-800-4-CANCER.

CERVICAL CANCER INCIDENCE RATES
(per 100,000 U.S. women)
Women under age 65…….. 7.0
Women age 65 and older……. 14.9

CERVICAL CANCER MORTALITY RATES
(per 100,000 U.S. women)
Women under age 65…….. 2.1
Women age 65 and older……. 8.7
Source: National Cancer Institute Surveillance,

HAD A PAP TEST IN THE LAST 3 YEARS
(U.S. women)
Women ages 18-64……... 83.3%
Women age 65 and older……. 59.8%

Promoting Colorectal Cancer Screening

Colorectal cancer (CRC) is the second leading cause of cancer-related deaths in the United States. The estimates for new cases and deaths from CRC in 2001 are 135,400 and 56,700 respectively. However, CRC is one of the most preventable cancers, as well as one of the most curable cancers when detected at an early stage.

Despite the advantages of CRC screening and the fact that Medicare covers CRC screening tests, utilization of this benefit is low. When testifying before the Special Committee on Aging in March 2000, the General Accounting Office (GAO) reported that in 1999, only 14.1 percent of Medicare beneficiaries had one or more of the covered CRC services for screening or diagnostic purposes. The utilization rate had changed little from the 1995 rate of 13.6 percent. While GAO noted numerous reasons for the low rates, including patient, physician, and delivery system issues, its report of the testimony states that there is "substantial room for better outreach and education." Participation from carriers and intermediaries in this effort is needed to increase the utilization of this important benefit.

Since implementation of Medicare's CRC screening benefit, HCFA has partnered with the Centers for Disease Control and Prevention (CDC) and the National Cancer Institute (NCI) to increase CRC screening within the Medicare population. Together CDC, HCFA, and NCI carry out the *Screen for Life* (SFL) campaign, which informs men and women aged 50 years and older—the group most at risk—about the importance of CRC screening for early detection and prevention of the disease.

Medicare providers are encouraged to discuss CRC screening with their patients. Research conducted to support the National CRC Awareness Month Campaing found that nearly half of the survey respondents who were 50 years of age or older reported that their doctors did not discuss CRC screening with them. However, nine out of ten survey respondents reported that they underwent the CRC screening tests that were recommended by their physicians.

Distribution of CRC Materials

Materials that are available include:

- "Good News" Poster (4 versions) targeting Caucasian, African-American, Asian-American, and Hispanic audiences, with tear-off cards that beneficiaries can take on visits to their doctors (stresses the importance of screening, mentions Medicare coverage);
- "No Symptoms" poster (points out that CRC often starts with no symptoms);
- "Let's Break the Silence" CRC brochures (English and Spanish versions);
- "Colorectal Cancer – Facts on Screening" (for patients); and
- "Colorectal Cancer – Health Professionals Facts on Screening."

In addition, other types of materials such as camera-ready slicks, television public service announcements (PSAs), and radio PSAs are available. Copies may be ordered from the CDC Internet site.

Colorectal Cancer (CRC) Screening Publications

To order copies from HCFA – fax, e-mail, or telephone:

Orders For 1-99 copies:

- Fax: 410-786-4786
- E-Mail: LBeasley@HCFA.gov
- Phone: Larry Beasley (410-786-7843)

Orders for 100 or more copies:

- Fax: 410-786-1905
- E-Mail: STaylor@HCFA.gov
- Phone: Susie Taylor (410-786-7849)

NOTE: *Publications may be ordered via fax or e-mail when possible. Because of the large volume of requests, an acknowledgment return call may not be received for orders placed on voice mail.*

To order or download publications from HCFA's Internet site:

- See information from the chart that follows for ordering or downloading "Let's Break the Silence" brochures from the HCFA Internet site.

To order or download publications from CDC:

- Visit the Internet site at: **http://www.cdc.gov./cancer/screenforlife,**
- Call **1-888-842-6355,** or
- Write cancerinfo@cdc.gov.

In addition, other types of materials such as camera ready slicks, television PSAs, and radio PSAs, which are not listed on the table that follows, can be ordered from the CDC Internet site.

To view materials before ordering

- Visit the CDC Internet site at: **http://www.cdc.gov./cancer/screenforlife**

COLORECTAL CANCER SCREENING CAMPAIGN PRINT MATERIALS

Campaign Print Material	Version	HCFA – CDC Pub No.	Additional Information
Poster	"Medicare Good News" (Caucasian Audience)	HCFA #10122	Order packets of tear-off cards (HCFA #10140 – English) to attach to poster. Order from HCFA.
Poster	"Medicare Good News" (African-Amer. Audience)	HCFA #10124	Order packets of tear-off cards (HCFA #10140 – English) to attach to poster. Order from HCFA.
Poster	"Medicare Good News" (Asian-Amer. Audience)	HCFA #10125	Order packets of tear-off cards (HCFA #10140 – English) to attach to poster. Order from HCFA.
Poster	"Medicare Good News" (Hispanic Audience)	HCFA #10142	Order packets of tear-off cards (HCFA #10141 – Spanish) to attach to poster. Order from HCFA.
Poster–***NEW***	"No Symptoms"	HCFA #10183 CDC #099-6478	Posterboard backing. Order from HCFA.
Tear-off cards For Medicare "Good News" Poster	English	HCFA #10140	Packet of English language tear-off information cards, which attaches to "Good News" poster. Provides info on eligibility for CRC screening under Medicare, Medicare coverage of CRC screening, and risk for CRC. Order from HCFA.
Tear-off cards for Medicare "Good News" Poster	Spanish	HCFA #10141	Packet of Spanish language tear-off information cards, which attaches to Hispanic version of "Good News" poster. Provides information on eligibility for CRC screening under Medicare, Medicare coverage of CRC screening, and risk for CRC. Order from HCFA.
Brochure	*"Let's Break the Silence"* - English	HCFA #95173 CDC #099-6010	Also can be viewed or downloaded from the HCFA or CDC Internet sites. (The HCFA site is located at: http://www.medicare.gov/Publications/coloeng.pdf.) NOTE: The English version of the brochure has an incorrect HCFA Pub No. listed on the back--#10126.)
Brochure	*"Let's Break the Silence"* - Spanish	HCFA #10158 CDC #099-6198	Also can be viewed or downloaded from the HCFA or CDC Internet sites. (The HCFA site is located at: http://www.medicare.gov/Publications/colspan.pdf.) NOTE: The Spanish brochure has an incorrect CDC Pub No. listed on the back--#099-6010.
Fact Sheet – ***NEW***	CRC Facts on Screening (Patients)	CDC #099-6486	A limited number of fact sheets currently are available. They may be ordered or downloaded from CDC's *Screen for Life* Internet Site. *(See instructions on page 1.)*
Fact Sheet – ***NEW***	CRC Health Professionals Facts on Screening	CDC #099-6487	A limited number of fact sheets currently are available. They may be ordered or downloaded from CDC's *Screen for Life* Internet Site. *(See instructions on page 1.)*

Reprintable Beneficiary Information

The information on the following page may be handled or placed in view of Medicare patients.

Some Important Facts You Should Know about Colorectal Cancer!

- **Colorectal cancer is the second leading cause of cancer related deaths for men and women in the United States.** Colorectal cancer (cancer of the colon or rectum) is second only to lung cancer in causing cancer-related deaths in the U.S. An estimated 135,400 new cases and 56,700 deaths from colorectal cancer are expected in 2001.
- **More than one-third of colorectal cancer deaths could be avoided if people over 50 had regular screening tests.**
- **Most colorectal cancers begin as polyps.** (Polyps are growths on the inner wall of the colon or rectum.)
- **Colorectal cancer starts with no symptoms.** Screening tests are so important because they can find colorectal cancer early, when treatment works best. When colorectal cancer is detected in the earliest stage of the disease (Stage 1), the survival rate is 96 percent.
- **Colorectal cancer is one of the most preventable cancers.** Screening tests can help prevent colorectal cancer by finding pre-cancerous polyps so they can be removed before they turn into cancer.
- **Risk increases as we age.** The risk of developing colorectal cancer increases with age. In fact, most cases occur in people 50 and older.
- **Both men and women are at risk.** Some people think that women are not at risk for colorectal cancer. However, both sexes may develop this cancer.
- **African-Americans are more likely than whites to be diagnosed with colorectal cancer at a more advanced stage and more likely to die of it once diagnosed.**
- **Medicare helps pay for colorectal cancer screening tests.** People with Medicare Part B coverage who are age 50 or older are eligible for colorectal cancer screenings. However, in the case of colonoscopy, there is no age limit. The following screening tests are covered by Medicare:
  - **Fecal Occult Blood Test** (done at home) – Covered once per year. You pay no coinsurance and no Part B deductible.
  - **Flexible Sigmoidoscopy** – Covered once every 4 years. You pay 20 percent of the Medicare approved amount after the yearly Part B deductible.
  - **Colonoscopy**

    High Risk Individuals - If you are at high risk for colorectal cancer, Medicare covers a colonoscopy or a barium enema every 2 years. You pay 20 percent of the Medicare approved amount after the yearly Part B deductible. (Your risk is greater if you have a history of inflammatory bowel disease, colorectal cancer, or polyps, and if you have a family history of colorectal cancer or polyps, or have certain hereditary syndromes.)

    Average Risk Individuals – Beginning July 1, 2001, if you are at average risk (i.e., not at high risk) for colorectal cancer, Medicare will cover a colonoscopy every 10 years. You pay 20 percent of the Medicare approved amount after the yearly Part B deductible. However, if you are at average risk and have had a covered flexible sigmoidoscopy, you must wait 4 years to be eligible for Medicare coverage of a colonoscopy.

    Barium Enema – This test can substitute for a flexible sigmoidoscopy or for a colonoscopy. You pay 20 percent of the Medicare approved amount after the yearly Part B deductible.

Steps You Can Take Now To Protect Your Health

- If you are 50 years old and have never been screened, talk to your doctor about having a screening test for colorectal cancer. Discuss the screening options that are right for you. Do not wait for symptoms.
- If you have any of the following symptoms, discuss them with your doctor. Only he or she can determine if cancer or other conditions are causing the symptoms. The symptoms are:
  - Blood in or on the stool,
  - A change in bowel habits,
  - Stools that are narrower than usual,
  - General stomach discomfort,
  - Frequent gas pains, and
  - Unexplained weight loss.
- Visit the Federal Government's *Screen for Life* website at: www.cdc.gov/cancer/ScreenforLife for more information about colorectal cancer screening tests.
- Call the Centers for Disease Control and Prevention's toll-free line at 1-888-842-6355 to order a copy of a helpful fact sheet called **Colorectal Cancer Facts on Screening.** It also can be downloaded from the *Screen for Life* website. The fact sheet can help you decide on which screening test(s) is right for you. It gives important information about colorectal cancer and describes the screening tests. It also includes a chart describing each test with information on the purpose of the test, important things to consider when choosing a test, how often to have the test, the cost, and insurance/Medicare coverage.
- Call the National Cancer Institute's Cancer Information Service on 1-800-4-CANCER (TTY 1-800-332-9615) for more information about colorectal cancer or any other cancer.
- When you visit the doctor, keep the following tips in mind so that you get the most from your visit.
  - Do not feel uncomfortable about asking questions. Bring a list of questions with you, and have it handy when you talk to the doctor.
  - Ask about colorectal cancer screening, even if your doctor does not mention it.
  - If you do not understand everything your doctor tells you, let him or her know.
  - Bring a notepad and write down notes to help you remember important points.
  - Ask your doctor for materials on colorectal cancer and other topics that you can read after you leave the office.

GENERAL COVERAGE

New CLIA Waived Tests

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

- Clearplan Easy Fertility Monitor (for luteinizing hormone), effective: July 17, 2000
- Clearplan Easy Fertility Monitor (for estrone 3 glucuronide), effective: July 17, 2000
- Metrika DRx® HbA1c (Professional Use Test System), effective: November 27, 2000
- ZymeTx Zstatflu® Test, effective: December 4, 2000

The following tests are effective for services **processed on or after July 1, 2001.**

TEST NAME	MANUFACTURER	CPT CODE	USE
Clearplan Easy Fertility Monitor (for luteinizing hormone)	Unipath Limited	83002QW	Detection of luteinizing hormone and estrone 3 glucuronide in urine to identify the optimal time for conceptionRoche Diagnostics Chemstrip Micral (urine dipstick)
Clearplan Easy Fertility Monitor (for estrone 3 glucuronide)	Unipath Limited	82679QW*	Detection of luteinizing hormone and estrone 3 glucuronide in urine to identify the optimal time for conceptionRoche Diagnostics Chemstrip Micral (urine dipstick)
Metrika DRξ® HbA1c (Professional Use Test System)	Metrika, Inc.	83036QW	Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes
ZymeTx Zstatflυ® Test	Zymetx, Inc.	87449QW	Qualitative determination of influenza types A and B from throat swab specimens

* This test may not be covered in all instances.

Intestinal and Multi-Visceral Transplantation

The Health Care Financing Administration (HCFA) has revised the national coverage decision on intestinal transplantation by expanding the coverage to multi-visceral transplantation.

Coverage

Effective April 1, 2001, Medicare covers intestinal and multi-visceral transplantation for the purpose of restoring intestinal function in patients with irreversible intestinal failure. Intestinal failure is defined as the loss of absorptive capacity of the small bowel secondary to severe, primary gastrointestinal disease or surgically-induced short bowel syndrome. Intestinal failure prevents oral nutrition and may be associated with mortality and profound morbidity. Multi-visceral transplantation includes organs in the digestive system (i.e., stomach, duodenum, pancreas, liver, intestine and colon).

This procedure is covered only when performed for patients who have failed total parenteral nutrition (TPN) and only when performed in facilities that meet approval criteria. TPN delivers nutrients intravenously, avoiding the need for absorption through the small bowel. Failed TPN for liver failure, thrombosis, frequency of infection, and dehydration are indicated in the following clinical situations:

- Impending or overt liver failure due to TPN induced liver injury. The clinical manifestations include elevated serum bilirubin and/or liver enzymes, splenomegaly, thrombocytopenia, gastroesophageal varices, coagulopathy, stomal bleeding or hepatic fibrosis/ cirrhosis.
- Thrombosis of the major central venous channels; jugular, subclavian, and femoral veins. Thrombosis of two or more of these vessels is considered a life threatening complication and failure of TPN therapy. The sequelae of central venous thrombosis is a lack of access for TPN infusion, fatal sepsis due to infected thrombi, pulmonary embolism, superior vena cava syndrome, or chronic venous insufficiency.
- Frequent line infection and sepsis. The development of two or more episodes of systemic sepsis secondary to line infection per year that requires hospitalization indicates failure of TPN therapy. A single episode of line related fungemia, septic shock and/or acute

Intestinal and Multi-Visceral Transplantation (continued)

respiratory distress syndrome are considered indicators of TPN failure.

- Frequent episodes of severe dehydration despite intravenous fluid supplement in addition to TPN. Under certain medical conditions such as secretory diarrhea and non-constructable gastrointestinal tract, the loss of the gastrointestinal and pancreatobiliary secretions exceeds the maximum intravenous infusion rates that can be tolerated by the cardiopulmonary system. Frequent episodes of dehydration are deleterious to all body organs, particularly kidneys and the central nervous system with the development of multiple kidney stones, renal failure, and permanent brain damage.

Aged patients and those with significant co-morbidities, such as cardiopulmonary disease and systemic malignancies, generally do not survive as long as younger and healthier patients receiving intestinal transplantation. Nonetheless, some older patients who are free from other contraindications have received the procedure and are progressing well. The NCD does not include specific exclusions from coverage for advanced age or co-morbidities. The Medicare contractor will base claim determinations regarding medical necessity considering the clinical condition of the individual patients.

There is no national coverage policy in effect for services furnished prior to April 1, 2001. In the absence of a national policy, the Medicare contractor will use discretion to make individual determinations regarding coverage on claims for intestinal transplantation services.

Approved Transplant Facilities

Medicare will cover intestinal transplantation if performed in an approved facility. The criteria for approval of centers will be based on a volume of 10 intestinal transplants per year with a 1-year actuarial survival of 65 percent using the Kaplan-Meier technique. In addition, the following definitions and rules must also be used:

- The date of transplantation (or, if more than one transplantation is performed, the date of the first transplantation) must be the starting date for calculation of the survival rate.
- For those deceased, the date of death is used, if known. If the date of death is unknown, it must be assumed as 1 day after the date of the last ascertained survival.
- For those who have been ascertained as surviving within 60 days before the fiducial date (the point in time when the facility's survival rates are calculated and its experience is reported), survival is considered to be the date of the last ascertained survival. Any patient who receives an intestinal transplant between 61 and 120 days before the fiducial date must be considered "lost to follow-up" if the patient is known to be deceased and his or her survival has not been ascertained for at least 60 days before the fiducial date. Any patient transplanted within 60 days before the fiducial date must be considered as "lost to follow-up" if he or she is not known to be dead and his or her survival has not been ascertained on the fiducial date.

  NOTE: The fiducial date cannot be in the future; it must be within 90 days of the date HCFA receives the application.
- Any patient who is not known to be deceased but whose survival cannot be ascertained to a date that is within 60 days before the fiducial date must be considered as "lost to follow-up" for the purposes of this analysis.
- A facility must submit its survival analyses using the assumption that each patient in the "lost to follow-up" category died one day after the last date of ascertained survival. However, a facility may submit additional analyses that reflect each patient in the "lost to follow-up" category as alive at the date of the last ascertained survival.
- Survival is calculated based on patient survival, not graft survival. Consequently, facilities should not consider retransplantation as termination.
- In addition to reporting actuarial survival rates, the facility must also submit the following information on every Medicare and non-Medicare patient who received an intestinal or multi- visceral transplantation:
  - Patient transplant number
  - Age
  - Sex
  - Clinical indication for transplant (diagnosis)
  - Date of transplant
  - Date of most recent ascertained survival
  - Date of death
  - Category of patient (living, dead, or "lost to follow-up")
  - In days, survival after organ transplant
  - Date of retransplant
  - Number of retransplants.

In certain limited cases, exceptions to the volume and survival criteria may be warranted if there is justification and the facility ensures our objectives of safety and efficacy. For example, HCFA might grant an exception to a facility that fails to meet the volume or survival criteria by a small number due to extraordinary circumstances. Also, HCFA might consider an exception for a facility that has only minimally missed the volume criteria but has displayed exemplary survival performance.

Completed applications must be sent to:

Bernadette Schumaker, Director
Division of Integrated Delivery Systems C4-25-02
7500 Security Boulevard
Baltimore, Maryland 21244-1850

A facility that submits a completed application to HCFA and meets all the requirements of this notice will be approved for intestinal transplants performed beginning on the date of the Administrator's approval letter, but no earlier than April 1, 2001.

A list of approved transplant facilities can be found at the following Web site: **www.hcfa.gov/medicare/intstnlist.htm.**

Payment

Medicare will not pay transplant facilities on a reasonable cost basis for organ acquisition for intestinal or multi-visceral transplants. The diagnosis related group (DRG) payment will be paid in full for hospital services related to this procedure.

Intestinal and Multi-Visceral Transplantation (continued)

Immunosuppressive therapy for intestinal transplantation is covered. The ICD-9-CM procedure code for intestinal transplantation is 46.97; there is no specific ICD-9-CM diagnosis code for intestinal failure. Although diagnosis codes exist to capture the causes of intestinal failure, some examples of intestinal failure include, but are not limited to:

- Volvulus 560.2
- Volvulus gastroschisis 756.79, other [congenital] anomalies of abdominal wall
- Volvulus gastroschisis 569.89, other specified disorders of intestine
- Necrotizing enterocolitis 777.5, necrotizing enterocolitis in fetus or newborn
- Necrotizing enterocolitis 014.8, other tuberculosis of intestines, peritoneum, and mesenteric
- Necrotizing enterocolitis and splanchnic vascular thrombosis 557.0, acute vascular insufficiency of intestine
- Inflammatory bowel disease 569.9, unspecified disorder of intestine
- Radiation enteritis 777.5, necrotizing enterocolitis in fetus or newborn
- Radiation enteritis 558.1

If an intestinal transplantation alone is performed on a patient with an intestinal principal diagnosis, the case would be assigned to either DRG 148 (Major Small & Large Bowel Procedures With Complications or Comorbidities) or DRG 149 (Major Small & Large Bowel Procedures Without Complications or Comorbidities).

If intestinal transplantation and liver transplantation are performed simultaneously, or if a multi-visceral transplantation includes a liver, the case would be assigned to DRG 480 (Liver Transplant).

If a multi-visceral transplantation that does not include a liver is performed, the case would be assigned to either DRG 148 or DRG 149.

Physicians will be paid for the transplant procedure using the fee schedule for CPT code 44135, intestinal transplantation from cadaver donor. The national coverage policy is silent with regard to coverage of living donor intestinal transplantation. Therefore, contractors have the discretion to determine coverage on CPT code 44136, intestinal allotransplantation from living donor.

Presently, the Medicare regulations do not authorize payment of organ acquisition costs on a reasonable cost basis for organs other than heart, liver, lung, kidney or pancreas. Hospitals should report any acquisition charges they incur for intestine, stomach, or colon on the bill for the transplant procedure. However, no interim pass-through acquisition payment will be made for these costs, and hospitals should not include the costs in the preparation of the schedule D-6 of their cost report. Acquisition costs for liver and pancreas may be paid o n a reasonable cost basis and reported on the cost report.

For acquisition of organs for intestinal and multi-visceral transplantation, physicians should report one of the following CPT codes for the donor enterectomy as appropriate: 44132, open with preparation and maintenance of allograft from cadaver donor, or 44133, partial from living donor. These codes will be paid under the physician fee schedule until such time as the regulatory definition of "organ" is revised, which would allow payment to be made on a reasonable cost basis.

Billing Instructions

In addition to the payment implications listed above, the following billing instructions also apply:

- ICD-9-CM procedure code 46.97 is effective for discharges on or after April 1, 2001
- Charges for ICD-9-CM code 46.97 should be billed under revenue code 360 – Operating Room Services.
- The procedure used to obtain the donor's organ on the same claim should be billed using appropriate ICD-9-CM procedure codes.
- Type of bill 11x should be used when billing for intestinal transplants.
- Immunosuppressive therapy must be billed based on the established Medicare guidelines.

Expanded Coverage of Positron Emission Tomography (PET) Scans and Related Claims Processing Changes

The Health Care Financing Administration (HCFA) has expanded Medicare coverage for positron emission tomography (PET) scans effective for claims with dates of service **on or after July 1, 2001.** Also effective for claims **received on or after July 1, 2001,** HCFA will no longer require the designation of the four PET scan modifiers (N, E, P, S) and has made the determination that no paper documentation needs to be submitted up front with PET scan claims. Documentation requirements such as physician referral and medical necessity determination are to be maintained by the provider as part of the beneficiary's medical record. This information must be made available to the fiscal intermediary upon request of additional documentation to determine appropriate payment of an individual claim.

Background

PET is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images, which are obtained from positron emitting radioactive tracer substances (radiopharmaceutical) such as FDG (2-{flourine-18}-fluoro-2-dexoy-D-glucose), which are usually administered intravenously to the patient. At this time Medicare only covers FDG PET scans.

Coverage Guidelines

Regardless of any other terms or conditions, all uses of PET scans, in order to be covered by the Medicare program, must meet the following conditions:

- **As of July 1, 2001,** PET scans are covered for those indications otherwise listed in this document. For indications covered beginning July 1, 2001, scans performed with dedicated full-ring scanners will be covered. Previously, HCFA had indicated that gamma camera systems with at least a one-inch thick crystal would be eligible for coverage. However, coverage of PET using camera-based systems is now under further review as a separate national coverage determination.

Expanded Coverage of PET Scans (continued)

A final decision on what systems other than dedicated PET will be eligible for coverage, if any, will be announced prior to July 1, 2001. For those indications covered prior to July 1, 2001, all PET scanners approved or cleared for marketing by the FDA remain covered.

- The provider must maintain on file the doctor's referral and documentation that the procedure involved: (a) only FDA approved drugs and devices and, (b) did not involve investigational drugs, or procedures using investigational drugs, as determined by the FDA.
- The ordering physician is responsible for certifying the medical necessity of the study according to the conditions. The physician must have documentation in the beneficiary's medical record to support the referral supplied to the PET scan provider.
- All other uses of PET scanners not listed in this instruction **are *not* covered.** (See Medicare Coverage Issues Manual (CIM) section 50-36 for specific coverage criteria for PET Scans.)

Expansion of Coverage, Effective July 1, 2001

The following is a brief summary of the expanded coverage. Detailed information can be found in the CIM section 50-36.

- PET is covered for diagnosis, initial staging and restaging of non-small cell lung cancer (NSCLC).
- Usage of PET for colorectal cancer has been expanded to include diagnosis, staging, and restaging.
- Usage of PET for the initial staging, and restaging of both Hodgkin's and non-Hodgkin's disease.
- Usage of PET for the diagnosis, initial staging, and restaging of melanoma. **(PET Scans are *NOT* covered for the evaluation of regional nodes.)**
- Medicare covers PET for the diagnosis, initial staging, and restaging of esophageal cancer.
- Usage of PET for head and neck cancers. **(PET scans for head and neck cancer is *NOT* covered for central nervous system or thyroid cancers.)**
- Usage of PET following an inconclusive single photon emission computed tomography (SPECT) only for myocardial viability. In the event that a patient has received a SPECT and the physician finds the results to be inconclusive, only then may a PET scan be ordered utilizing the proper documentation.
- Usage of PET for pre-surgical evaluation for patients with refractory seizures.

Definitions

The following definitions apply for all uses of PET, excluding Rubidium 82 for perfusion of the heart, myocardial viability and refractory seizures:

1. **Diagnosis**: PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers, as well as in melanoma, should be rare. PET is not covered for other diagnostic uses, and is not covered for screening (testing of patients without specific signs and symptoms of disease).
2. **Staging and/or Restaging**: PET is covered in clinical situations in which (1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or, (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient and, (2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence.
3. **Monitoring:** Use of PET to monitor tumor response during the planned course of therapy (i.e. when no change in therapy is being contemplated) is **NOT covered.** Restaging only occurs after a course of treatment is completed, and this is covered, subject to the conditions above.

Limitations

For staging and restaging: PET is covered in either/or both of the following circumstances:

1. The stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound).
2. The clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

PET is not covered for other diagnostic uses, and is not covered for screening (testing of patients without specific symptoms). Use of PET to monitor tumor response during the planned course of therapy (i.e. when no change in therapy is being contemplated) is not covered.

Medical Documentation

Additional medical documentation (other than the information needed on the claim form) is no longer required for the submission of PET scan claims. The fiscal intermediary will conduct periodic analysis of the utilization data for PET scans to identify aberrant providers and conduct post-payment reviews to determine that the use of PET scans is consistent with this instruction.

Provider records must maintain the following information:

- PET scanning facilities must keep patient record information on file for each Medicare patient for whom such a PET scan claim is made.
- The medical records can be used in any post-payment review and must include the information necessary to substantiate the need for the PET scan.

- The medical records must include standard information (e.g., age, sex, and height) along with any annotations regarding body size or type that indicate a need for a PET scan to determine the patient's condition.

HCPCS for PET Scans

For dates of service **on or after July 1, 2001,** Medicare has established the following new PET scan HCPCS codes:

G0210 PET Imaging *whole body;* diagnosis; lung cancer, non-small cell
G0211 PET Imaging *whole body; initial* staging; lung cancer; non-small cell **(**replaces G0126**)**
G0212 PET Imaging *whole body;* restaging; lung cancer; non-small cell
G0213 PET Imaging *whole body;* diagnosis; colorectal cancer
G0214 PET Imaging *whole body; initial* staging; colorectal cancer
G0215 ET Imaging *whole body;* restagin*g;* colorectal cancer **(**replaces G0163**)**
G0216 PET Imaging *whole body;* diagnosis; melanoma
G0217 PET Imaging *whole body; initial* staging; melanoma
G0218 PET Imaging *whole body;* restaging; melanoma **(**replaces G0165**)**
G0219 PET Imaging whole body; melanoma for non-covered indications
G0220 PET Imaging *whole body;* diagnosis; lymphoma
G0221 PET Imaging *whole body; initial* staging; lymphoma **(**replaces G0164**)**
G0222 PET Imaging *whole body;* restaging; lymphoma **(**replaces G0164**)**
G0223 PET Imaging *whole body or regional*; diagnosis; head and neck cancer; excluding thyroid and CNS cancers
G0224 PET Imaging *whole body or regional; initial* staging; head and neck cancer; excluding thyroid and CNS cancers
G0225 PET Imaging *whole body or regional;* restaging; head and neck cancer, excluding thyroid and CNS cancers
G0226 PET Imaging *whole body;* diagnosis; esophageal cancer
G0227 PET Imaging *whole body; initial* staging; esophageal cancer
G0228 PET Imaging *whole body;* restaging; esophageal cancer
G0229 PET Imaging; Metabolic brain imaging for pre-surgical evaluation of refractory seizures
G0230 PET Imaging; Metabolic assessment for myocardial viability following inconclusive SPECT study

NOTE: G0125 has a definition change: "PET imaging regional or whole body; single pulmonary nodule" G0126, G0163, G0164 and G0165 will be discontinued June 30, 2001; there is no grace period.

Billing Requirements

Claims for PET scan services must be billed on a HCFA-1450 (UB-92) claim form or the electronic equivalent with the appropriate "G" HCPCS and diagnosis codes to indicate the conditions under which a PET scan was done. These codes represent the technical component costs associated with these procedures when furnished to hospital outpatients and are paid under the outpatient prospective payment system. Claims for PET scan are billed under revenue code 404 (PET scan).

Verteporfin

The Health Care Financing Administration has established guidelines for the processing of claims for services related to the drug **verteporfin** when it is furnished intravenously incident to a physician's service. Verteporfin is approved by the Food and Drug Administration (FDA) for ocular photodynamic therapy (OPT), which is a treatment for age-related macular degeneration (AMD). Medicare covers verteporfin, subject to the instructions contained in this article.

OPT combines a light-sensitive medication and laser to destroy diseased tissue and abnormal blood vessels in the eye. A photosensitive drug is introduced into the body. The drug selectively identifies and adheres to diseased tissue, but it remains inactive until it is exposed by means of a laser to a specific wavelength of light. Activation of the drug results in a photochemical reaction that treats the diseased tissue without affecting surrounding normal tissue.

Verteporfin, a benzoporphyrin derivative, is an intravenous lipophilic photosensitive drug with an absorption peak of 690 nm. The FDA first approved this drug on April 12, 2000. On July 18, 2000, it was approved for inclusion in the United States Pharmacopoeia, thereby meeting the definition of a drug set forth under section 1861(t)(1) of the Social Security Act.

Medicare Coverage Policy

CPT code 67221 – Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion), and **HCPCS code Q3013** – Verteporfin (per 15 mg) are covered services when billed with diagnosis code **ICD-9-CM 362.52** – Exudative senile macular degeneration. This policy is effective for services furnished **on or after July 1, 2001.**

Intermediary Claims Processing Instructions for Hospital Outpatient Services:

- For hospital outpatient services, payment for CPT code 67221 and **HCPCS code C1203** will be allowed when billed with diagnosis code ICD-9-CM 362.52.
  To receive a transitional pass-through payment under the outpatient PPS, hospitals must use HCPCS code C1203 to bill for verteporfin.
- Claims for CPT code 67221 and HCPCS code C1203 will be denied when billed with either ICD-9-CM 362.51 or 362.50.

NOTE: Payment for intravenous infusion is packaged into CPT code 67221. No separate payment will be made for intravenous infusion services.

Intermediary Claims Processing Instructions for Hospital Inpatient Services:

For inpatient services, report diagnosis code 362.52, and procedure codes 14.24 (Destruction of chorioretinal lesion by laser photocoagulation) and 99.29 (Injection or infusion of other therapeutic or prophylactic substance).

NOTE: Proof of a fluorescein angiogram (FA) must be maintained in the patient's file for auditing purposes.

HOSPITAL SERVICES

Postacute Care Transfer Policy

The Health Care Financing Administration (HCFA) has developed coding clarifications for hospitals and postacute care facilities, with respect to their responsibility for ensuring correct and appropriate discharge status coding on claims, according to the ten diagnosis related group (DRG) postacute care transfer provision in section 1886(d)(5)(I) of the Social Security Act (Act).

Instructions for Discharge Status Coding According to The 10 Postacute Care Transfer Provision

Under section 1886(d)(5)(I) of the Act, a **discharge** is a situation in which a beneficiary leaves a PPS acute care hospital after receiving complete acute care treatment. A **transfer** is a situation in which the beneficiary is transferred to another acute care PPS hospital for related care. Section 4407 of the Balanced Budget Act of 1997 (BBA) added section 1886(d)(5)(J) to the Act. Under this provision, if a beneficiary has a qualified discharge from one of ten DRGs to a postacute care provider, **the discharge will be treated as a transfer case.** Section 1886(d)(5)(J)(ii) of the Act, defines ***qualified discharge*** as a discharge from a PPS hospital of an individual whose hospital stay is classified in one of the ten selected DRGs if, upon discharge, the patient is:

- admitted to a hospital or hospital unit that is not reimbursed under PPS;
- admitted to a SNF; or
- provided home health services if the services relate to the condition or diagnosis for which the individual received inpatient hospital services and if these services are provided within an appropriate period as defined by the Secretary. According to 42 CFR 412.4 (c) (3), the transfer policy is applicable if the individual was discharged to home under a written plan of care for the provision of home health services and the services begin within three days after the date of discharge.

According to 42 CFR 412.4 (d), the ten DRGs selected by the Secretary pursuant to this authority, are as follows:

DRG	Title
014	Specific Cerebrovascular Disorders Except Transient Ischemic Attack
113	Amputation for Circulatory System Disorders Excluding Upper Limb and Toe
209	Major Joint Reattachment Procedures of Lower Extremity
210	Hip and Femur Procedures Except Major Joint Age>17 with Complications and Cormorbidities (CC)
211	Hip and Femur Procedures Except Major Joint Age > 17 Without CC
236	Fractures of Hip and Pelvis
263	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis With CC
264	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis Without CC
429	Organic Disturbances and Mental Retardation
483	Tracheostomy Except for Face, Mouth, and Neck Diagnoses

Hospitals must be coding discharge claims based on the discharge plan for a patient; i.e., a ***qualified discharge.*** If hospitals subsequently learn that postacute care was provided to a patient for whom they submitted a claim with a discharge status code 01; i.e., discharge to home with no postacute treatment, then hospitals should submit adjustments to those claims.

Discharge status code 01 is only appropriate for the ten DRGs in instances where a patient is discharged from an inpatient facility, and

(1) is not admitted on the same day to another inpatient facility or SNF, or
(2) does not receive any home health services within a 3-day period from the date of discharge.

In addition, all postacute care facilities and hospitals, especially those that submit large volumes of claims for these services, must have clear communication between themselves and patient physicians regarding the use of subsequent home health services. Hospitals must be able to ensure that when physicians authorize postacute care in a patient's medical records, that the physician also indicates postacute care on the patient's discharge documents.

Independent Laboratory Billing for the Technical Component (TC) of Physician Pathology Services to Hospital Patients

In the final physician fee schedule regulation published in the ***Federal Register*** on November 2, 1999, the Health Care Financing Administration (HCFA) stated that it would implement a policy to pay only hospitals for the technical component (TC) of physician pathology services furnished to hospital inpatients. Prior to this proposal, any independent laboratory could bill the carrier under the physician fee schedule for the TC of physician pathology to a hospital inpatient.

Background

The ***Federal Register*** regulation provided that, for services furnished on or after January, 1, 2001, the carriers would no longer pay claims to the independent laboratory under the physician fee schedule for the TC of physician pathology services for hospital inpatients. Similar treatment was provided under the outpatient prospective payment system for the TC of physician pathology services to hospital outpatients. (The TC of physician pathology services includes the TC of cytopathology and surgical pathology physician services as described in the American Medical Association's Current Procedural Terminology (CPT) book. This change was to take effect for services furnished on or after January 1, 2001.

However, section 542 of the Benefits Improvement and Protection Act of 2000 (BIPA) provides that the Medicare carrier can continue to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a **covered hospital.** This provision applies to TC services furnished during the 2-year period beginning on January 1, 2001.

Definition of Covered Hospital

For this provision**, covered hospital** means a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the TC of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients or outpatients and submitted claims for payment for the TC to a carrier. The TC could have been submitted separately or combined with the professional component and reported as a combined service.

The term "fee-for-service Medicare beneficiary" means an individual who:

1. Is entitled to benefits under Part A or enrolled under Part B of title XVIII or both; and
2. Is not enrolled in any of the following:
   a. A Medicare + Choice plan under Part C of such title;
   b. A plan offered by an eligible organization under section1876 of the Act;
   c. A program of all-inclusive care for the elderly under section1894 of the Act; or
   d. A social health maintenance organization demonstration project established under section 4108(b) of the Omnibus Budget Reconciliation Act of 1987.

Implementation of BIPA Provision

In implementing section 542, Medicare will consider as independent laboratories those entities that Medicare has previously recognized and paid as independent laboratories.

An independent laboratory that has acquired another independent laboratory that had an arrangement on July 22, 1999, with a covered hospital, can bill the TC of physician pathology services for that hospital's inpatients and outpatients under the physician fee schedule.

The following examples illustrate the application of the statutory provision to arrangements between hospitals and independent laboratories.

Example 1: Prior to July 22, 1999, independent laboratory A had an arrangement with a hospital in which this laboratory billed the carrier for the TC of physician pathology services. In July 2000, independent laboratory B acquires independent laboratory A. Independent laboratory B bills the carrier for the TC of physician pathology services for this hospital's patients in 2001 and 2002.

If a hospital is a covered hospital, any independent laboratory that furnishes the TC of physician pathology services to that hospital's inpatients or outpatients can bill the carrier for these services furnished in 2001 and 2002.

Example 2: As of July 22, 1999, the hospital had an arrangement with an independent laboratory, laboratory A, under which that laboratory billed the carrier for the TC of physician pathology service to hospital inpatients or outpatients. In 2001, the hospital enters into an arrangement with a different independent laboratory, laboratory B, under which laboratory B wishes to bill its carrier for the TC of physician pathology services to hospital inpatients or outpatients. Because the hospital is a "covered hospital," independent laboratory B can bill the carrier for the TC of physician pathology services to hospital inpatients or outpatients.

If the arrangement between the independent laboratory and the covered hospital limited the provision of TC physician pathology services to certain situations or at particular times, then the independent laboratory can bill the carrier only for these limited services.

An independent laboratory that furnishes the TC of physician pathology services to inpatients or outpatients of a hospital that is **not** a covered hospital may **not** bill the carrier for TC of physician pathology services furnished in 2001 or 2002.

The hospital cannot bill under the outpatient prospective system for the TC of physician pathology services if the independent laboratory that services that hospital outpatients is receiving payment from its carrier under the physician fee schedule.

Providers will be advised of any change in the claim processing requirements in future issues of the Medicare A Bulletin as theses changes become available.

End Stage Renal Disease Drug Pricing Update

The following revised End Stage Renal Disease (ESRD) drug pricing list updates and replaces section 22 of the Medicare Part A ESRD Processing Manual. This list may also be used as a stand-alone reference for ESRD drugs and/or pharmacy services. Prices are effective for services rendered ***on and after January 1, 2001,*** and represent the Medicare maximum reimbursement for separately billable ESRD drugs and/or pharmaceuticals.

All prices, as mandated by the Health Care Financing Administration (HCFA), are 95 percent of either:

- the lesser of the median average wholesale price of all generic forms of the drug, or
- the lowest brand name average wholesale price.

ESRD providers may order the 2000 *Drug Topics® Red Book®*. Call **(800) 222-3045**, toll-free, or write to:

Drug Topics® Red Book®
5 Paragon Drive
Montvale, NJ 07645-1742

- The drugs listed in this section are arranged in alphabetical order, based on the first initial of the drug name.
- When a drug is billed on the HCFA-1450 (UB-92) billing format, an ICD-9-CM diagnosis code (excluding 585 – Chronic Renal Disease) must be reported.
- Diagnosis code 585 (Chronic Renal Disease) must be reported as principal diagnosis code on all ESRD bill types (type of bill code 72x).
- The drug prices in this revision include a 5 percent price reduction as mandated by HCFA.

LEGEND

CPT/HCPCS CODE HCFA Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) code, and locally assigned code reportable on the HCFA-1450 (UB-92) billing format.
NAME Name of drug (brand name and/or generic).
PRICE Medicare Part A reimbursement allowance for specific drug administered via ESRD environment.

CPT/HCPCS CODE	NAME	PRICE
J0170	Adrenalin Epinephrine, 1 mg/1 cc ampule	$1.55
*J0210	Aldomet, up to 250 mg	$7.45
J2997	Alteplase, Recombinant (Activase), 1 mg	$26.12
00047	Amikin, Amikacin, 100 mg/2 cc	$41.84
J0280	Aminophylline, 250 mg	$1.15
J0285	Amphotericin B, Fungizone, 50 mg	$16.94
J0290	Ampicillin, 500 mg	$0.98
J0690	Ancef, Kefzol, 500 mg	$2.47
*J0360	Apresoline Hcl (Hydralazine), 20 mg	$13.06
J3430	Aquamephyton (Vitamin K), 1 mg	$2.24
*J0380	Aramine, Metaraminol Bitartrate, 10 mg	$1.21
J7504	Atgam, 250 mg	249.16
J2060	Ativan (Lorazepam), 2 mg	$8.33
J0460	Atropine Sulfate, 0.3 mg	$3.62
X0004	Azactam (Aztreonam), 1 gm	$17.09
00151	Bactrim, 80 mg/ml-16 mg/ml, 5 cc	$3.99
J0530	Bicillin C-R (Penicillin-G), 600,000 units	$7.32
J0540	Bicillin C-R (Penicillin-G), 1,200,000 units	$13.99
J0550	Bicillin C-R (Penicillin-G), 2,400,000 units	$30.82

CPT/HCPCS CODE	NAME	PRICE
J0560	Bicillin La (Penicillin-G), 600,000 units	$10.07
J0570	Bicillin La (Penicillin-G), 1,200,000 units	$6.65
J0580	Bicillin La (Penicillin-G), 2,400,000 units	$36.99
X0007	Buprenex (Buprenorphine), .3 mg/1 cc	$2.53
J0635	Calcijex (Calcitriol), 1 mcg/ml	$13.21
J0630	Calcitronin-Salmon, up to 400 units	$3.73
X0014	Calcium Chloride 10%, 10 cc	$6.69
J0610	Calcium Gluconate, 10 ml	$1.22
J1955	Carnitine (Levocarnitine), 1 gm	$34.20
J0710	Cefadyl (Cepharin Sodium), 1 gm	$1.55
J0715	Ceftizoxime Sodium (Cefizox), 500 mg	$10.82
00248	Cefobid, 1 gm	$16.08
X0016	Cefotan, 1 gm	$11.43
J0698	Cefotaxime, Claforan, 1 gm	$12.12
J0702	Celestone Soluspan, 3 mg	$4.87
J0743	Cilastatin Sodium, Impenum (Primaxin IV), 250 mg	$15.01
87000	Cipro, 200 mg	$14.82
X0017	Cleocin Phosphate (Clindamycin), 300 mg	$6.16

*This drug is included in the composite rate.

End Stage Renal Disease Drug Pricing Update (continued)

CPT/HCPCS CODE	NAME	PRICE
J0745	Codeine Phosphate, 30 mg	$1.06
J0835	Cortrosyn, 0.25 mg	$15.34
J1570	Cytovene, Ganciclovir Sodium , 500 mg	$33.88
J9070	Cytoxan (Cyclophosphamide), 100 mg	$5.97
J9080	Cytoxan (Cyclophosphamide), 200 mg	$11.34
J9090	Cytoxan (Cyclophosphamide), 500 mg	$24.12
J9091	Cytoxan (Cyclophosphamide), 1 gm	$47.64
J9092	Cytoxan (Cyclophosphamide), 2 gm	$95.26
J2597	Ddavp (Desmopressin Acetate), 1 mcg	$4.67
J1100	Dexamethasone Sodium Phosphate, 1 mg	$0.57
J0970	Delestrogen, 40 mg	$2.28
J2175	Demerol (Meperidine HCL), 100 mg	$1.03
J1090	Depo-Testosterone, 50 mg/1 cc	$0.60
J1070	Depo-Testosterone, 100 mg/1 cc	$1.21
J1080	Depo-Testosterone, 200 mg/1 cc	$2.80
J0895	Desferal (Deferoxamine Mesylate), 500 mg/5 cc	$12.61
J7060	Dextrose 5%, 50 cc	$9.74
*J1730	Diazoxide, Hyperstat, 300 mg/20 ml	112.50
J1450	Diflucan, 200 mg	$83.85
*J1160	Digoxin (Lanoxin), up to 0.5 mg	$2.35
J1165	Dilantin, 50 mg	$0.90
J1170	Dilaudid, 4 mg	$1.28
*J1200	Diphenhydramine HCL (Benadryl), up to 50 mg	$3.90
*X0023	Dopamine, Intropin, 40 mg/1 cc	$1.84
J1240	Dramamine (Dimenhydrinate), 50 mg	$0.69
J1364	Erythromycin Lactobionate, 500 mg	$11.63
J2915	Ferrlecit, 62.5 mg/5 ml	$40.85
00623	Flagyl, Metronidazole, 500 mg	$31.10
J9190	Fluorouracil, 500 mg	$2.72
X0100	Folic Acid, 5 mg/cc	$1.22
J0713	Fortaz, Ceftazidime, 500 mg	$9.67
J1470	Gamma Globulin, 2 cc	$42.75
J1550	Gamma Globulin, 10 cc	114.00
J1580	Garamycin (Gentamicin), 80 mg	$3.58

CPT/HCPCS CODE	NAME	PRICE
J1630	Haldol, 5 mg	$7.54
*J1644	Heparin Sodium 1000 units	$0.35
00739	Hepatitis B Immune Globulin, 1 ml	135.43
90371	Hepatitis B Immune Globulin, 5 ml	649.80
90740	Hepatitis B Vaccine, (3 dose schedule)	179.78
90747	Hepatitus B Vaccine, 40mcg/2 ml (4 dose schedule)	104.69
J1720	Hydrocortisone Sodium Succinate (Solu-Cortef), 100 mg	$1.80
J3410	Hydroxyzine, 25 mg	$0.70
J1561	Immune Globulin (Gammimune N 5%, 500 mg)	$38.00
J1563	Immune Globulin, intravenous 1 gm	$76.00
J7501	Imuran, Azathioprine, 100 mg	$78.57
J1790	Inapsine (Droperidol), 5 mg	$3.65
*J1800	Inderal, 1 mg/1 cc	$5.93
J1750	Infed (Iron Dextran), 50 mg	$17.91
90657	Influenza virus vaccine, split virus, 6-35 months dosage	$4.91
90658	Influenza virus vaccine, split virus, 3 years and above dosage	$6.70
90659	Influenza virus vaccine, whole virus	$4.91
*J1820	Insulin, 100 units	$4.38
J1840	Kantrex, Kanamycin, 500 mg	$3.19
J1890	Keflin-Cephalothin Sodium, 1 gm	$10.26
J3301	Kenalog (Triamcinolone Acetonide), 10 mg	$1.48
J1940	Lasix (Furosemide), 20 mg	$1.04
X0056	Levophed 0.1%, 4 cc	$15.79
X0043	Levothyroxine, 0.2 mg	$24.84
J1990	Librium, 100 mg	$24.66
*J2000	Lidocaine HCL, 50 cc	$3.45
00971	Mandol, Cefamandole, 1 gm	$8.60
*J2150	Mannitol 25%, 50 cc	$3.26
J1050	Medroxyprogesterone Acetate (Depo-Provera), 100 mg	$13.10
J0694	Mefoxin, Cefoxitin Sodium, 1 gm	$10.83
00987	Mezlin, Mezlocillin, 1 gm	$4.24

*This drug is included in the composite rate.

End Stage Renal Disease Drug Pricing Update (continued)

CPT/HCPCS CODE	NAME	PRICE
J0695	Monocid, Cefonicid Sodium, 1 gm	$24.79
J2270	Morphine, 10 mg	$0.70
J7505	Muromonab-CD3, parenteral, 5 mg	741.00
X0027	Nafcil (Nafcillin Sodium), 500 mg	$1.07
J2320	Nandrolone Decanoate (Deca Durabolin), 50 mg	$5.20
J2321	Nandrolone Decanoate (Deca Durabolin), 100 mg	$6.31
J2322	Nandrolone Decanoate (Deca Durabolin), 200 mg	$24.39
J2310	Narcan (Naloxone HCL), 1 mg	$2.03
J3260	Nebcin, Tobramycin, 80 mg	$10.80
J2300	Nubain (Nalbuphine Hcl), 10 mg/1 cc	$1.44
X0101	Pentam, 300 mg	$93.81
J2550	Phenergan, Promethazine, 50 mg	$0.93
J2560	Phenobarbital Sodium, 120 mg	$3.18
01231	Pipracil, Piperacillin, 1 gm	$6.42
90732	Pneumovax, 0.5 cc	$17.09
*J3480	Potassium Chloride, 2 meq/ml	$2.66
J1410	Premarin, 25 mg	$46.20
J2510	Procaine, Penicillin, 600,000 units	$6.23
J0780	Prochlorperazine (Compazine), up to 10 mg	$1.57
X0076	Prolastin, 500 mg	104.50
J2680	Prolixin Decanoate (Fluphenazine), 25 mg	$15.20
*J2690	Pronestyl, 1 gm	$11.02
J2700	Prostaphlin, Oxacillin Sodium, 250 mg	$2.00
*J2720	Protamine Sulfate, 10 mg	$0.77
J2765	Reglan, Metoclorpramide, 10 mg	$1.90
J0696	Rocephin, Ceftriaxone Sodium, 250 mg	$14.94
89991	Sandoglobulin, 1gm	$86.81
X0102	Septra, 80 mg/ml-16 mg/ml, 5 ml	$3.99
X0038	Sodium Bicarbonate 8.4%, 50 cc	$10.32
00515	Sodium Chloride 9%, 30 cc	$1.42
00510	Sodium Chloride 9%, 50 cc	$3.01
00511	Sodium Chloride 9%, 100 cc	$3.94
00512	Sodium Chloride 9%, 150 cc	$9.72
00513	Sodium Chloride 9%, 250 cc	$10.50
00514	Sodium Chloride 9%, 500 cc	$9.18
J2920	Solu-Medrol, 40 mg	$2.01
J2930	Solu-Medrol, 125 mg	$3.54
01478	Stadol, 1 mg	$7.68
01479	Stadol, 2 mg	$7.99
J2970	Staphcillan, 1 gm	$5.57
J3010	Sublimaze (Fentanyl), 2 cc	$1.62
J3070	Talwin Lactate, 30 mg	$3.17
J3120	Testosterone Enanthate (Delatestryl) , up to 100 mg	$1.24
J3130	Testosterone Enanthate (Delatestryl), 200 mg	$2.03
J3150	Testosterone Propionate, up to 100 mg	$1.09
90703	Tetanus Toxoid, 0.5 cc	$6.00
J3230	Thorazine, Chlorpromazine, up to 50 mg	$1.90
01671	Ticar, Ticarcillan, 1 gm	$4.25
J3250	Tigan Trimethobenzamide Hydrocl, up to 200 mg	$3.04
X0042	Timentin, 100 mg-3 gm	$14.34
J3280	Torecan, 10 mg	$5.01
J3320	Trobicin (Spectinomycin Hydrochloride), 2 gm	$26.79
J0295	Unasyn, 1.5 gm	$7.27
J3360	Valium, 5 mg	$1.42
J3370	Vancocin, Vancomycin, 500 mg	$5.19
*X0057	Verapamil, Calan, 5 mg	$1.56
J2250	Versed (Midazolam), 1 mg	$2.17
X0044	Vibramycin (Doxycycline), 100 mg	$17.94
J3420	Vitamin B-12, 1000 mcgm	$0.77
X0105	Zemplar, 1 ml Fliptop vial	$25.15
J0697	Zinacef (Cefuroxime Sodium), 750 mg	$6.42
X0062	Zofran, 2 mg/1 cc	$12.17
01958	Zovirax, 500 mg	$53.68

*This drug is included in the composite rate.

SKILLED NURSING FACILITY SERVICES

Clarification and HCPCS Coding Update: Part B Fee Schedule and Consolidated Billing for Skilled Nursing Facility (SNF) Services

The Health Care Financing Administration (HCFA) has issued guidelines that update and clarify information published in the Second Quarter 2001 *Medicare A Bulletin* pages 12-18. The issues addressed in this article are:

1. An update to the list of HCPCS codes included in Program Memorandum (PM) A-00-88. The HCPCS codes have been updated to reflect the 2001 HCPCS changes. In addition, as authorized under section 103 of the Balanced Budget Refinement Act of 1999 (BBRA), HCFA has updated the list of HCPCS codes excluded from consolidated billing by the BBRA, updates for 2001.
2. Rescheduling the implementation of the Radiology and other Diagnostic Services fee schedule. The radiology fee schedule is still under development, and will not be available for use on April 1, 2001. SNF Part B radiology bills will continue to be paid using the existing payment methodology and will be cost settled until the radiology schedule has been finalized and scheduled for implementation.

Fee schedules will go into effect April 1, 2001, as scheduled, for the following services:

- Therapy
- Clinical laboratory
- Prosthetic and orthotic devices
- Surgical dressings.

All changes are shown in bold type. This article includes only those service categories for which codes have changed from those previously published.

System changes and new contractor actions related to this initiative have been put on hold until further notice. However, this does not relieve providers and suppliers of their responsibilities to comply with all requirements for SNF consolidated billing.

These program requirements are described in section 4432(b) of the Balanced Budget Act of 1997, Part 42 of the Code of Federal Regulations section 411.15(p)(3)(iii) published on May 12, 1998, section 103 of the BBRA of 1999, and section 313 of the Benefits Improvement and Protection Act of 2000.

"Part B" physical, occupational, and speech therapy services (that is, those services furnished to SNF patients during noncovered days) remain subject to consolidated billing regulations. SNFs may choose to bill for other Part B services and supplies, and will be paid in accordance with the provisions of this PM. However, SNFs may elect to have suppliers continue to bill Medicare directly for these non-therapy Part B services.

SNF Services Not Covered by the Part B Fee Schedule

The article published in the Second Quarter 2001 *Medicare A Bulletin* pages 12-18 listed the HCPCS codes for which an applicable Part B fee schedule has not yet been developed. This list has been updated to reflect coding modifications made in 2001. **The changes to this list are shown below in bold type.** These changes should be added to the previous published coding list.

Therapeutic Shoes

A5500	A5501	A5502	A5503	A5504	A5505	
A5506	A5507	**A5508**				

PEN Codes – See Medicare Intermediary Manual section 3660.6 for Part B coverage. These services, if covered under Part B, continue to be billed to the DMERC.

B4034	B4035	B4036	B4081	B4082	B4083	B4084
B4085	B4150	B4151	B4152	B4153	B4154	B4155
B4156	B4164	B4168	B4172	B4176	B4178	B4180
B4184	B4186	B4189	B4193	B4197	B4199	B4216
B4220	B4222	B4224	B5000	B5100	B5200	B9000
B9002	B9004	B9006	E0776XA		**B9098**	**B9099**

Blood Products

P9010	P9011	P9012	P9013	P9016	P9017	P9018
P9019	P9020	P9021	P9022	P9023	P9031	P9032
P9033	P9034	P9035	P9036	P9037	P9038	P9039
P9040	P9041	P9042	P9043	P9044		

Codes deleted effective December 31, 2000: P9013 and P9018

Transfusion Medicine and Other Procedures

86850	86860	86870	86880	86885	86886	86890
86891	86900	86901	86903	86904	86905	86906
86915	86920	86921	86922	86927	86930	86931
86932	86945	86950	86965	86970	86971	86972
86975	86976	86977	86978	86985	89250	89251
89252	89253	89254	89255	89256	89257	89258
89259	89260	89261	89264			

Fee Schedule for SNF Part B Services

Fee schedules currently exist for the following services, and will go into effect on April 1, 2001:

- Therapy
- Clinical laboratory
- Prosthetic and orthotic devices
- Surgical dressings

The fee schedule for Radiology and Other Diagnostic Tests is not yet available. Providers will be notify when this fee schedule will go into effect.

Part B Fee Schedule and Consolidated Billing for SNF Services (continued)

Services Not Included in SNF Part A PPS

Services excluded from SNF PPS that must be billed separately by the rendering provider or supplier are listed below.

A. Outpatient Services Furnished in a Medicare-participating Hospital or Critical Access Hospital

1. Computerized Axial Tomography (CT Scans)

CT scans are not included in SNF PPS when furnished in a Medicare participating hospital or critical access hospital. The following HCPCS codes identify the excluded services.

70450	70460	70470	70480	70481	70482	70486
70487	70488	70490	70491	70492	**70496**	**70498**
71250	71260	71270	**71275**	72125	72126	72127
72128	72129	72130	72131	72132	72133	**72191**
72192	72193	72194	73200	73201	73202	**73206**
73700	73701	73702	**73706**	74150	74160	74170
74175	**75635**	76355	76360	76370	76375	76380
G0131	G0132					

2. Magnetic Resonance Imaging (MRIs)

MRIs are not included in SNF PPS when furnished in a Medicare participating hospital or critical access hospital. The following HCPCS codes identify the excluded services.

70336	70540	70542	70543	70544	70545	70546
70547	70548	70549	70551	70552	70553	71550
71551	71552	71555	72141	72142	72146	72147
72148	72149	72156	72157	72158	72159	72195
72196	72197	72198	73721	73218	73219	73220
73221	73222	73223	73225	73718	73719	73720
73721	73722	73723	73725	74181	74182	74183
74185	75552	75553	75554	75555	75556	76093
76094	76390	76400				

NOTE: Codes 72198, 73225 and 75556 are valid HCPCS codes but are not covered under Medicare.

3. Radiation Therapy

Radiation therapy is not included in SNF PPS when furnished in a Medicare participating hospital or critical access hospital. The following HCPCS codes identify the excluded services.

77261	77262	77263	77280	77285	77290	77295
77299	77300	77305	77310	77315	77321	77326
77327	77328	77331	77332	77333	77334	77336
77370	77399	77401	77402	77403	77404	77406
77407	77408	77409	77411	77412	77413	77414
77416	77417	77427	77431	77432	77470	77499
77520	**77522**	**77523**	**77525**	77600	77605	77610
77615	77620	77750	77761	77762	77763	77776
77777	77778	77781	77782	77783	77784	77789
77790	77799					

4. Ambulatory Surgery Involving the Use of a Hospital Operating Room

Most ambulatory surgery services performed in a hospital or CAH operating room are excluded from SNF Part A consolidated billing. This exclusion does not apply to services provided in an ASC.

Generally, ambulatory surgery codes ranging from 10040 through 69979 are excluded from SNF Part A consolidated billing. However, there are some minor procedures that are included under SNF Part A consolidated billing, and must be billed by the SNF. The ambulatory surgery codes that are included under SNF PPS are listed below.

10040	10060	10080	10120	11040	11041	11042
11043	1104411721		11740	11900	11901	11920
11921	11922	11950	11951	11952	11954	11975
11976	11977	15780	15781	15782	15783	15786
15787	15788	15789	15792	15793	15810	15811
16000	16020	17000	17003	17004	17110	17111
17250	17340	17360	17380	17999	20000	20974
21084	21085	21497	26010	29058	29065	29075
29085	29105	29125	29126	29130	29131	29200
29220	29240	29260	29280	29345	29355	29358
29365	29405	29425	29435	29440	29445	29450
29505	29515	29540	29550	29580	29590	29700
29705	29710	29715	29720	29730	29740	29750
29799	30300	30901	31720	31725	31730	36000
36140	36400	36405	36406	**36415**	36430	36468
36469	36470	36471	36489	36600	36620	36680
44500	51772	51784	51785	51792	51795	51797
53601	53660	53661	53670	53675	54150	54235
54240	54250	55870	57160	57170	58300	58301
58321	58323	59020	59025	59425	59426	59430
62367	62368	64550	65205	69000	69090	69200
69210	95970	95971	95972	95973	95974	95977
95976						

Code 36415 is a valid HCPCS code but is not covered under Medicare.

B. Additional Excluded Services Rendered by a Certified Provider

The following services, when provided by any Medicare provider licensed to provide them, are excluded from PPS. The services referenced in this section were excluded from consolidated billing by the BBRA. As authorized under the BBRA, we have reviewed and updated the list of HCPCS codes. **These additions do not represent a change in policy to exclude additional types of services, but simply incorporate new HCPCS codes for the same types of services specified in the statute.**

1. Chemotherapy

Chemotherapy services identified by the following HCPCS codes, when provided by any Medicare provider licensed to provide them, are excluded from PPS.

J9000	**J9001**	J9015	J9020	J9040	J9045	J9050
J9060	J9062	J9065	J9070	J9080	J9090	J9091
J9092	J9093	J9094	J9095	J9096	J9097	J9100
J9110	J9120	J9130	J9140	J9150	J9151	**J9160**
J9170	**J9180**	J9181	J9182	J9185	J9200	J9201
J9206	J9208	J9211	J9230	J9245	J9265	J9266
J9268	J9270	J9280	J9290	J9291	J9293	J9310
J9320	J9340	J9350	**J9355**	**J9357**	J9370	J9375
J0939	J9390	J9600				

Part B Fee Schedule And Consolidated Billing for (SNF) Services (continued)

2. Certain Customized Prosthetic Devices

The following customized prosthetic devices are not considered included in the Part A PPS rate and are excluded from consolidated billing. The supplier must bill for these furnished services. **In this article, each valid HCPCS code is listed separately versus a range of codes previously published.**

L5050	L5060	L5100	L5105	L5150	L5160	L5200
L5210	L5220	L5230	L5250	L5270	L5280	L5300
L5310	L5320	L5330	L5340	L5500	L5505	L5510
L5520	L5530	L5535	L5540	L5560	L5570	L5580
L5585	L5590	L5595	L5600	L5610	L5611	L5613
L5614	L5616	L5617	L5618	L5620	L5622	L5624
L5626	L5628	L5629	L5630	L5631	L5632	L5634
L5636	L5637	L5638	L5639	L5640	L5642	L5643
L5644	L5645	L5646	L5647	L5648	L5649	L5650
L5651	L5652	L5653	L5654	L5655	L5656	L5658
L5660	L5661	L5662	L5663	L5664	L5665	L5666
L5667	L5668	L5669	L5670	L5672	L5674	L5675
L5676	L5677	L5678	L5680	L5682	L5684	L5686
L5688	L5690	L5692	L5694	L5695	L5696	L5697
L5698	L5699	L5700	L5701	L5702	L5704	L5705
L5706	L5707	L5710	L5711	L5712	L5714	L5716
L5718	L5722	L5724	L5726	L5728	L5780	L5785
L5790	L5795	L5810	L5811	L5812	L5814	L5816
L5818	L5822	L5824	L5826	L5828	L5830	L5840
L5845	L5846	L5850	L5855	L5910	L5920	L5925
L5930	L5940	L5950	L5960	L5962	L5964	L5966
L5968	L5970	L5972	L5974	L5975	L5976	L5978
L5979	L5980	L5981	L5982	L5984	L5985	L5986
L5988	L6050	L6055	L6100	L6110	L6120	L6130
L6200	L6205	L6250	L6300	L6310	L6320	L6350
L6360	L6370	L6400	L6450	L6500	L6550	L6570
L6580	L6582	L6584	L6586	L6588	L6590	L6600
L6605	L6610	L6615	L6616	L6620	L6623	L6625
L6628	L6629	L6630	L6632	L6635	L6637	L6640
L6641	L6642	L6645	L6650	L6655	L6660	L6665
L6670	L6672	L6675	L6676	L6680	L6682	L6684
L6686	L6687	L6688	L6689	L6690	L6691	L6692
L6693	L6700	L6705	L6710	L6715	L6720	L6725
L6730	L6735	L6740	L6745	L6750	L6755	L6765
L6770	L6775	L6780	L6790	L6795	L6800	L6805
L6806	L6807	L6808	L6809	L6810	L6825	L6830
L6835	L6840	L6845	L6850	L6855	L6860	L6865
L6867	L6868	L6870	L6872	L6873	L6875	L6880
L6920	L6925	L6930	L6935	L6940	L6945	L6950
L6955	L6960	L6965	L6970	L6975	L7010	L7015
L7020	L7025	L7030	L7035	L7040	L7045	L7170
L7180	L7185	L7186	L7190	L7191	L7260	L7261
L7266	L7272	L7274	L7362	L7364	L7366	

Delay in Edit Implementation for Consolidated Billing for Skilled Nursing Facility (SNF) Residents, and Fee Schedule for Part B Residents and Outpatients

The Health Care Financing Administration (HCFA) has delayed the implementation of the edits for skilled nursing facility (SNF) consolidated billing (CB) services that were scheduled to be in effect on April 1, 2001. (See Second Quarter 2001 *Medicare A Bulletin* pages 12-18). However, this delay does not relieve providers and suppliers of their responsibilities to comply with all requirements for SNF CB as described in section 4432(b) of the Balanced Budget Act of 1997, Part 42 of the Code of Federal Regulations section 411.15(p)(3)(iii) published on May 12, 1998, section 103 of the Balanced Budget Refinement Act of 1999, and section 313 of the Benefits Improvement and Protection Act of 2000.

The delayed edits are:

- Common working file (CWF) edit requirements relating to consolidated billing for SNF Part A services, and related contractor resolution procedures.
- CWF edits to detect duplicate Part B claims billed by SNFs and other providers and suppliers.
- Intermediary payment to SNFs under a fee schedule for SNF Part B services.

Also, effective April 1, 2001, the fiscal intermediary will make payment for **all** Part B services rendered to Part B inpatients and outpatients (types of bill 22x and 23x) based on the applicable fee schedule (or charge if lower than the fee schedule amount). If there is no fee schedule for the service or item being billed, the fiscal intermediary will make payment based on cost. Consequently, **all** services billed under Part B are to be billed using **HCPCS codes,** whether the beneficiary resides in a certified bed or a non-certified bed.

If HCPCS codes exist for the service, they must be included on the HCFA-1450 (UB-92) claim form or its electronic equivalent. If the HCPCS codes are not included on the bill, the claim will be returned to the provider with a message saying HCPCS codes are required when billing this service. The rescission of Part B CB under BIPA of 2000 does not affect this provision. The source of the requirement for HCPCS codes, with a line item date of service, that will be paid on a fee basis is: Balanced Budget Act of 1997, section 4432(b)(3); also identified as section 1888(e)(9) and (10) of the Social Security Act.

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES

Extension of Moratorium on the Application of the $1,500 Financial Limitation for Outpatient Rehabilitation Services

The Health Care Financing Administration placed a two-year moratorium on the application of the $1,500 financial limitations for outpatient rehabilitation services furnished from January 1, 2000 through December 31, 2001.

Section 421 of the Medicare, Medicaid, and SCHIP Beneficiary Improvement and Protection Act of 2000, (BIPA) extends the moratorium on application of the financial limitation for claims for outpatient rehabilitation services with dates of service **January 1, 2002, through December 31, 2002.**

Therefore, the moratorium is now for a three-year period and will apply to outpatient rehabilitation claims with dates of service **January 1, 2000, through December 31, 2002.**

The three-year moratorium applies to claims for all outpatient physical therapy services, speech-language pathology services, and outpatient occupational therapy services. Although claims or therapy services will not be subject to a financial limitation, these claims may be reviewed to ensure that the services provided are covered and medically necessary.

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

CRITICAL ACCESS HOSPITAL SERVICES

Clinical Diagnostic Laboratory Tests Furnished by Critical Access Hospitals (CAHs)

This article contains payment instructions implementing section 201 of the Benefits Improvement and Protection Act of 2000 (BIPA 2000) – "Clarification of No Beneficiary Cost-Sharing for Clinical Diagnostic Laboratory Tests Furnished by Critical Access Hospitals."

Effective for services furnished on or after the enactment of Balanced Budget Refinement Act of 1999 (BBRA), Medicare beneficiaries are not liable for any coinsurance, deductible, co-payment, or other cost sharing amount with respect to clinical diagnostic laboratory services furnished as a CAH outpatient service. **The effective date is November 29, 1999; however, the implementation date is July 1, 2001.** Laboratory claims will be processed on a reasonable cost basis, with no adjustment for deductible or coinsurance amounts, on July 1, 2001, with a service date of November 29, 1999, or later.

Further instructions, on adjustments for any CAH that was paid under the fee schedule for outpatient lab services furnished on or after the BBRA effective date, November 29, 1999, through June 30, 2001, will be released at a later date.

Salary Equivalency Guidelines Update Factors

The Health Care Financing Administration (HCFA) has updated the salary equivalency guidelines regulations published as a final rule in the ***Federal Register*** on January 30, 1998. The final rule set forth revisions to the salary equivalency guidelines for Medicare payment for the reasonable costs of physical therapy and respiratory therapy services furnished under arrangements by an outside contractor. The final rule also set forth new salary equivalency guidelines for Medicare payment for the reasonable costs of speech language pathology and occupational therapy services, furnished under arrangements by an outside contractor. Fiscal intermediaries use these guidelines to determine the maximum allowable cost of those services.

The salary equivalency guidelines implement statutory requirements found in section 1861(v)(5) of the Social Security Act, which specify that the reasonable costs for these services may not exceed an amount equal to the salary that would reasonably have been paid for the services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them, if they had been performed in an employment relationship, with a provider or other organization (rather than under such an arrangement), plus allowances for certain expenses that may be incurred by the contracting therapy organization in furnishing the services as the Secretary in regulations determines to be appropriate.

Salary equivalency guideline regulations apply to the services of physical, occupational, speech-language pathologists, and other therapists and services of other health specialists (other than physicians) furnished under arrangements with a provider of services, a clinic, a rehabilitation agency, or a public health agency.

In the preamble to the final rule, HCFA stated that the implementation of prospective payment systems will eliminate the need to revise the salary for equivalence guidelines regulations.

Furthermore, regulations at 42 CFR 413.106(f)(3), Exception for Inpatient Hospital Services, state: "Effective with cost reporting periods beginning on or after October 1, 1983, the costs of therapy services furnished under arrangements to a hospital inpatient are excepted from the guidelines issued under this section if such costs are subject to the provisions of 413.40 or part 412 of this chapter. The intermediary will grant the exception without request from the provider."

After publishing the salary equivalency guidelines final rule HCFA has learned that CAHs or CAHs which furnish swing bed services are not subject to the limits found in regulatory provisions at 42 CFR 412 (hospital inpatient prospective payment system) or 413.40 (rate of ceiling increase). In fact, CAHs will continue to be paid on a reasonable cost basis. Further, section 203 of the Benefits Improvement and Protection Act of 2000, enacted on December 21, 2000, provided an exemption for CAH swing beds from the SNF prospective payment system. That section provided, "Notwithstanding any other provision of this title, a CAH shall be paid for covered SNF services furnished under an agreement entered into under this section on the basis of the reasonable costs of such services (as determined under 1861(v))."

Based on the above, because CAHs and CAH swing beds are not paid under the inpatient prospective payment system or subject to the rate of increase ceiling, and continue to be paid on the basis of reasonable cost, the salary equivalency guidelines continue to apply to them.

Therefore, HCFA has provided a list of additional adjusted hourly salary equivalency amount monthly inflation factors for cost reporting periods **beginning April 2001 t**hrough cost reporting periods **beginning November 2010.**

A list of adjusted hourly salary equivalency amount monthly inflation factors for critical access hospitals (CAHs) and CAH swing beds can be found at the following Web site: **www.hcfa.gov.**

FRAUD AND ABUSE

Fraud and Abuse in the Medicare Program

This article is intended to inform Medicare providers and health care organizations about the situations they may encounter concerning potential fraud and abuse of the Medicare program.

Fraud and abuse in the Medicare program accounts for a substantial percentage of Medicare's annual spending. In recent years, the estimated cost for fraud and abuse in the Medicare program was as high as $23 billion. However, as a result of the federal government's commitment to combating it as well as the public's growing awareness, this amount was reduced through efforts focused on prevention, education, detection, and enforcement. As of 1999, it was estimated that $12.6 billion could be attributed to fraud and abuse; and in 2000, that estimate was $11.9 billion.

Although these figures appear large, they must be put into perspective — that is; they actually represent a fraction of the Medicare program's total expenditures. For example, the $12.6 billion lost in 1999 represents 7.1 percent of all payments made and the $11.9 billion in 2000 represents 6.8 percent. Thus, it is understood that most health care providers and Medicare recipients are honest. However, those who are intentionally attempting to defraud the Medicare program are doing it well.

The taxpayer dollars lost to health care fraud and abuse are the financial resources that should be used to pay for services and items that keep Medicare recipients in good health. The federal government, its agencies and contractors are aggressively working in dealing with these issues. In addition, many health care providers and Medicare recipients are taking active roles in ensuring the integrity of the Medicare program.

What Is Fraud?

Fraud is defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program. Some of the most common examples of fraud are listed below:

- Billing for services or items not actually furnished.
- Soliciting, offering, or receiving a kickback, bribe, or rebate in return for the referral of patients or to induce the performance of a service.
- Falsifying information on medical records, claims, applications, or cost reports in order to increase reimbursement or to receive payment that is not due.
- Misrepresenting services or items that would otherwise be considered not covered as covered services.
- Falsely billing for services or items either furnished to or by a person or entity not authorized under the Medicare program.

What Is Abuse?

Abuse may, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid programs, improper payment, or payment for services which fail to meet professionally recognized standards of care, or that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Although many types of inappropriate practices may be considered abusive, they may evolve into fraud.

What Happens When Fraud or Abuse Is Suspected?

The Health Care Financing Administration and its contractors not only administer the Medicare program, they have a responsibility in ensuring that the tax dollars used to pay medical benefits are used appropriately. They accomplish this through efforts in prevention, detection, and recovery.

It cannot be assumed that all inappropriate payments are the result of some type of fraudulent activity. The investigation and subsequent prosecution of cases of fraud are reserved for those instances when the fraudulent activity is substantiated and documented by repeated patterns of abuse. Therefore, health benefit payers must be prudent in their actions as their decisions could adversely affect individuals or organizations.

For those instances when fraud is not substantiated, there are a variety of remedies that may used to further prevent or recover inappropriate payments:

- Education – Potentially inappropriate activities may be addressed through education such as letters, personal contacts, and/or corrective action plans.
- Review – Claim payments may be reviewed on a pre-payment or retrospective basis. In these instances, inappropriate payments may be identified and denied before they are made or they may be identified and recovered after payment.
- Refunds – Inappropriate payments may be identified by either Medicare or by the recipient of payment. In these cases, the Medicare program may request a refund with or without further punitive action.
- Suspension of payments – In cases where fraud is suspected and it is determined that an individual or entity has received payment inappropriately, the Medicare contractor, through the authority of the Health Care Financing Administration, may suspend a health care provider's payments. That is, the contractor will continue to accept and process the provider's claims, but will withhold all payments.

Fraud and Abuse in the Medicare Program (continued)

For those instances when fraud is substantiated and documented through repeated patterns of abuse, Medicare contractors will initiate an investigation and refer the case to federal law enforcement agencies (i.e., the Office of the Inspector General, the Federal Bureau of Investigation, the United States Attorney' Office) for prosecution. In these instances, substantial criminal fines/restitution, incarceration and/or civil penalties may be imposed. In addition, the Department of Health and Human Services may exclude a health care provider from participating in any federally funded health benefit program if the provider is prosecuted for health care fraud.

How Can Health Care Providers Help?

The Medicare program has become big business and has attracted – as big businesses sometimes do – a few unsavory characters. As such, health care providers, although honest, must treat their organization as a business and protect it from any potentially inappropriate activities. Here are a few simple suggestions that health care providers may use in ensuring that they do not fall victim to potentially fraudulent activities:

- Stay informed of and follow Medicare regulations, policies, and guidelines as they relate to their particular type of organization. It has been demonstrated that many inappropriate activities could have been avoided if a provider would have understood the Medicare regulations that apply to their organization.
- Understand and monitor the terms of employment or contracts to ensure that they are not in violation of any law or regulation governing the Medicare program.
- Ensure that those individuals or entities authorized to bill and/or receive payment on behalf of the health care provider have the appropriate knowledge and expertise in dealing with the Medicare program.
- Ensure that there are no violations of laws or regulations when conducting business with individuals or entities outside of the provider's organization.
- Ensure that any document filed to the Medicare program is accurate and meets the appropriate standards (e.g., claims, medical records, cost reports, applications, etc.).
- If a health care provider suspects any type of fraudulent activity, report it to the Medicare contractor or federal law enforcement agency.

REIMBURSEMENT ISSUES

Implementation of Updates to the Federal Fiscal Year 2001 Inpatient Hospital Payments and Disproportionate Share Hospital Thresholds and Adjustments as Required by the Benefits Improvement and Protection Act (BIPA) of 2000 (Public Law 106-554)

Program Memorandum (PM) A-01-11 dated January 18, 2001, described several provisions contained in BIPA 2000. This PM announces the new FY 2001 operating standardized amounts effective April 1, 2001, as required by section 301 of BIPA 2000, and the new DSH thresholds and adjustments required by section 211 of BIPA 2000. In conjunction with the new standardized amount, the PM also announces new capital rates and outlier adjustment factor thresholds to be effective April 1, 2001. Post this notice immediately on your web site, advise your provider relation's staff, and include a notice of these changes in your next bulletin. HCFA will publish these changes in an upcoming ***Federal Register*** interim final rule with comment.

The standardized amounts effective for discharges occurring on or after April 1, 2001 and before October 1, 2001 are:

Final FY 2001 Operating Rates

	Large Urban Areas		Other Areas	
	Labor-Related	***Nonlabor-Related***	***Labor-Related***	***Nonlabor-Related***
National	$2,925.82	$1,189.26	$2,879.51	$1,170.43
National PR	$2,900.64	$1,179.02	$2,900.64	$1,179.02
Puerto Rico	$1,402.79	$564.66	$1,380.58	$555.72
SCHs	$2,895.02	$1,176.74	$2,849.20	$ 1,158.11

Final FY 2001 Capital Rates

National	$380.85
Puerto Rico	$184.61

Due to the changes to the standardized amounts, we recalculated the fixed loss cost outlier threshold applicable for discharges on or after April 1, 2001 and before October 1, 2001. The new thresholds are equal to the prospective payment rate for the DRG plus the IME and DSH payments plus $16,350 ($14,940 for hospitals that have not yet entered the prospective payment system for capital-related costs).

In addition, section 211 of BIPA 2000 revised the thresholds by which certain classes of hospitals qualify for the disproportionate share adjustment, effective for discharges occurring on or after April 1, 2001. Section 211 also revised the adjustment computations for these hospitals. The specific changes are identified below.

Urban Hospitals	**Qualifying DSH Percent**	**Adjustment Computation**
0-99 Beds	=15%, <19.3% =19.3%	2.5% + [.65 x (DSH pct.-15)] 5.25%
100+ Beds (No Change in Law)	=15%,<20.2% =20.2%	2.5% + [.65 x (DSH pct.-15%)] 5.88% + [.825 x (DSH pct.-20.2%)]
Rural Hospitals		
Sole Community Hospitals (SCH)	=15%, <19.3% =19.3%,<30% =30%	2.5% + [.65 x (DSH pct.-15%)] 5.25% 10%
Rural Referral Centers (RRC)	=15%,<19.3% =19.3%,<30% =30%	2.5% + [.65 x (DSH pct.-15%)] 5.25% 5.25% + [.6 x (DSH pct.-30%)]
Both SCH and RRC	=15%	higher of SCH or RRC adjustment
Other Rural Hospitals		
0-499 Beds	=15%,<19.3% =19.3%	2.5% + [.65 x (DSH pct.-15%)] 5.25%
500+ Beds (No Change in Law)	=15%,<20.2% =20.2%	2.5% + [.65 x (DSH pct.-15%)] 5.88% + [.825 x (DSH pct. -20.2%)]

ELECTRONIC DATA INTERCHANGE

Elimination of HCFA Free Billing Software

Since the late 1980s, the Health Care Financing Administration (HCFA) has required Medicare contractors, such as First Coast Service Options, Inc., (FCSO), to offer free (or "at cost") electronic billing software to our providers upon request. These generally simple pieces of software allowed providers to submit electronic claims to Medicare, using Medicare specific electronic data interchange formats, either the National Standard Format, the UB-92, or the X12N 837 format. FCSO was required to offer this software in order to increase electronic claim submissions. The software gave our providers an opportunity to try electronic billing at low cost, with the expectation that providers would experience the benefits and procure or develop more sophisticated practice management or billing software that would do additional functions. Additionally, use of this software reduced processing costs to the Medicare program as providers switch from paper to electronic claims.

With the advent of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards, there will no longer be Medicare specific electronic formats. Providers will use the same format to submit claims to any payer. This is expected to reduce the costs of electronic transaction software for providers, and should encourage more providers to use electronic transactions. These changes have prompted HCFA to assess whether or not to continue offering the free billing software in the post-HIPAA environment. HCFA will require FCSO to begin phasing out the free billing software requirement effective with the fiscal year 2004, approximately one year after HIPAA standards are implemented. This will give providers enough time to find substitute software that can work with all payers. Providers, suppliers and vendors will be notified when the transition period will begin to phase out the free billing software.

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 **June 22, 2001**, and after, unless otherwise noted.

Medicare Part A Medical Policy Procedures

Medical policies may be applied to Medicare claims on a pre-payment or post-payment basis. Medicare providers are accountable for complying 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.

Medical Policy Table of Contents

Use of the American Medical Association's (AMA's) Current Procedural Terminology (CPT) Codes on Contractors' Web Sites

The Health Care Financing Administration (HCFA) and the AMA recently signed an amendment to the original 1983 Agreement on HCFA's use of CPT coding. This new amendment covers the use of CPT codes, descriptions, and other materials on contractors' Web sites and in other electronic media. A requirement of the agreement is that contractors must differentiate between CPT and other coding structures, such as HCPCS and ICD-9-CM procedure codes, even though CPT codes are carried on HCPCS.

Florida Medicare provides electronic copies of printed publications (such as the *Medicare A Bulletin*) on our provider Web site exactly as they were produced in hard copy format. This assures that publications downloaded from the Web have the same content as the hard copies that were mailed. In order to maintain this consistency, beginning with this issue, the "HCPCS Codes" section of Florida Medicare's LMRPs will now say "CPT/HCPCS Codes," if there is CPT and non-CPT material, or simply "CPT Codes" if the codes in a policy are exclusively CPT. In the event that a policy contains only HCPCS procedure codes, the section title remains unchanged.

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

29540: Strapping

Policy Number
29540

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Strapping

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

Original Policy Effective Date
06/22/2001

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Strapping of the ankle and/or toe(s) consists of the application of nonmedicated, adhesive gauze dressings, applied by overlapping wraps of gauze to exert pressure and hold a structure in place for the purpose of providing structural support, immobilization or compression for the ankle, foot and/or toe(s).

Unna boot is a paste bandage which consists of gauze that has been impregnated with zinc oxide, gelatin, glycerin, and sometimes calamine. The bandage is applied to the leg from the toe to the knee by overlapping wraps of impregnated gauze. The Unna boot forms a semirigid soft cast which should be left in place for 4 to 7 days.

The Unna boot bandage restricts the volume of the leg, controls edema, and encourages more normal prograde venous blood flow with reduction in the subcutaneous blood pressure. The net effect is improved healing of venous stasis ulcers of the lower extremities.

Indications and Limitations of Coverage and/or Medical Necessity

Strapping (Procedure codes 29540 and 29550)

Florida Medicare will consider Strapping of the ankle and/or toe(s) medically reasonable and necessary for the following symptomatic conditions:

- Strains, sprains, dislocations, tendinitis and certain fractures not accompanied by ulceration. It is not generally expected that strapping of the ankle and/or toe(s) would be done more often than weekly. However, there are circumstances that warrant application of straps several times per week, such as, whirlpool treatments which require removal and reapplication of the straps.

Unna boot (Procedure code 29580)

Florida Medicare will consider the use of the Unna boot bandage medically reasonable and necessary for the following indications:

- To treat venous vascular insufficiency;
- For the treatment of ulcers with and without inflammation of the lower extremities which are caused by increased venous pressure, venous insufficiency or capillary dysfunction; and
- For the management of sprains, strains, dislocations and minor fractures.

It is not expected that Unna boot application would be done more often than once or twice per seven days. Unna boot application is not indicated for use with ulcers resulting from arterial disease or diabetes.

CPT/HCPCS Section & Benefit Category
Surgery/Musculoskeletal System

Type of Bill Code
Hospital – 13x
Skilled Nursing Facility – 21x, 22x, 23x
Rural Health Clinic – 71x
Outpatient Rehabilitation Facility – 74x
Comprehensive Outpatient Rehabilitation Facility – 75x

Revenue Code
42x Physical Therapy

CPT/HCPCS Codes

29540	Strapping; ankle
29550	Strapping; toes
29580	Strapping; Unna boot

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

For CPT codes **29540** and **29550**, the following diagnoses are considered medically reasonable and necessary:

718.37	Recurrent dislocation of joint, ankle and foot
718.87	Other joint derangement, not elsewhere classified, ankle and foot

29540:* Strapping *(continued)

719.27	Villonodular synovitis, ankle and foot
726.70	Enthesopathy of ankle and tarsus, unspecified
726.71	Achilles bursitis or tendinitis
726.72	Tibialis tendinitis
726.73	Calcaneal spur
726.79	Enthesopathy of ankle and tarsus, other
727.06	Tenosynovitis of foot and ankle
735.0	Hallux valgus (acquired)
728.71	Plantar fascial fibromatosis
734	Flat foot
735.1	Hallux varus (acquired)
735.3	Hallux malleus
735.4	Other hammer toe (acquired)
735.5	Claw toe (acquired)
735.8	Other acquired deformities of the toe
736.79	Other acquired deformities of the ankle and foot
824.0	Fracture of medial malleolus, closed
824.2	Fracture of lateral malleolus, closed
825.0	Fracture of calcaneus, closed
825.20-825.29	Fracture of other tarsal and metatalsal bones, closed
826.0	Fracture of one or more phalanges of foot, closed
837.0	Closed dislocation of ankle
838.00-838.09	Closed dislocation of foot
845.00-845.19	Sprains and strains of ankle and foot
924.20-924.21	Contusion of ankle and foot, excluding toe(s)
924.3	Contusion of toe

For CPT code **29580**, the following diagnoses are considered medically reasonable and necessary:

451.0-451.2	Phlebitis and thrombophlebitis of lower extremities
454.0	Varicose veins of lower extremities, with ulcer
454.1	Varicose veins of lower extremities, with inflammation
454.2	Varicose veins of lower extremities, with ulcer and inflammation
824.0-824.9	Fracture of ankle
825.0	Fracture of calcaneus, closed
825.20-825.29	Fracture of other tarsal and metatarsal bones, closed
826.0	Fracture of one or more phalanges of foot, closed
837.0-837.1	Dislocation of ankle
838.00-838.19	Dislocation of foot
845.00-845.19	Sprains and strains of ankle and foot

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

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

Utilization Guidelines
N/A

Other Comments
N/A

Sources of Information and Basis for Decision
Sources of information may be found online under Medical Policies in the Part A section on our provider Web site *www.floridamedicare.com.*

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 advisory groups, which includes representatives from numerous specialties.

Start Date of Comment Period
11/15/2000

End Date of Comment Period
12/30/2000

Start Date of Notice Period
05/01/2001

Revision History

Revision Number:	Original
Start Date of Comment Period:	11/15/2000
Start Date of Notice Period:	05/01/2001
	3rd Qtr 2001 *Bulletin*
Original Effective Date:	06/22/2001

33282: Insertable Loop Recorder (ILR)

Revision Overview—CPT/HCPCS Codes section has been revised since the code to report the implantable reveal device has been changed from C1361 to C1764.

Policy Number
33282

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Insertable Loop Recorder (ILR)

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

Original Policy Effective Date
02/25/2000

Original Policy Ending Date
N/A

Revision Effective Date
06/22/2001

Revision Ending Date
06/21/2001

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

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

	SYSTEM
Reveal® ILR	Subcutaneously placed, rogrammable cardiac event recorder with looping memory
Reveal® Activator	Hand-held, telemetry unit used by the patient to activate ECG storage
9790 Programmer	Used to program Reveal® ILR and retrieve, display, and print stored data

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

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

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

CPT/HCPCS Section & Benefit Category
Cardiovascular System/Surgery/Medicine

Type of Bill Code
Hospital – 13x

Revenue Codes
361 Minor Surgery
636 Drugs Requiring Detailed Coding
739 Other EKG/ECG

CPT/HCPCS Codes
33282	Implantation of patient-activated cardiac event recorder (Initial implantation includes programming. For subsequent electronic analysis and/or reprogramming, use 93727)
33284	Removal of an implantable, patient-activated cardiac event recorder
93727	Electronic analysis of implantable loop recorder (ILR) system (Includes retrieval of recorded and stored ECG data, physician review and interpretation of retrieved ECG data and reprogramming)
C1764	Event recorder, cardiac (implantable)

Not Otherwise Classified Codes (NOC)
N/A

33282: **Insertable Loop Recorded (ILR)** ***(continued)***

ICD-9-CM Codes that Support Medical Necessity

780.2 Syncope and collapse

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.

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

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

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

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

The ILR device itself should be coded as C1764 with revenue code 636.

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

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

Documentation Requirements

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

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information and Basis for Decision

Sources of information may be found online under Medical Policies in the Part A section on our provider Web site *www.floridamedicare.com.*

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 advisory groups, which includes representatives from numerous societies.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

05/01/2001

Revision History

Revision Number	2
Start Date of Comment Period	N/A
Start Date of Notice Period	05/01/2001 3rd Qtr 2001 *Bulletin*
Revised Effective Date	06/22/2001

Explanation of Revision: The establishment of categories for use in coding devices eligible for transitional pass-through payments under the hospital OP PPS.

Revision Number	1
Start Date of Comment Period	N/A
Start Date of Notice Period	08/01/2000 Aug/Sept 2000 *Bulletin*
Revised Effective Date	08/01/2000

Explanation of Revision: Outpatient PPS Implementation

Revision Number	Original
Start Date of Comment Period:	08/23/1999
Start Date of Notice Period:	12/1999 Dec 1999 Special Issue *Bulletin*
Original Effective Date	02/25/2000

67221: Ocular Photodynamic Therapy (OPT) with Verteporfin

Revision Overview—The number of the policy has been changed from HCPCS code C1203 to CPT 67221. Indications and limitations of coverage and documentation requirements in this policy have been revised.

Policy Number
67221

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Ocular Photodynamic Therapy (OPT) with Verteporfin

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Sections 35-100 and 45-30
Medicare Hospital Manual, Section 442.7
Medicare Intermediary Manual, Sections 3101.3, 3112.4, 3627.9

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
03/15/2001

Original Policy Ending Date
N/A

Revision Effective Date
07/01/2001

Revision Ending Date
06/30/2001

LMRP Description
Ocular photodynamic therapy (OPT) is a form of treatment for the "wet" or exudative form of age-related macular degeneration. The wet form of macular degeneration involves the growth of abnormal blood vessels called choroidal neovascularization (CNV) beneath the retina resulting in leakage and bleeding. Without treatment, a majority of patients eventually develop scar tissue beneath the macula, which results in loss of central vision. The concept of OPT is to selectively close the abnormal blood vessels, eliminate the bleeding and leakage, and stabilize or improve the vision.

OPT is similar to traditional laser ablation in that abnormal blood vessels are destroyed; however, it is unique in that the low intensity laser activation of the drug verteporfin (VISUDYNE™) preserves the surrounding structures from destruction that is an unfortunate side effect of traditional thermal laser. This feature allows use of this treatment for preservation of vision when the CNV occurs close to the center of the macula.

OPT is a two-step process. In the first step, the patient receives an intravenous injection of verteporfin. The verteporfin circulates through the body and adheres to the walls of the abnormal blood vessels beneath the macula. A laser is then used to shine light into the back of the eye. When this light beam activates the verteporfin, there is closure of the blood vessel. Over time, the body is able to absorb the blood and fluid, which results in stabilization or improvement of visual function.

Over the course of 1-3 months, the blood vessels that have been treated with OPT typically open again and leakage may recur. Treatment is performed at three-month intervals if there is evidence of continued leakage from the blood vessels.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider OPT with verteporfin medically reasonable and necessary when performed for the following indication:

For the treatment of age-related macular degeneration in patients with predominantly classic subfoveal CNV lesions (where the area of classic CNV occupies = 50% of the area of the entire lesion) at the initial visit as determined by a fluorescein angiogram.

Prior to verteporfin OPT retreatment, documentation of the patient's condition must include fluorescein angiographic evidence of current leakage from CNV.

Florida Medicare will not consider the performance of OPT with verteporfin medically reasonable and necessary when any of the following circumstances exist:

- Inability to obtain photographs and an adequate, legible fluorescein angiogram to document CNV (including difficulty with venous access) unless there is a documented history of fluorescein allergy; and
- There is no evidence of CNV leakage (as determined by fluorescein angiography).

CPT/HCPCS Section & Benefit Category
Surgery/ Eye and Ocular Adnexa

Type of Bill Code
Hospital – 13x

Revenue Code
361 Minor surgery
636 Drugs Requiring Detailed Coding

CPT/HCPCS Codes
67221 Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion) (Effective 04/01/2001)
C1203 Injection, Visudyne, (verteporfin)

67221: **Ocular Photodynamic Therapy (OPT) with Verteporfin *(continued)***

G0184	Destruction of localized lesion of choroid (for example, neovascularization); ocular photodynamic therapy (includes intravenous infusion), other eye

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

362.52	Exudative senile macular degeneration

Diagnosis that Support Medical Necessity

N/A

ICD-9-Codes that DO NOT Support Medical Necessity

362.50	Macular degeneration (senile), unspecified
362.51	Nonexudative senile macular degeneration

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.

The use of verteporfin with laser activation is the only form of OPT that is FDA-approved. Other drugs for OPT remain experimental, and therefore noncovered by Medicare.

Effective July 1, 2001, Verteporfin (C1203) that is not used in conjunction with OPT will be denied.

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

CPT code 67221 must be used for claims for photodynamic therapy services performed on or after 04/01/2001.

CPT code G0184 should only be billed when performing OPT on a second eye at the same session as the first eye.

OPT is considered a unilateral service.

Claims submitted for OPT performed on both eyes on the same day will only receive a single reimbursement rate for verteporfin, as a single infusion is adequate for treatment of both eyes.

Revenue code 636 is required for C1203 (verteporfin) in order to receive a transitional pass-through payment under the outpatient PPS.

Documentation Requirements

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

The documentation maintained by the performing physician should include the following:

- Evaluation and management exam including the name and total calculated drug dose (mg) of the photodynamic therapy drug administered and the patient's body surface area on which the dose of the drug is based.
- Fluorescein angiography report, which should include the description of the lesion (e.g., predominantly classic, minimally classic, no classic), unless there is a documented history of fluorescein allergy.

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

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information and Basis for Decision

Sources of information may be found online under Medical Policies in the Part A section on our provider Web site *www.floridamedicare.com.*

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 advisory groups, which includes representatives from the Florida Society of Ophthalmology.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

05/01/2001

Revision History

Revision Number:	1
Start Date of Comment Period	N/A
Start Date of Notice Period	05/01/2001 3rd Qtr 2001 *Bulletin*
Revised Effective Date:	07/01/2001

Explanation of Revision: Transmittal A-01-40 indicates the C-code C1360 is replaced by HCPCS code 67221 effective 04/01/2001. Transmittal 135 provides coverage information for photodynamic therapy and photosensitive drugs effective 07/01/2001. Transmittal AB-01-37 provides processing instructions for services related to the drug verteporfin effective 07/01/2001. These changes have been incorporated into the policy.

Revision Number:	Original
Start Date of Comment Period	08/15/2000
Start Date of Notice Period	02/01/2001 2nd Qtr 2001 *Bulletin*
Original Effective Date:	03/15/2001

70450: Computerized Tomography Scans

Revision Overview—CPT codes 70450, 70460 and 70470 have been added to the title for "ICD-9-CM Codes that Support Medical Necessity" section of the policy.

Policy Number
70450

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Computerized Tomography Scans

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Section 50-12 A-E

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
01/21/1999

Original Policy Ending Date
N/A

Revision Effective Date
04/12/2001

Revision Ending Date
04/11/2001

LMRP Description
Tomography is the recording of internal body images at a pre-determined plane by x-ray. Computerized axial tomography, or CAT scans, involve the measurement of the emergent x-ray beam by a scintillation counter. The electronic pulses are recorded on a magnetic disk and then processed by a minicomputer for reconstruction display of the body in cross-section on a cathode ray tube.

Indications and Limitations of Coverage and/or Medical Necessity

Computerized Tomography Scans
Florida Medicare will only consider computerized tomography scans to be reasonable and necessary when performed for documented cases of illness or injury.

Computerized Tomography Scans:- Head [(Procedure codes 70450 – 70470)]

Florida Medicare will consider a computerized tomography scan of the head to be medically reasonable and necessary when performed to establish a diagnosis or to monitor treatment for the following conditions:

Intracranial neoplasms, cerebral infarctions, ventricular displacement or enlargement, cortical atrophy, cerebral aneurysms, intracranial hemorrhage and hematoma, infection, edema, degenerative processes, cyst formation, multiple sclerosis, seizure disorders, head trauma, congenital abnormalities, presence of a foreign body, and radiation treatment planning.

Coverage for headache should only be for the following situations:

- Patient suffering from headaches after a head injury. Head CAT scan is performed to rule out the possibility of a bleed.
- Patient suffering from headaches unusual in duration and not responding to medical therapy. Head CAT scan is performed to rule out the possibility of a tumor.

Patient suffering from headaches characterized by sudden onset and severity. Head CAT scan is performed to rule out possibility of aneurysm and/or arteriovenous malformation.

CPT/HCPCS Section & Benefit Category
Radiology/Diagnostic Radiology (Diagnostic Imaging)

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

Revenue Codes
32x Radiology-Diagnostic
350 CT Scan: General Classification
351 CT Scan: Head Scan
352 CT Scan: Body Scan
359 CT Scan: Other CT Scans

CPT/HCPCS Codes

70450	Computerized axial tomography, head or brain; without contrast material
70460	with contrast material(s)
70470	without contrast material, followed by contrast material(s) and further sections
70480	Computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material
70481	with contrast material(s)
70482	without contrast material, followed by contrast material(s) and further sections
70486	Computerized axial tomography, maxillofacial area; without contrast material
70487	with contrast material(s)
70488	without contrast material, followed by contrast material(s) and further sections
70490	Computerized axial tomography, soft tissue neck; without contrast material
70491	with contrast material(s)

70450: **Computerized Tomography Scans *(continued)***

70492	without contrast material, followed by contrast material(s) and further sections
71250	Computerized axial tomography, thorax; without contrast material
71260	with contrast material(s)
71270	without contrast material, followed by contrast material(s) and further sections
72125	Computerized axial tomography, cervical spine; without contrast material
72126	with contrast material(s)
72127	without contrast material, followed by contrast material(s) and further sections
72128	Computerized axial tomography, thoracic spine; without contrast material
72129	with contrast material(s)
72130	without contrast material, followed by contrast material(s) and further sections
72131	Computerized axial tomography, lumbar spine; without contrast material
72132	with contrast material(s)
72133	without contrast material, followed by contrast material(s) and further sections
73200	Computerized axial tomography, upper extremity; without contrast material
73201	with contrast material(s)
73202	without contrast material, followed by contrast material(s) and further sections
73700	Computerized axial tomography, lower extremity; without contrast material
73701	with contrast material(s)
73702	without contrast material, followed by contrast material(s) and further sections
74150	Computerized axial tomography, abdomen; without contrast material
74160	with contrast material(s)
74170	without contrast material, followed by contrast material(s) and further sections

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity (70450, 70460, 70470)

006.5	Amebic brain abscess
013.00-013.36	Tuberculosis of meninges and central nervous system
013.60-013.96	Tuberculosis encephalitis or myelitis or other specified or unspecified tuberculosis of central nervous system
036.0-036.2	Meningococcal infection
042	Human immunodeficiency virus (HIV) disease
046.0-046.9	Slow virus infection of central nervous system
047.0-047.9	Meningitis due to enterovirus
049.0-049.9	Other non-arthropod-borne viral diseases of central nervous system
052.0	Postvaricella encephalitis
053.0	Herpes zoster with meningitis
054.3	Herpetic meningoencephalitis
054.72	Herpes simplex meningitis
055.0	Postmeasles encephalitis
056.01	Encephalomyelitis due to rubella
062.0-062.9	Mosquito-borne viral encephalitis
063.0-063.9	Tick-borne viral encephalitis
064	Viral encephalitis transmitted by other and unspecified arthropods
072.1-072.2	Mumps meningitis or encephalitis
090.40-090.49	Juvenile neurosyphilis
094.0-094.9	Neurosyphilis
112.83	Candidal meningitis
114.2	Coccidioidal meningitis
115.01	Infection by Histoplasma capsulatum with meningitis
115.11	Infection by Histoplasma duboisii with meningitis
115.91	Histoplasmosis, unspecified, meningitis
130.0	Meningoencephalitis due to toxoplasmosis
162.0-162.9	Malignant neoplasm of trachea, bronchus, and lung
170.0	Malignant neoplasm of bones of skull and face, except mandible
191.0-191.9	Malignant neoplasm of brain
192.0-192.1	Malignant neoplasm of cranial nerves or cerebral meninges
194.3-194.4	Malignant neoplasm of pituitary gland and craniopharyngeal duct or pineal gland
195.0	Malignant neoplasm of head, face, and neck
196.0	Secondary and unspecified malignant neoplasm of lymph nodes of head, face, and neck
198.3-198.5	Secondary malignant neoplasm of brain and spinal cord, or other parts of nervous system, or bone and bone marrow
199.0-199.1	Malignant neoplasm without specification of site
200.11	Lymphosarcoma involving lymph nodes of head, face, and neck
200.21	Burkitt's tumor or lymphoma involving lymph nodes of head, face, and neck
201.11	Hodgkin's granuloma involving lymph nodes of head, face, and neck
201.21	Hodgkin's sarcoma involving lymph nodes of head, face, and neck
201.41	Hodgkin's disease, lymphocytic-histiocytic predominance, involving lymph nodes of head, face, and neck
201.51	Hodgkin's disease, nodular sclerosis, involving lymph nodes of head, face, and neck
201.61	Hodgkin's disease, mixed cellularity, involving lymph nodes of head, face, and neck
201.71	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of the head, face, and neck
201.91	Hodgkin's disease, unspecified, involving lymph nodes of the head, face, and neck
213.0	Benign neoplasm of bones of skull and face
225.0-225.2	Benign neoplasm of brain and other parts of nervous system

70450: **Computerized Tomography Scans *(continued)***

225.8	Benign neoplasm of other specified sites of nervous system
227.3-227.4	Benign neoplasm of pituitary gland and craniopharyngeal duct (pouch) or pineal gland
237.0-237.1	Neoplasm of uncertain behavior of pituitary gland and
239.6-239.7	Neoplasm of unspecified nature of brain or endocrine glands and other parts of nervous system
250.20-250.23	Diabetes with hyperosmolarity
250.30-250.33	Diabetes with other coma
253.0-253.9	Disorders of the pituitary gland and its hypothalamic control
255.0-255.9	Disorders of adrenal glands
290.0-290.9	Senile and presenile organic psychotic conditions
293.0-293.83	Transient organic psychotic conditions
294.0-294.9	Other organic psychotic conditions (chronic)
298.9	Unspecified psychosis
310.0-310.9	Specific nonpsychotic mental disorders due to organic brain damage
320.0-326	Inflammatory diseases of the central nervous system
330.0-334.9	Hereditary and degenerative diseases of the central nervous system
341.0-341.9	Other demyelinating diseases of central nervous system
342.00-342.92	Hemiplegia and hemiparesis
343.0-343.9	Infantile cerebral palsy
344.00-344.9	Other paralytic syndromes
345.00-345.91	Epilepsy
348.0-348.9	Other conditions of brain
349.1-349.9	Other and unspecified disorders of the nervous system
350.1-350.9	Trigeminal nerve disorders
351.0-351.9	Facial nerve disorders
352.0-352.9	Disorders of other cranial nerves
368.11	Sudden visual loss
368.12	Transient visual loss
368.2	Diplopia
368.40	Visual field defect, unspecified
368.8	Other specified visual disturbances
368.9	Unspecified visual disturbance
374.31	Paralytic ptosis
377.00-377.01	Papilledema, unspecified or associated with increased intracranial pressure
377.51-377.52	Disorders of optic chiasm associated with pituitary neoplasms and disorders or associated with other neoplasms
377.61	Disorders of other visual pathways associated with neoplasms
377.71	Disorders of visual cortex associated with neoplasms
378.51-378.56	Paralytic strabismus
386.2	Vertigo of central origin
388.2	Sudden hearing loss, unspecified
388.5	Disorders of acoustic nerve
430-438.9	Cerebrovascular disease
572.2	Hepatic coma
674.00-674.04	Cerebrovascular disorders in the puerperium
738.10-738.19	Other acquired deformity of head
740.0-740.2	Anencephalus and similar anomalies
742.0-742.4	Other congenital anomalies of nervous system
742.8	Other specified anomalies of nervous system
742.9	Unspecified anomaly of brain, spinal cord, and nervous system
747.81	Anomalies of cerebrovascular system
756.0	Anomalies of skull and face bones
759.2-759.9	Other and unspecified congenital anomalies
765.00-765.19	Disorders relating to short gestation and unspecified low birthweight
767.0	Birth trauma, subdural and cerebral hemorrhage
767.1	Birth trauma, injury to scalp
767.3	Birth trauma, other injuries to skeleton (skull)
768.5	Severe birth asphyxia
768.6	Mild or moderate birth asphyxia
768.9	Unspecified birth asphyxia in liveborn infant
770.8	Other respiratory problems after birth
772.1-772.2	Intraventricular or subarachnoid hemorrhage
779.0-779.2	Other and ill-defined conditions originating in the perinatal period
780.01-780.09	Alteration of consciousness
780.1	Hallucinations
780.2	Syncope and collapse
780.31-780.39	Convulsions
780.4	Dizziness and giddiness
780.6	Fever
780.9	Other general symptoms
781.0-781.8	Symptoms involving nervous and musculoskeletal systems
781.99	Other symptoms involving nervous and musculoskeletal systems
784.0	Headache
784.2	Swelling, mass, or lump in head and neck
784.3	Aphasia
784.5	Other speech disturbance
784.60-784.69	Other symbolic dysfunction
793.0	Nonspecific abnormal findings on radiological and other examination of skull and head
794.00-794.09	Nonspecific abnormal results of function studies of brain and central nervous system
800.00-804.99	Fracture of skull
850.0-854.19	Intracranial injury, excluding those with skull fracture
873.0-873.1	Other open wound of scalp with or without mention of complication
873.9	Other and unspecified open wound of head, complicated
950.0-950.9	Injury to optic nerve and pathways

70450: **Computerized Tomography Scans *(continued)***

951.0-951.9	Injury to other cranial nerve(s)
959.01	Head injury, unspecified
996.2	Mechanical complication of nervous system device, implant, and graft
997.00-997.09	Nervous system complications
V10.85	Personal history of malignant neoplasm of brain
V10.86	Personal history of malignant neoplasm of other parts of nervous system
V10.88	Personal history of malignant neoplasm of other endocrine glands and related structures
V45.2	Presence of cerebrospinal fluid drainage device
V67.1	Follow-up examination, following radiotherapy
V67.2	Follow-up examination, following chemotherapy

Diagnosis that Support Medical Necessity

N/A

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

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

N/A

Documentation Requirements

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

N/A

Sources of Information and Basis for Decision

Sources of information may be found online under Medical Policies in the Part A section on our provider Web site *www.floridamedicare.com.*

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 advisory groups, which includes representatives from the Florida Diagnostic Radiology Society and the Florida Neurology Society.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

05/01/2001

Revision History

Revision Number	5
Start Date of Comment Period	N/A
Start Date of Notice Period	05/01/2001 3rd Qtr 2001 *Bulletin*
Revised Effective Date	04/12/2001

Explanation of Revision: Added codes 70450, 70460, 70470 to the title - ICD-9-CM Codes That Support Medical Necessity

Revision Number	4
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	3
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 OP PPS implementation

Revision Number	2
Start Date of Comment Period	N/A
Start Date of Notice Period	08/01/1999 Aug/Sept 1999 *Bulletin*
Revised Effective Date	07/09/1999

Explanation of Revision: This policy has been revised to add diagnosis 959.01 for coverage.

Revision Number	1
Start Date of Comment Period	N/A
Start Date of Notice Period	02/08/1999
Revised Effective Date	01/21/1999

Explanation of Revision: This policy has been revised to add the diagnosis range 1620-162.9 for coverage.

Revision Number	Original
Start Date of Comment Period:	08/05/1998
Start Date of Notice Period:	12/07/1998
Original Effective Date	01/21/1999

76090: Diagnostic Mammography

Revision Overview—Several sections of this policy affecting the indications and limitations, type of bill, revenue code, CPT/HCPCS codes, coding guidelines and other comments have been revised to reflect the new payment methodology.

Policy Number
76090

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Diagnostic Mammography

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Section 50-21
Skilled Nursing Facility Manual, Section 538
Program Memorandum Transmittal AB-01-20

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
01/19/1995

Original Policy Ending Date
N/A

Revision Effective Date
04/01/2001

Revision Ending Date
03/31/2001

LMRP Description
The word "diagnostic" in diagnostic mammography denotes the identifying of a disease from its signs and symptoms, using both ionizing and non-ionizing radiations. Diagnostic mammography involves obtaining exposures of the breast to provide specific analytical information to be used in problem solving for a suspected breast disease. A radiologist is available at the time of the study to review the images and request immediate additional evaluation if necessary.

As of January 1, 1996, the definition of diagnostic mammography has been expanded to include as candidates for this service men or women with signs or symptoms of breast disease, a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease. Previously, only symptomatic men or women were candidates for diagnostic mammography.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare covers diagnostic mammograms when the beneficiary:

- presents signs, symptoms or physical findings suggestive of breast disease (e.g., lump, pain, nipple discharge or retraction, or skin changes such as dimpling, skin thickening or orange peel skin, radiologic evidence of breast abnormality);
- has been or is being treated for breast cancer;
- has a personal history of biopsy-proven benign breast disease; or
- is still at the facility for a screening exam, has a screening mammogram exam interpreted by the radiologist as nonspecific abnormal finding requiring additional films.

Diagnostic mammograms are covered as often as is medically necessary. A physician's order is required for coverage of a diagnostic mammogram. The physician may be the treating physician, or in the case of a screening mammogram converted to a diagnostic mammogram, the interpreting radiologist.

CPT/HCPCS Section & Benefit Category
Radiology/Diagnostic Radiology

Type of Bill Code
Hospital – 14x
Skilled Nursing Facility – 22x, 23x

Revenue Codes
401 Diagnostic Mammography

CPT/HCPCS Codes

76090	Mammography; unilateral
76091	bilateral
G0204	Diagnostic mammography, direct digital image, bilateral, all views
G0205	Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views
G0206	Diagnostic mammography, direct digital image, unilateral, all views
G0207	Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

174.0-174.8	Malignant neoplasm of female breast
175.0-175.9	Malignant neoplasm of male breast
198.2	Secondary malignant neoplasm of skin of breast
198.81	Secondary malignant neoplasm of breast
217	Benign neoplasm of breast
233.0	Carcinoma in situ of breast
238.3	Neoplasm of uncertain behavior of breast

76090: Diagnostic Mammography (continued)

610.0-610.8	Benign mammary dysplasias
611.0-611.8	Other disorders of breast
793.8	Nonspecific abnormal findings on radiological and other examination of breast
879.0	Open wound of breast, without mention of complication
879.1	Open wound of breast, complicated
996.54	Mechanical complications due to breast prothesis
V10.3	Personal history of malignant neoplasm, breast
V15.89	Other specified personal history presenting hazards to health (Personal history of benign breast disease)
V71.1	Observation for suspected malignant lesion

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

Services performed by a non-certified center will be denied.

Services performed by a facility whose certificate is suspended or revoked will be denied.

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

As a reminder, effective April 1, 1995, all mammography facilities (**both diagnostic and screening**) require a certification number. A copy of your certification with the 6-digit number may be submitted to the Provider Audit Reimbursement Department to ensure proper processing of claims.

When you obtain mammography services for your patients under arrangements with another facility, **you** must ensure that the facility performing the services has been certified.

Radiologists who interpret screening mammographies are allowed, per Balanced Budget Act-97, to order and interpret additional films based on the results of the screening mammogram while a beneficiary is still at the facility for the screening exam. Where a radiologist's interpretation results in the need for additional films, the mammography is no longer considered a screening exam for payment purposes. When this occurs, the claim will be paid as a diagnostic mammogram instead of a screening mammogram. In this instance, the claim must be prepared utilizing HCPCS Codes 76090, 76091, G0204, G0205, G0206 or G0207 with modifier GH. The treating physician's UPIN is to be used to represent the ordering physician. It is expected that the radiologist will refer back to the treating physician for his/her UPIN and also report to the treating physician the condition of the patient.

Documentation Requirements

If you **REFER** a patient for mammography, include the following information in your order:

- the ICD-9-CM diagnosis code that reflects the reason for the test; and
- the type of test (diagnostic); and
- maintain on file records which support medical necessity such as history and physical and progress notes.

If you **PERFORM** the mammography test, obtain the following information:

- A physician's order that specifically prescribes a diagnostic mammogram as well as the medical reason for the test; and
- Maintain on file the radiology report.

Utilization Guidelines

N/A

Other Comments

Asymptomatic women without medical record documentation to support a personal history of breast cancer, biopsy-proven benign breast disease, or radiologic evidence of breast abnormality are candidates for screening mammography.

Sources of Information and Basis for Decision

Sources of information may be found online under Medical Policies in the Part A section on our provider Web site *www.floridamedicare.com.*

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 advisory groups, which includes representatives from the Florida Radiological Society.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

05/01/2001

Revision History

Revision Number	4
Start Date of Comment Period	N/A
Start Date of Notice Period	05/01/2001
	3rd Qtr 2001 Bulletin
Revised Effective Date	04/01/2001

Explanation of Revision: BIPA 2000 provided for new payment methodologies for diagnostic and screening mammograms performed with new technologies.

76092: Screening Mammograms

Revision Overview—Several sections of this policy affecting the revenue code, CPT/HCPCS codes, and coding guidelines have been revised to reflect the new payment methodology.

Policy Number
76092

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Screening Mammograms

AMA CPT Copyright Statement

HCFA National Coverage Policy
42 Code of Federal Regulation, Section 410.34
Hospital Manual, Section 451
Intermediary Manual, Sections 3660.10, 3660.12 and, 3600.Q
Skilled Nursing Facility Manual, Sections 537 and 538
Program Memorandum, Transmittal AB-01-20

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
02/25/1998

Original Policy Ending Date
N/A

Revision Effective Date
04/01/2001

Revision Ending Date
03/31/2001

LMRP Description
Screening mammography is a radiologic procedure for women for the early detection of breast cancer. They are conducted for preventative purposes, when there are no clinical indications or symptoms. Screening mammographies include a physician's interpretation of the results.

A screening mammogram, at a minimum, is a 2-view exposure (cranio-caudal and a medial lateral oblique view) of each breast. On occasion, supplementary views may be required to visualize breast tissue optimally (eg, augmented breast, large breast, patient with depressed sternum or pronounced ribs).

Indications and Limitations of Coverage and/or Medical Necessity
A physician's order is not required for coverage of a screening mammogram. Age and statutory frequency parameters are used to determine if payment can be made for a screening mammogram.

Age	Screening Period
35-39	Baseline (only one allowed for this age group)
over age 39	Annual (11 full months must have elapsed following the month of the last screening)

Counting Screening Periods:

Count months between mammographies beginning the month **after** the date of the examination.

Example: The beneficiary received a screening mammography in January 1997. Start your count beginning with February 1997.

Limitation of Liability for Screening Mammograms:

Limitation of liability provisions pertain to items and services denied as "not reasonable and necessary" for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Screening mammograms denied as being performed more frequently than allowed under Medicare law, or because they were not performed at a Medicare-approved screening center, fall under limitation of liability regulations as well.

CPT/HCPCS Section & Benefit Category
Radiology/Diagnostic Radiology

Type of Bill Code
Hospital – 14x
Skilled Nursing Facility – 22x, 23x

Revenue Codes
403 Screening Mammography

CPT/HCPCS Codes
76092	Screening mammography, bilateral (two view film study of each breast)
G0202	Screening mammography producing direct digital image, bilateral, all views
G0203	Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
V76.12	Other screening mammogram

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

76092: Screening Mammograms (continued)

Reasons for Denial

Not within the screening period designated in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Services performed by a non-certified center will be denied.

Services performed by a facility whose certificate is suspended or revoked will be denied.

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

Effective January 1, 1998 you must enter V76.12 as the principle diagnosis code.

As a reminder, all mammography facilities **(both diagnostic and screening)** require a certification number. A copy of your certification with the 6-digit number may be submitted to the Provider Audit Reimbursement Department to ensure proper processing of claims.

When you obtain mammography services for your patients under arrangements with another facility, *you* must ensure that the facility performing the services has been issued a certificate by the FDA.

Providers bill the Intermediary on the HCFA-1450 for the technical component portion of the screening mammography and the carrier on the HCFA-1500 for the professional component portion.

Providers bill for the technical component under bill type 14x, 22x, or 23x using Revenue Code 403 and HCPCS codes 76092, G0202 or G0203. This billing requirement applies to inpatient services as well as outpatient services. A separate bill is required. Only include mammography screening charges on the bill.

Effective July 1, 1998 **Special Billing Instructions:** Radiologists who interpret screening mammographies are allowed, per BBA-97, to order and interpret additional films based on the results of the screening mammogram while a beneficiary is still at the facility for the screening exam. Where a radiologist's interpretation results in the need for additional films, the mammography is no longer considered a screening exam for payment purposes. When this occurs, the claim will be billed and paid as a diagnostic mammography.

The claim must be prepared reflecting revenue code 401, HCPCS code 76090, 76091**, G0204, G0205, G0206 or G0207** and modifier GH (diagnostic mammogram converted from screening mammogram on same day). Regular billing instructions remain in place for screening mammographies that do not fit this situation.

Documentation Requirements

If you **REFER** a patient for screening mammography, include the following information in your order:

- the type of test (screening);
- the date of the last screening mammogram.

If you **PERFORM** the mammography test, obtain the following information:

- an order that specifically prescribes a screening mammogram, if the test is referred by a physician;
- the date of the last screening mammogram, if a screening mammogram has been ordered by the physician;
- the date of the last screening mammogram, if the beneficiary has no physician's order; and
- maintain on file the radiology report.

Utilization Guidelines

Section 4101 of the Balanced Budget Act (BBA) of 1997 provides for annual screening mammographies for women over age 39.

Other Comments

The substance of the present definition of screening mammography has been retained so that women with a personal history of breast cancer or a personal history of biopsy-proven benign breast disease can be considered candidates for a screening mammogram if the patient's attending physician determines it is appropriate.

Breast cancer is the most commonly diagnosed cancer, and the second leading cause of death among women.

The need to do supplemental views in order to visualize the breast tissue optimally (more than two views each breast) does not have any effect on the payment amount because payment is prescribed by statute.

The screening mammography payment is a final payment, not a payment limit, and is not subject to the radiology blend.

Sources of Information and Basis for Decision

Sources of information may be found online under Medical Policies in the Part A section on our provider Web site *www.floridamedicare.com.*

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 advisory groups, which includes representatives from the Florida Radiological Society.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

05/01/2001

Revision History

Revision Number	3
Start Date of Comment Period	N/A
Start Date of Notice Period	05/01/2001
	3rd Qtr 2001 *Bulletin*
Revised Effective Date	04/01/2001

Explanation of Revision: BIPA 2000 provided for new payment methodologies for diagnostic and screening mammograms performed with new technologies.

82947: Blood Glucose Testing

Policy Number
82947

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Blood Glucose Testing

AMA CPT Copyright Statement

HCFA National Coverage Policy
Provider Reimbursement Manual, Section 2202.6, 2203.1, 2203.2
Skilled Nursing Facility Manual, Section 541
Transmittals AB-00-99, AB-00-108, and AB-00-109

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
06/22/2001

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Glucose, the body's main source of cellular energy, is formed from the digestion of carbohydrates and the conversion of glycogen by the liver. Glucose is essential for brain and erythrocyte function. Excess glucose is stored as glycogen in the liver and muscle cells. Hormones which influence glucose metabolism include insulin, glucagon, thyroxine, somatostatin, cortisol, and epinephrine. Glucagon accelerates glycogen breakdown in the liver and causes the blood glucose to rise. Insulin increases cell membrane permeability to glucose, transports glucose into cells for metabolism, stimulates glycogen formation, and reduces blood glucose levels.

Blood glucose testing is used to aid in the diagnosis, treatment, and follow-up of carbohydrate metabolism disorders.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider Blood Glucose Testing to be medically necessary under any of the following circumstances:

In the presence of signs and symptoms of hyperglycemia, which can include the following:

-polyuria
-polydipsia
-weight loss, in spite of normal or excessive dietary intake
-candidal vaginitis in women

Conditions related to hyperglycemia include, but are not limited to, the following:

-diabetes mellitus
-acute stress response (e.g., myocardial infarction, severe infection)
-Cushing's disease
-pheochromocytoma
-hyperparathyroidism
-adenoma of the pancreas
-pancreatitis
-pituitary adenoma
-glucagonoma
-chronic liver disease
-chronic renal disease
-acromegaly

In the presence of signs and symptoms of hypoglycemia, which can include the following:

-diaphoresis
-tremulousness
-hunger
-faintness
-palpitations
-confusion
-inappropriate behavior
-visual disturbances
-coma
-seizures

Conditions related to hypoglycemia include, but are not limited to, the following:

-insulinoma
-hypothyroidism
-hypopituitarism
-Addison's disease
-extensive liver disease
-extrapancreatic neoplasm
-drug-induced hypoglycemia (eg, sulfonylurea, insulin, ethanol, salicylates)
-enzyme deficiency diseases (eg, galactosemia, inherited maple syrup disease)
-starvation

For the purpose of managing insulin therapy (shots, medication, diet).

If home-use glucose monitoring devices are used in the hospital and nursing home settings, it must be ordered by the physician, the record must demonstrate that the ordering

82947: Blood Glucose Testing (continued)

physician has used the result in the management of the beneficiary's specific medical problem, and the laboratory result must be reported to the physician promptly in order for the physician to use the result and instruct continuation or modification of patient care.

For a laboratory service to be considered reasonable and necessary, it must not only be ordered by the physician, but the ordering physician must also use the result in the management of the beneficiary's medical condition. Implicitly, the blood glucose result must be reported to the physician promptly so that the physician can use the result and instruct continuation or modification of patient care.

CPT/HCPCS Section & Benefit Category

Pathology and Laboratory/Chemistry

Type of Bill Code

Hospital – 12x, 13x, 14x
Skilled Nursing Facility – 21x, 22x, 23x

Revenue Codes

30x Laboratory

CPT/HCPCS Codes

82947	Glucose; quantitative, blood (except reagent strip)
82948	blood, reagent strip
82962	Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

112.0	Candidiasis of mouth
112.1	Candidiasis of vulva and vagina
112.2	Candidiasis of other urogenital sites
157.0-157.8	Malignant neoplasm of pancreas
194.0	Malignant neoplasm of adrenal gland
211.6	Benign neoplasm of pancreas, except islets of Langerhans
211.7	Benign neoplasm of islets of Langerhans
227.0	Benign neoplasm of adrenal gland
250.00-250.93	Diabetes mellitus
251.0	Hypoglycemic coma
251.1	Other specified hypoglycemia
251.3	Postsurgical hypoinsulinemia
251.4	Abnormality of secretion of glucagon
251.8	Other specified disorders of pancreatic internal secretion
252.0	Hyperparathyroidism
253.0	Acromegaly and gigantism
253.2	Panhypopituitarism
253.7	Iatrogenic pituitary disorders
255.0	Cushing's syndrome
255.4	Corticoadrenal insufficiency
276.5	Volume depletion
356.8	Other specified idiopathic peripheral neuropathy
357.8	Other inflammatory and toxic neuropathy
571.0	Alcoholic fatty liver
571.2	Alcoholic cirrhosis of liver
571.49	Chronic hepatitis, other
571.5	Cirrhosis of liver without mention of alcohol
571.6	Biliary cirrhosis
571.8	Other chronic nonalcoholic liver disease
577.0	Acute pancreatitis
577.1	Chronic pancreatitis
648.80-648.84	Other current conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium, abnormal glucose tolerance
780.01	Coma
780.1	Hallucinations
780.2	Syncope and collapse
780.31-780.39	Convulsions
780.4	Dizziness and giddiness
780.8	Hyperhidrosis
783.21	Loss of weight
783.5	Polydipsia
783.6	Polyphagia
788.41	Urinary frequency
788.42	Polyuria
790.2	Abnormal glucose tolerance test
790.6	Other abnormal blood chemistry
791.5	Glycosuria
V67.51	Follow-up examination following completed treatment with high-risk medications, not elsewhere classified

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

When billing for the diagnosis of elevated blood sugar, use ICD-9-CM code 790.6 (other abnormal blood chemistry). ICD-9-CM code 790.6 is indicated for other abnormal blood chemistry; however, for blood glucose testing it is only covered when the test is being performed for an elevated blood sugar.

For a patient who is hospitalized and eligible for Medicare Part B but who is not in a Part A covered hospital stay, submit TOB 12x and revenue code 30x for payment under the clinical laboratory fee schedule.

If a Part B only patient resides in a nursing home certified bed, submit TOB 22x and revenue code 30x. The

82947: Blood Glucose Testing (continued)

laboratory cost center of the cost report must reflect the corresponding glucose monitoring costs and charges even when the provider is registered for laboratory testing with only a certificate of waiver from CLIA.

If a Part B only patient resides in a non-certified bed, payment is made under the clinical laboratory fee schedule. Submit TOB 23x and revenue code 30x.

Documentation Requirements

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

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

Utilization Guidelines

N/A

Other Comments

Terms Defined:

Glucose quantitative method—a complex assay performed after blood is clotted and separated. The serum or plasma is assayed in a laboratory device generally designed for multiple sequential assays.

Glucose reagent strip method—a drop of whole blood is placed on the glucose oxidase strip, blotted at a prescribed interval, and the resulting color is compared against a color chart on the side of the vial which contains unused reagent strips.

Glucose monitoring device method—a drop of whole blood is obtained (usually by finger stick device) and assayed by glucose oxidase, hexokinase, or electrochemical methods and spectrophotometry using a small portable device designed, and approved by the FDA, for home blood glucose monitoring use.

Sources of Information and Basis for Decision

Berkow, R., Fletcher, A.J.,Bondy, P.K., Dilts, P.V., Jr., Douglas, R.G., Jr. Drossman, D.A. et al (Eds.). (1992). *The Merck Manual* (16th ed.). Rachway, NJ: Merck Research Laboratories. Identified covered indications.

Chernecky, C.C., Krech, R.L., & Berger, B.J. (Eds.). (1993). *Laboratory Tests and Diagnostic Procedures.* Philadelphia, PA: W.B. Saunders Company. Identified covered indications.

Fischbach, F.T. (1996). *A Manual of Laboratory & Diagnostic Tests* (5th ed.). Philadelphia, PA: Lippincott. Identified covered indications.

Henry, J.B. (Ed.). (1991). *Clinical Diagnosis & Management by Laboratory Methods*. Philadelphia, PA: W.B. Saunders Company. Identified covered indications.

Pagana, K.D. & Pagana, T.J. (Eds.). (1995). *Mosby's Diagnostic and Laboratory Test Reference.* (2nd ed.). St. Louis, MO: Mosby. Identified covered indications.

Rakel, R.E. (Ed.). (1996). *Saunders Manual of Medical Practice.* Philadelphia, PA: W.B. Saunders Company. Identified covered indications.

Rakel, R.E. (Ed.). (1995). *Textbook of Family Practice.* (5th ed.). Philadelphia, PA: W.B. Saunders Company. Identified covered indications.

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 advisory groups, which includes representatives from numerous societies.

Start Date of Comment Period

02/21/2000

End Date of Comment Period

04/06/2000

Start Date of Notice Period

05/01/2001

Revision History

Revision Number:	Original
Start Date of Comment Period	02/21/2000
Start Date of Notice Period	05/01/2001
	3rd Qtr 2001 *Bulletin*
Original Effective Date:	06/22/2001

86353: Lymphocyte Transformation

Policy Number
86353

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Lymphocyte Transformation

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

Original Policy Effective Date
06/22/2001

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Lymphocyte transformation tests evaluate lymphocyte competence using in vitro tests to assess the ability of the lymphocytes to proliferate and to recognize and respond to antigens. Two types of lymphocyte transformation tests, mitogen assay and antigen assay, are discussed in this policy.

The mitogen assay, performed using nonspecific plant lectins, evaluates the mitotic response of T and B lymphocytes to a foreign antigen. In the mitogen assay, a purified culture of lymphocytes from the patient's blood is incubated with a nonspecific mitogen for 72 hours. The culture is then pulse-labeled with tritiated thymidine, which is incorporated in the newly formed DNA of dividing cells. The uptake of radioactive thymidine can be measured by a liquid scintillation spectrophotometer in counts per minute, which parallels the rate of mitosis. Lymphocyte responsiveness, or the extent of mitosis, is then reported as a stimulation index, determined by dividing the counts per minute of the stimulated culture by the counts per minute of a control culture.

The antigen assay uses specific antigens, such as purified protein derivative (PPD), Candida, mumps, tetanus toxoid, and streptokinase, to stimulate lymphocyte transformation. After incubation of 4 ½ to 7 days, transformation is measured by the same method used in the mitogen assay.

In the mitogen and antigen assays, a low stimulation index or unresponsiveness indicates a suppressed or defective immune system.

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

- To assess and monitor genetic and acquired immunodeficiency states (e.g., caused by marrow failure, certain drugs, etc.); and
- To monitor immunosuppressive or immunoenhancing therapy.

NOTE: This test is only covered when the patient has a suspected or known genetic or acquired immunologic disorder as demonstrated by the patient's history and physical. It is not covered as a screening test. In addition, it is expected that the results of this test will be used in the management of the patient.

Type of Bill Code
Hospital – 12x, 13x, 14x
Rural Health Clinic – 71x

Revenue Codes
302 Immunology

CPT/HCPCS Section & Benefit Category
Immunology/Pathology and Laboratory

CPT/HCPCS Codes
86353	Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
042	Human immunodeficiency virus [HIV] disease
279.00-279.9	Disorders involving the immune mechanism
E933.1	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antineoplastic and immunosuppressive drugs

Diagnosis that Support Medical Necessity
N/A

86353: Lymphocyte Transformation (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

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

N/A

Sources of Information and Basis for Decision

Illustrated Guide to Diagnostic Tests (2nd ed.). (1998). Springhouse, PA: Springhouse Corporation.

Jacobs, D. S., DeMott, W. R., Grady, H. J., Horvat, R. T., Huestis, D. W., & Kasten, B. L. (1996). *Laboratory Test Handbook* (4th ed.). Hudson: Lexi-Comp Inc.

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 advisory groups, which includes representatives from numerous societies.

Start Date of Comment Period

08/15/2000

End Date of Comment Period

09/29/2000

Start Date of Notice Period

05/01/2001

Revision History

Revision Number:	Original
Start Date of Comment Period	08/15/2000
Start Date of Notice Period	05/01/2001
	3rd Qtr 2001 *Bulletin*
Original Effective Date:	06/22/2001

93922: Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries

Revision Overview—Indications and limitations of coverage, type of bill, and the list of ICD-9-CM sections of the policy have been revised.

Policy Number
93922

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Sections 50-6, 50-7, 35-10

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
05/15/2000

Original Policy Ending Date
N/A

Revision Effective Date
06/22/2001

Revision Ending Date
06/21/2001

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

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

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider noninvasive physiologic studies of the upper or lower extremity arteries to be medically necessary under any of the following circumstances:

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

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

- Continuous burning of the feet is considered to be a neurologic symptom.
- "Leg pain, nonspecific" and "Pain in limb" as single

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

diagnoses are too general to warrant further investigation unless they can be related to other signs and symptoms.

- Edema rarely occurs with arterial occlusive disease unless it is in the immediate postoperative period, in association with another inflammatory process or in association with rest pain.
- Absence of relatively minor pulses (e.g., dorsalis pedis or posterior tibial) in the absence of symptoms. The absence of pulses is not an indication to proceed beyond the physical examination unless it is related to other signs and/or symptoms.

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

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

CPT/HCPCS Section & Benefit Category

Medicine/Non-Invasive Vascular Diagnostic Studies

Type of Bill Code

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

Revenue Codes

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

CPT/HCPCS Codes

93922	Non-invasive physiologic studies of upper or lower extremity arteries, single level, bilateral (e.g., ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)
93923	Non-invasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study (e.g., segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmography, segmental transcutaneous oxygen tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia)
93924	Non-invasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, complete bilateral study

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

440.0	Atherosclerosis of aorta
440.20-440.24	Atherosclerosis of native arteries of the extremities
440.30-440.32	Atherosclerosis of bypass graft of the extremities
441.00-441.03	Dissection of aorta
442.0	Other aneurysm of artery of upper extremity
442.3	Other aneurysm of artery of lower extremity
443.0	Raynaud's syndrome
443.1	Thromboangiitis obliterans [Buerger's disease]
443.81	Peripheral angiopathy in diseases classified elsewhere
443.9	Peripheral vascular disease, unspecified
444.0	Arterial embolism and thrombosis of abdominal aorta
444.1	Arterial embolism and thrombosis of thoracic aorta
444.21-444.22	Arterial embolism and thrombosis of arteries of the extremities
444.81-444.89	Arterial embolism and thrombosis of other specified artery
447.0	Arteriovenous fistula, acquired
447.1	Stricture of artery
447.2	Rupture of artery
707.10-707.19	Ulcer of lower limbs, except decubitus
707.8	Chronic ulcer of other specified sites
785.4	Gangrene
903.00	Injury to axillary vessel(s), unspecified
903.02	Injury to axillary vein
903.1	Injury to brachial blood vessels
903.2	Injury to radial blood vessels
903.3	Injury to ulnar blood vessels
903.4	Injury to palmar artery
903.5	Injury to digital blood vessels
903.8	Injury to other specified blood vessels of upper extremity
904.0	Injury to common femoral artery
904.1	Injury to superficial femoral artery
904.41	Injury to popliteal artery
904.51	Injury to anterior tibial artery
904.53	Injury to posterior tibial artery
904.6	Injury to deep plantar blood vessels
904.7	Injury to other specified blood vessels of lower extremity
996.1	Mechanical complication of other vascular device, implant, and graft
996.70-996.79	Other complications of internal (biological) (synthetic) prosthetic device, implant, and graft
998.11-998.13	Hemorrhage or hematoma or seroma complicating a procedure
998.2	Accidental puncture or laceration during a procedure

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

444.21-444.22	Arterial embolism and thrombosis of arteries of the extremities

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

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

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

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

For evaluation of dialysis access, see local medical review policy 93990.

Documentation Requirements

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

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

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

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information and Basis for Decision

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

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 advisory groups, which includes representatives from the Florida Vascular Society.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

05/01/2001

Revision History

Revision Number	3
Start Date of Comment Period	N/A
Start Date of Notice Period	05/01/2001 3rd Qtr 2001 Bulletin
Revised Effective Date	06/22/2001

Explanation of Revision: HCFA released Transmittal 129 modifying national coverage for Hyperbaric Oxygen (HBO) therapy.

C1300: Hyperbaric Oxygen Therapy (HBO Therapy)

Revision Overview—The policy has been revised to incorporate the national coverage revision published in the First Quarter 2001 Medicare A Bulletin and clarification on multiple provider issues.

Policy Number
C1300

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Hyperbaric Oxygen Therapy (HBO Therapy)

AMA CPT Copyright Statement

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

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
01/19/1995

Original Policy Ending Date
N/A

Revision Effective Date
05/01/2001

Revision Ending Date
04/30/2001

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

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

Indications and Limitations of Coverage and/or Medical Necessity
HBO therapy is covered by Medicare for the following conditions:

1. **Acute carbon monoxide intoxication** induces hypoxic stress. The cardiac and central nervous systems are the most susceptible to injury from carbon monoxide. The administration of supplemental oxygen is essential treatment. Hyperbaric oxygen causes a higher rate of dissociation of carbon monoxide from hemoglobin than can occur breathing pure air at sea level pressure. The chamber compressions should be between 2.5 and 3.0 atm abs. It is not uncommon in patients with persistent neurological dysfunction to require subsequent treatments within six to eight hours, continuing once or twice daily until there is no further improvement in cognitive functioning.
2. **Decompression illness** arises from the formation of gas bubbles in tissue or blood in volumes sufficient enough to interfere with the function of an organ or to cause alteration in sensation. The cause of this enucleated gas is rapid decompression during ascent. The clinical manifestations range from skin eruptions to shock and death. The circulating gas emboli may be heard with a Doppler device. Treatment of choice for decompression illness is HBO with mixed gases. The result is immediate reduction in the volume of bubbles. The treatment prescription is highly variable and case specific. The depths could range between 60 to 165 feet of sea water for durations of 1.5 to over 14 hours. The patient may or may not require repeat dives.
3. **Gas embolism** occurs when gases enter the venous or arterial vasculature embolizing in a large enough volume to compromise the function of an organ or body part. This occlusive process results in ischemia to the affected areas. Air emboli may occur as a result of surgical procedures (e.g., cardiovascular surgery, intra-aortic balloons, arthroplasties, or endoscopies), use of monitoring devices (e.g., Swan-Ganz introducer, infusion pumps), in nonsurgical patients (e.g., diving, ruptured lung in respirator-dependent patient, injection of fluids into tissue space), or traumatic injuries (e.g., gunshot wounds, penetrating chest injuries). Hyperbaric oxygen therapy is the treatment of choice. It is most effective when initiated early. Therapy is directed toward reducing the volume of gas bubbles and increasing the diffusion gradient of the embolized gas. Treatment modalities range from high pressure to low pressure mixed gas dives.
4. **Gas gangrene** is an infection caused by the clostridium bacillus, the most common being clostridium perfringens. Clostridial myositis and myonecrosis (gas gangrene) is an acute, rapidly growing invasive infection of the muscle. It is characterized by profound toxemia, extensive edema, massive death of tissue and variable degree of gas production. The most prevalent toxin is the alpha-toxin which in itself is hemolytic, tissue-necrotizing and lethal. The diagnosis of gas gangrene is based on clinical data supported by a positive gram-stained smear obtained from tissue fluids. X-ray radiographs, if obtained, can visualize tissue gas.

C1300: Hyperbaric Oxygen Therapy (HBO Therapy) (continued)

The onset of gangrene can occur one to six hours after injury and presents with severe and sudden pain at the infected area. The skin overlying the wound progresses from shiny and tense, to dusky, then bronze in color. The infection can progress as rapidly as six inches per hour. Hemorrhagic vesicles may be noted. A thin, sweet-odored exudate is present. Swelling and edema occur. The noncontractile muscles progress to dark red to black in color.

The acute problem in gas gangrene is to stop the rapidly advancing infection caused by alpha-toxin. Medical treatment is aimed at stopping the production of alpha-toxin and to continue treatment until the advancement of the disease process has been arrested. The goal of HBO therapy is to stop alpha-toxin production thereby inhibiting further bacterial growth at which point the body can use its own host defense mechanisms. HBO treatment starts as soon as the clinical picture presents **and** is supported by a positive gram-stained smear. A treatment approach utilizing HBO, is adjunct to antibiotic therapy and surgery. Initial surgery may be limited to opening the wound. Debridement of necrotic tissue can be performed between HBO treatments when clear demarcation between dead and viable tissue is evident. The usual treatment consists of oxygen administered at 3.0 atm abs pressure for 90 minutes three times in the first 24 hours. Over the next four to five days, treatment sessions twice a day are usual. The sooner HBO treatment is initiated, the better the outcome in terms of life, limb and tissue saving.

5. **Crush injuries** and **suturing of severed limbs, acute traumatic peripheral ischemia** (ATI), and **acute peripheral arterial insufficiency**: Acute traumatic ischemia is the result of injury by external force or violence compromising circulation to an extremity. The extremity is then at risk for necrosis or amputation. Secondary complications are frequently seen: infection, non-healing wounds, and non-united fractures.

The goal of HBO therapy is to enhance oxygen at the tissue level to support viability. When tissue oxygen tensions fall below 30mmHg., the body's ability to respond to infection and wound repair is compromised. Using HBO at 2-2.4 atm, the tissue oxygen tension is raised to a level such that the body's responses can become functional again. The benefits of HBO therapy for this indication are enhanced tissue oxygenation, edema reduction and increased oxygen delivery per unit of blood flow thereby reducing the complication rates for infection, nonunion and amputation.

The usual treatment schedule is three 1.5 hour treatment periods daily for the first 48 hours. Additionally, two 1.5 hour treatment sessions daily for the next 48 hours may be required. On the fifth and sixth days of treatment, one 1.5 hour session would typically be utilized. At this point in treatment, outcomes of restored perfusion, edema reduction and either demarcation or recovery would be sufficient to guide discontinuing further treatments.

For acute traumatic peripheral ischemia, crush injuries and suturing of severed limbs, Hyperbaric Oxygen Therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures, when loss of function, limb, or life is threatened. Arterial insufficiency ulcers may be treated by HBO therapy if they are persistent after reconstructive surgery has restored large vessel function.

6. The principal treatment for **progressive necrotizing infections** (necrotizing fasciitis) is surgical debridement and systemic antibiotics. HBO therapy is recommended as an adjunct only in those settings where mortality and morbidity are expected to be high despite aggressive standard treatment. Progressive necrotizing fasciitis is a relatively rare infection. It is usually a result of a group A streptococcal infection beginning with severe or extensive cellulitis that spreads to involve the superficial and deep fascia, producing thrombosis of the subcutaneous vessels and gangrene of the underlying tissues. A cutaneous lesion usually serves as a portal of entry for the infection, but sometimes no such lesion is found.

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

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

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

The patients who suffer from soft tissue damage or bone necrosis present with disabling, progressive, painful tissue breakdown. They may present with wound dehiscence, infection, tissue loss and graft or flap loss. The goal

C1300: Hyperbaric Oxygen Therapy (HBO Therapy) (continued)

of HBO treatment is to increase the oxygen tension in both hypoxic bone and tissue to stimulate growth in functioning capillaries, fibroblastic proliferation and collagen synthesis. The recommended daily treatments last 90-120 minutes at 2.0 to 2.5 atm abs. The duration of HBO therapy is highly individualized.

10. **Cyanide poisoning** carries a high risk of mortality. Victims of smoke inhalation frequently suffer from both carbon monoxide and cyanide poisoning. The traditional antidote for cyanide poisoning is the infusion of sodium nitrite. This treatment can potentially impair the oxygen carrying capacity of hemoglobin. Using HBO therapy as an adjunct therapy adds the benefit of increased plasma dissolved oxygen. HBO's benefit for the pulmonary injury related to smoke inhalation remains experimental. The HBO treatment protocol is to administer oxygen at 2.5 to 3.0 atm abs for up to 120 minutes during the initial treatment. Most patients with combination cyanide and carbon monoxide poisoning will receive only one treatment.

11. **Actinomycosis** is a bacterial infection caused by Actinomyces israelii. Its symptoms include slow growing granulomas that later breakdown, discharging viscid pus containing minute yellowish granules. The treatment includes prolonged administration of antibiotics (penicillin and tetracycline). Surgical incision and draining of accessible lesions is also helpful. Only after the disease process has shown refractory to antibiotics and surgery, could HBO therapy be covered by Medicare. HBO therapy must be utilized adjunct to conventional therapy.

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

Indications of effective treatment outcomes for HBO include:

- Improvement or healing of wounds.
- Improvement of tissue perfusion.
- New epithelial tissue growth and granulation.
- Tissue PO_2 of at least 30 mmHg of oxygen is necessary for oxidative function to occur.
- Mechanical reduction in the bubble size of air emboli alleviates decompression sickness and gas/ air emboli.
- Tissue PO_2 of 40 or greater defines resolved hypoxia. The body can now resume host functions of wound healing and anti-microbial defenses without the need of HBO therapy.

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

CPT/HCPCS Section & Benefit Category

Medicine/Other Services and Procedures

Type of Bill Code

Hospital – 13x
Skilled Nursing Facility – 21x

Revenue Codes

413 Respiratory Services Hyperbaric Oxygen Therapy

CPT/HCPCS Codes

C1300	Hyperbaric oxygen per 30 minutes
G0167	Hyperbaric oxygen treatment not requiring physician attendance, per treatment session

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

039.0-039.9	Actinomycotic infections
040.0	Gas gangrene
444.21-444.22	Arterial embolism and thrombosis of arteries of the extremities
444.81	Arterial embolism and thrombosis of iliac artery
526.89	Other specified diseases of the jaws
728.86	Necrotizing fasciitis
730.10-730.19	Chronic osteomyelitis
902.53	Injury to blood vessels of iliac artery
903.01	Injury to blood vessels of axillary artery
903.1	Injury to brachial blood vessels
904.0	Injury to blood vessels of common femoral artery
904.41	Injury to blood vessels of popliteal artery
927.00-927.09	Crushing injury of shoulder and upper arm
927.10-927.11	Crushing injury of elbow and forearm
927.20-927.21	Crushing injury of wrist and hand(s) except finger(s) alone
927.8	Crushing injury of multiple sites of upper limb
927.9	Crushing injury of unspecified site of upper limb
928.00-928.01	Crushing injury of hip and thigh
928.10-928.11	Crushing injury of knee and lower leg
928.20-928.21	Crushing injury of ankle and foot, excluding toe(s) alone
928.3	Crushing injury of toe(s)
928.8-928.9	Crushing injury of multiple sites and unspecified site of lower limb
929.0-929.9	Crushing injury of multiple and unspecified sites
958.0	Early complication of trauma, air embolism
986	Toxic effect of carbon monoxide
987.7	Toxic effect of hydrocyanic acid gas
989.0	Toxic effect of hydrocyanic acid and cyanides
990	Effects of radiation, unspecified
993.2	Other and unspecified effects of high altitude
993.3	Caisson disease
996.52	Mechanical complication due to graft of other tissue, not elsewhere classified
996.90-996.99	Complications of reattached extremity or body part
999.1	Complications of medical care, air embolis

C1300: Hyperbaric Oxygen Therapy (HBO Therapy) (continued)

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.

Topical application of oxygen (Topox) does not meet the definition of HBO therapy. Also, its clinical efficacy has not been established; therefore, no reimbursement may be made.

National coverage policy for HBO therapy requires that a physician be present during an HBO therapy session. Services performed in the absence of a physician will not be reimbursed (G0167).

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

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

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

Evaluation and management services and/or procedures (e.g., wound debridement, transcutaneous PO_2 determinations) provided in a hyperbaric oxygen treatment facility in conjunction with a hyperbaric oxygen therapy session may be reported separately.

Outpatient hospital HBO services for dates of service on or after August 1, 2000, must be billed with HCPCS code C1300. Each unit of service represents 30 minutes of treatment. This coding requirement is the result of OP PPS implementation. To appropriately report C1300 the first unit reported must be at least 16 minutes in length. The second unit cannot be coded unless the session is at least 46 minutes long; the third unit cannot be coded unless the session is at least 76 minutes long; the fourth unit cannot be coded unless the session is at least 106 minutes long. In general, an additional unit of service cannot be coded unless the patient is in the chamber receiving hyperbaric oxygen treatment for at least 16 minutes beyond the previous 30-minute period.

The number of units billed is to be based only upon the time that the patient receives treatment with hyperbaric oxygen. Although we recognize that the patient may need attention both before and after receiving hyperbaric oxygen, this care is bundled into the payment for the time spent receiving hyperbaric oxygen treatment and should not be billed as a separate service unless a different codable service is also being delivered.

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

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

Documentation Requirements

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

C1300: Hyperbaric Oxygen Therapy (HBO Therapy) (continued)

This medical documentation must include:

1. An initial assessment which will include a medical history detailing the condition requiring HBO therapy. The medical history should list prior treatments and their results including antibiotic therapy and surgical interventions. This assessment should also contain information about adjunctive treatment currently being rendered.
2. Physician progress notes.
3. Any communication between physicians detailing past or future (proposed) treatments.
4. Positive gram-stain smear is required to support the diagnosis of gas gangrene.
5. Definitive radiographic evidence and bone culture with sensitivity studies are required to confirm the diagnosis of osteomyelitis.
6. HBO treatment records describing the physical findings, the treatment rendered and the effect of the treatment upon the established goals for therapy.

Utilization Guidelines

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

Other Comments

N/A

Sources of Information and Basis for Decision

Dorlands Illustrated Medical Dictionary, 28th edition. Philadelphia. W.B. Saunders Co.

Undersea and Hyperbaric Medical Society. (1996, 1999). *Hyperbaric Oxygen Therapy: A committee report.*

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 advisory groups, which includes representatives from Florida College of Emergency Physicians and Florida Orthopaedic Society.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

05/01/2001

Revision History

Revision Number 13
Start Date of Comment Period N/A
Start Date of Notice Period 05/01/2001
3rd Qtr 2001 *Bulletin*
Revised Effective Date 05/01/2001
Explanation of Revision: HCFA released Transmittal No. 129 modifying national coverage for Hyperbaric Oxygen (HBO) Therapy that was published in the 1st Quarter 2001 Bulletin. Multiple provider issues clarified.

Revision Number 12
Start Date of Comment Period N/A
Start Date of Notice Period 08/01/2000
Aug/Sept 2000 *Bulletin*
Revised Effective Date 08/01/2000
Explanation of Revision: Outpatient PPS implementation

Revision Number 11
Start Date of Comment Period N/A
Start Date of Notice Period 12/1999 Dec 1999
Special Issue *Bulletin*
Revised Effective Date 01/01/2000
Explanation of Revision: 2000 HCPCS

Revision Number 10
Start Date of Comment Period N/A
Start Date of Notice Period Aug/Sept 1999 Bulletin
Revised Effective Date 08/26/1999

Revision Number 9
Start Date of Comment Period N/A
Start Date of Notice Period 08/26/1999
Aug/Sept 1999 *Bulletin*
Revised Effective Date
Explanation of Revision: The HCFA revised Coverage Issues Manual 35-10 to define the medical conditions, restate the physician supervision requirement for constant attendance and add credentialing requirements that must be met to qualify for payment. This revision was communicated through transmittals 112 and AB-99-21.

Revision Number 8
Start Date of Comment Period 02/08/1999
Start Date of Notice Period 02/08/1999
Revised Effective Date
Explanation of Revision: Statement of physician location during HBO session updated as was American College of Hyperbaric Medicine's statement.

Revision Number 7
Start Date of Comment Period N/A
Start Date of Notice Period 08/26/1998
Aug/Sept 1999 *Bulletin*
Revised Effective Date 10/10/19987
Explanation of Revision: HCFA central office provided clarification of National policy for HBO requiring physician presence during the session.

Revision Number 6
Start Date of Comment Period N/A
Start Date of Notice Period N/A
Revised Effective Date 05/96/98

Revision Number 5
Start Date of Comment Period N/A
Start Date of Notice Period 02/23/98
Revised Effective Date 03/23/98

C1305: Apligraf® (Graftskin)

Policy Number
C1305

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Apligraf® (Graftskin)

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

Original Policy Effective Date
06/22/2001

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

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

Apligraf® should be applied to a clean, debrided, thoroughly irrigated wound. Oozing or bleeding should be stopped through the use of gentle pressure. With sterile gloved hands, Apligraf® is placed dermal side down in direct contact with the wound surface. Apligraf® is trimmed to cover the wound bed with 1/8-1/4" margins. The package insert recommends securing Apligraf® with a three-layer dressing to assure contact to the wound bed.

The wound should be inspected and the dressing changed at weekly intervals. Highly exudative wounds may require more frequent dressing changes. Additional applications of Apligraf® may be necessary. Non-adherent remnants should be gently removed, the wound bed cleansed, and additional applications applied. Additional applications should not be placed over adherent areas. Healing tissue or adherent Apligraf® should not be disrupted.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider Apligraf® reasonable and medically necessary for the following two indications:

When used with standard therapeutic compression for the treatment of non-infected partial and full-thickness skin ulcers due to venous insufficiency that have not adequately responded to conventional venous insufficiency ulcer therapy; or

When used with standard diabetic foot ulcer care for the treatment of non-infected full-thickness neuropathic diabetic foot ulcers that have not adequately responded to conventional diabetic foot ulcer therapy.

Coverage for Apligraf® for **venous insufficiency ulcers** will be considered when ALL of the following conditions are met:

- The venous stasis ulcer has been present for a minimum of three months duration.
- The venous stasis ulcer must have failed to respond to documented conservative measures of at least eight weeks duration. Conservative measures include debridement of necrotic tissue to promote healing. Debridement can take the form of wet-to-dry dressings, the use of enzymatic debridement (e.g., Elase, Travase), the application of dressings that enhance leukocyte migration for shallow wounds, or surgical debridement. A moist wound-healing environment must be provided. Excess wound exudate must be removed at each dressing change. Clinical infections must be eradicated. Graduated venous compression must be applied to eliminate edema. Possible choices for compression include elastic stockings with at lease 35 mm of compression, Zinc oxide bandages changed weekly, multilayer elastic wraps, and intermittent mechanical compression. Adequate circulation and oxygenation to the wound bed must be maintained. Prior to Apligraf® application, it is expected the medical record documentation will contain evidence that the conservative measures have failed as evidenced by an ulcer that has increased in size and depth or that there has been no change in baseline size or depth with no sign of improvement or no indication that improvement is likely (lack of granulation or progress toward closing).
- The venous stasis ulcer is confirmed as being either partial or full thickness and free of infection. The ulcer must be free of cellulitis, eschar or obvious necrotic material as this will interfere with the device adherence and wound healing.
- The patient must have adequate arterial blood supply to support tissue growth.

C1305: Apligraf® (Graftskin) (continued)

- The patient is competent or has the support system required to participate in follow-up care associated with treatment of the wound with Apligraf®.

Coverage for Apligraf® for *neuropathic diabetic foot ulcers* will be considered when ALL of the following conditions are met:

- The type 1 or type 2 diabetic is under current medical management.
- The full thickness neuropathic diabetic foot ulcer has been present for a minimum of four weeks duration.
- The neuropathic diabetic foot ulcer must have failed to respond to documented conservative measures of at least four weeks duration. Conservative measures include aggressive sharp or surgical debridement of necrotic tissue, saline moistened dressings and a non-weight-bearing regime. Clinical infections must be eradicated. Prior to Apligraf® application, it is expected the medical record documentation will contain evidence that the conservative measures have failed as evidenced by an ulcer that has increased in size and depth or that there has been no change in baseline size or depth with no sign of improvement or no indication that improvement is likely (lack of granulation or progress toward closing).
- The ulcer is located on the plantar, medial, or lateral surface of the foot excluding the heel and free of infection, tunnels, and tracts. Additionally, the ulcer must be free of cellulitis, eschar, or obvious necrotic material as this will interfere with the device adherence and wound healing.
- The extremity must be free of active Charcot's arthropathy.
- The patient must have adequate arterial blood supply to support tissue growth.
- The patient is competent or has the support system required to participate in follow-up care associated with treatment of the wound with Apligraf®.

Apligraf® is contraindicated:

For use on clinically infected wounds;

In patients with known allergies to bovine collagen; or

In patients with known hypersensitivity to the components of the Apligraf® agarose shipping medium (which contains agarose, L-glutamine, hydrocortisone/ bovine serum albumin, bovine insulin, human transferrin, triiodothyronine, ethanolamine, O-phosphorylethanolamine, adenine, seleniuos acid, DMEM powder, HAM's F-12 powder, sodium bicarbonate, calcium chloride, and water for injection).

In vitro and *in vivo* histology studies have shown that Apligraf® either degrades or its cell viability is reduced when the device is exposed to the following cytotoxic agents: Dakin's solution, Mafenide acetate, Scarlet red dressing, Tincoban, Zinc sulfate, Povodine-iodine solution, Chlorhexidine, or Polymixin/Nystatin. The use of Apligraf® with these solutions will be considered not reasonable and necessary and will result in denial of reimbursement.

The safety and effectiveness of Apligraf® have not been established for patients receiving more than five device applications.

CPT/HCPCS Section & Benefit Category

Drugs and Biologicals

Type of Bill Code

Hospital – 13x

Revenue Codes

636 Drugs Requiring Detailed Coding

CPT/HCPCS Codes

C1305 Apligraf, per 44 square centimeters (this code exclusive for OP PPS affected providers only)

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

250.80-250.81 Diabetes with other specified manifestations [full thickness neuropathic foot ulcer]

454.0 Varicose veins of lower extremities with ulcer

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

Providers utilize HCPCS codes 15000, 15342 and, if applicable, 15343 to represent the work involved with preparing the ulcer site and applying Apligraf®. The Apligraf® device itself is identified by utilizing C1305. Hospital OP PPS affected providers must bill the Apligraf® device under revenue code 636 utilizing HCPCS code C1305 with each biological billed representing one increment of 44 square centimeters. Since the coding is based on a per 44 square centimeters basis, the units field on the UB-92 form should reflect a unit of "1" for each package used.

Documentation Requirements

Medical record documentation maintained by the treating provider must substantiate the medical necessity for the use of Apligraf®. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the

C1305: Apligraf® (Graftskin) (continued)

history and physical, office/progress notes, hospital notes, and/or procedure report.

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

The record must identify the duration of the ulcer's presence with a description of the conservative treatment measures taken. The medical record must contain a description of the wound at baseline (prior to beginning conservative treatment) relative to size, location, stage and presence of infection. The documentation must provide an updated description of the wound prior to Apligraf® application in terms of response to treatment (i.e., ulcer measurement and progress toward healing). Following Apligraf® application, continue to document the changes in the ulcer in terms of complete wound closure. Any additional applications must also be noted.

The diabetic's managing physician must be identified in the medical record if different from the physician managing the wound care.

Utilization Guidelines

N/A

Other Comments

Venous insufficiency is caused by venous hypertension. The underlying pathology is most commonly valvular insufficiency resulting in edema and ultimately tissue breakdown. Venous stasis ulcers most often appear on the medial aspect of the lower legs above the malleolus. The accepted standard of care for venous ulcers is moist wound healing under graduated compression bandages.

Diabetic neuropathy may present with foot pain and is occasionally associated with diminished pulses and trophic skin changes. Loss of light touch and decreased vibratory senses are distinguishing characteristics.

Partial thickness skin ulcer—wound base is visible and the ulcer does not extend through the dermis.

Full thickness skin ulcer—wound base is visible and the ulcer extends through the dermis but not into the subcutaneous tissue to fascia, muscle or bone.

Sources of Information and Basis for Decision

American Diabetes Association (1998). Foot care in patients with diabetes mellitus. [On-line]. Available: http://www.diabetes.org/diabetescare/supplement198/s54.htm Used to determine conservative treatment.

Falanga, V. (1999). Care of venous leg ulcers. Ostomy/Wound Management, 45(suppl 1A), 33S-43S. Used to determine conservative treatment.

Falanga, V., & Sabolinski, M. (1999). A bilayered living skin construct (APLIGRAF®) accelerates complete closure of hard to heal venous ulcers. Wound Repair and Regeneration, 7, 201-207. Used to identify science-based knowledge.

Prescribing Information: Apligraf® (Graftskin). Organogenisis, Inc. Used to determine indications and limitations.

Rakel, R.E. (Eds.). (2000). Saunders manual of medical practice (2nd ed.). Philadelphia, PA: W.B. Saunders Company. Used to determine diagnosis and conservative treatment.

Santilli, J.D., & Santilli, S.M. (1999). Chronic critical limb ischemia: Diagnosis, treatment and prognosis. [On-line]. Available: http://www.aafp.org/afp/990401ap/1899.html Used to determine diagnosis and treatment.

University of Pennsylvania School of Medicine. (2000) Venous leg ulcer guideline. [On-line]. Available: http://www.guideline.gov/VIEWS/summary.a…rief_summary&sSearch_string=venous+ulcer Used to determine conservative treatment.

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 advisory groups, which includes representatives from various specialties

Start Date of Comment Period

11/15/2000

End Date of Comment Period

01/01/2001

Start Date of Notice Period

05/01/2001

Revision History

Revision Number:	Original
Start Date of Comment Period:	11/15/2000
Start Date of Notice Period:	05/01/2001
	3rd Qtr 2001 *Bulletin*
Original Effective Date	06/22/2001

J0207: Amifostine (Ethyol®)

Policy Number
J0207

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Amifostine (Ethyol®)

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Hospital Manual, Section 442.7
Medicare Intermediary Manual, Sections 3101.3, 3112.4, 3133.5, 3627.9, and 3627.10
Skilled Nursing Facility Manual, Section 230.5

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
07/17/2000

Original Policy Ending Date
N/A

Revision Effective Date
06/22/2001

Revision Ending Date
06/21/2001

LMRP Description
Amifostine (Ethyol®) is categorized as an antineoplastic adjunct and cytoprotective agent.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider Amifostine (Ethyol®) medically reasonable and necessary for any of the following FDA approved indications:

- Nephrotoxicity, Cisplatin-induced (prophylaxis)- to reduce cumulative nephrotoxicity associated with Cisplatin therapy in patients with advanced ovarian carcinoma, non-small cell lung carcinoma (NSCLC), or advanced solid tumors of non-germ cell origin.
- Moderate to severe xerostomia, radiation induced- to reduce the incidence of moderate to severe xerostomia in patients undergoing post operative radiation treatment for head and neck cancers where the radiation port includes a substantial portion of the parotid gland.

Clinical trials have also demonstrated the efficacy of Amifostine in the reduction of additional complications related to antineoplastic administration. Florida Medicare will cover Amifostine for its FDA approved uses as well as for treatment of the following conditions:

- Bone marrow toxicity, antineoplastic agent-induced (prophylaxis) - to reduce acute and cumulative hematologic toxicities associated with a Cisplatin and Cyclophosphamide (CP) regimen in patients with advanced solid tumors of non-germ cell origin. Amifostine is also indicated to decrease bone marrow toxicity during treatment with high dose Cisplatin alone for head and neck carcinoma, Cyclophosphamide alone for malignant lymphoma, Carboplatin for NSCLC, and Carboplatin plus radiation therapy for head and neck carcinoma.
- Neurotoxicity, Cisplatin-induced (prophylaxis) - to decrease the frequency or severity of Cisplatin-induced peripheral neuropathy and ototoxicity.

CPT/HCPCS Section & Benefit Category
Drugs Administered Other Than Oral Method

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

Revenue Code
636 Drugs Requiring Detailed Coding

CPT/HCPCS Codes
J0207 Injection, amifostine, 500mg

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

990	Effects of radiation, unspecified (radiation induced moderate to severe xerostomia)
E933.1	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antineoplastic and immunosuppressive drugs (nephrotoxicity, bone marrow toxicity, and/or neurotoxicity associated with Cisplatin and/or cyclophosphamide regimen).

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

J0207: Amifostine (Ethyol®) (continued)

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

Infusion Therapy Coding: Use code Q0081 (Infusion therapy, using other than chemotherapeutic drugs, per visit.)

Documentation Requirements

Medical record documentation maintained by the performing physician must substantiate the medical necessity for the use of Amifostine by clearly indicating the condition for which this drug is being used. This documentation is usually found in the history and physical or in the office/progress notes.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information and Basis for Decision

Amifostine package insert, 7/99

Compendia-Based Drug Bulletin, Summer Update (August 2000). Vol. 9(3). The Association of Community Cancer Centers.

The United States Pharmacopeia Drug Information (USPDI) (2000) *Oncology Drug Information.* (3rd ed.). Maryland: The Association of Community Cancer Centers (ACCC).

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 advisory groups, which includes representatives from numerous societies.

Start Date of Comment Period

11/15/2000

End Date of Comment Period

12/30/2000

Start Date of Notice Period

05/01/2001

Revision History

Revision Number	1
Start Date of Comment Period	11/15/2000
Start Date of Notice Period	05/01/2001 3rd Qtr 2001 *Bulletin*
Revised Effective Date	06/22/2001

Explanation of Revision: Based on the analysis performed through the FMR process, it was determined that Amifostine was being billed with diagnoses that did not support medical necessity. Therefore, a revision was needed to add a covered diagnosis list.

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

J9293: Mitoxantrone Hydrochloride

Revision Overview—Mitoxantrone (J9293) was removed from Antineoplastic Drugs (J9999) policy because a new non-cancer indication of multiple sclerosis was added to the policy.

Policy Number
J9293

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Mitoxantrone Hydrochloride

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Hospital Manual, Section 442.7
Medicare Intermediary Manual, Sections 3101.3, 3112.4, 3627.9, and 3627.10

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
07/17/2000

Original Policy Ending Date
N/A

Revision Effective Date
03/06/2001

Revision Ending Date
03/05/2001

LMRP Description
Mitoxantrone hydrochloride (**Novantrone®**) is an anthracenedione, which inhibits DNA and RNA synthesis.

Indications and Limitations of Coverage and/or Medical Necessity
Mitoxantrone hydrochloride is FDA approved for treatment of the following:

- Advanced symptomatic prostate carcinoma,
- Acute non-lymphocytic leukemia, **and**
- Secondary (chronic) progressive, progressive relapsing, or worsening relapsing-remitting multiple sclerosis.

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

- Breast carcinoma
- Acute lymphocytic leukemia
- Non-Hodgkin's lymphoma
- Hepatoma

CPT/HCPCS Section & Benefit Category
Chemotherapy Drugs

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

Revenue Codes
636 Drugs Requiring Detailed Coding

CPT/HCPCS Codes
J9293 Injection, mitoxantrone HCl, per 5 mg

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

155.0-155.2	Malignant neoplasm of liver and intrahepatic bile ducts
174.0-174.9	Malignant neoplasm of female breast
175.0-175.9	Malignant neoplasm of male breast
185	Malignant neoplasm of prostate
200.00-200.88	Lymphosarcoma and reticulosarcoma
202.00-202.98	Other malignant neoplasms of lymphoid and histiocytic tissue
204.00-204.01	Acute lymphoid leukemia
205.00-205.01	Acute myeloid leukemia
206.00-206.01	Acute monocytic leukemia
207.00-207.01	Acute erythremia and erythroleukemia
340	Multiple Sclerosis

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

J9293: Mitoxantrone Hydrochloride (continued)

Coding Guidelines

Chemotherapy administration codes 96400-96450, & 96542 are to be used when Mitoxantrone is being infused for the treatment of a patient with a cancer diagnosis. Infusion codes 90780-90784 should be used when this drug is being given for the treatment of Multiple Sclerosis (ICD-9-CM code 340).

Documentation Requirements

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

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

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information and Basis for Decision

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

Compendia-Based Drug Bulletin, Winter 2001 Update (February 2001). Vol. 10(1). The Association of Community Cancer Centers.

Deglin, J.H., Vallerand, A.H. (Eds.) (1995). *Davis' Drug Guide for Nurses* (4th ed.). Philadelphia: F.A. Davis Company.

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

The United States Pharmacopeia Drug Information (USPDI) (2000) *Oncology Drug Information*. (3rd ed.). Maryland: The Association of Community Cancer Centers (ACCC).

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 advisory groups, which includes representatives from numerous societies.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

05/01/2001

Revision History

Revision Number	1
Start Date of Comment Period:	N/A
Start Date of Notice Period	05/01/2001 3rd Qtr 2001 *Bulletin*
Revised Effective Date	03/06/2001

Explanation of Revision: Mitoxantrone J9293 was removed from J9999, Antineoplastic policy because a new non-cancer indication was added, multiple sclerosis.

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

70544: Magnetic Resonance Angiography – Revision to Policy

The local medical review policy (LMRP) for Magnetic Resonance Angiography – 70544 was published in the Second Quarter 2001 *Medicare A Bulletin* on pages 28-30. In the "ICD-9-CM Codes that Support Medical Necessity" section of the policy, the ICD-9-CM code for respiratory abnormality, unspecified, was published incorrectly as 786.0. The correct ICD-9-CM code for respiratory abnormality, unspecified, for CPT code 71555 (chest) is 786.00.

82728: Serum Ferritin—Revision to Policy

The local medical review policy (LMRP) for Serum Ferritin – 82728, was published in the August/ September 2000 *Medicare A Bulletin* on pages 34-35. In order to clarify the last bullet in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy, the following statement, "Use ICD-9-CM codes 280.0-280.9 for these indications" was added to the policy. If a patient has a suspected deficiency of iron due to a history of a prior gastrectomy, the appropriate ICD-9-CM code to use would be 280.9.

J1561: Intravenous Immune Globulin – Addition to Policy

The local medical review policy (LMRP) for Intravenous Immune Globulin – J1561 was published in the April/ May 2000 *Medicare A Bulletin* on pages 25-28. Since then, the ICD-9-CM code 340 (Multiple sclerosis) has been added to the policy as a covered indication for the following procedure codes: J1561 and J1563.

This change is effective for services performed **on or after February 20, 2001.**

82435: Chloride – Correction to Policy

The local medical review policy (LMRP) for Chloride – 82435 was published in the Second Quarter 2001 *Medicare A Bulletin* on pages 46-47. In the "ICD-9-CM Codes that Support Medical Necessity" section of the policy, the ICD-9-CM code for Cushing's syndrome was published incorrectly as 255.1. The correct ICD-9-CM code for Cushing's syndrome is 255.0. In addition, the ICD-9-CM code range for Disorder of fluid, electrolyte, and acid–based balance, was published incorrectly as 276.0-276.6. The correct ICD-9-CM code for Disorder of fluid, electrolyte, and acid–based balance, is 276.0-276.9.

94010: Spirometry – Revision to Policy

The local medical review policy (LMRP) for Spirometry – 94010 was published in the June/July 2000 *Medicare A Bulletin* on pages 37-40. Through the outpatient prospective payment system (OPPS) implementation, revenue code 461 was inadvertently added to the policy. The correct revenue code should have been 469 (Other Pulmonary Function). Therefore, the correct revenue codes to report spirometry services are:

460 Pulmonary Function, General Classification
469 Other Pulmonary Function

J9999: Doxorubicin HCL – Revision to Antineoplastic Drugs Policy

The local medical review policy (LMRP) for Antineoplastic Drugs – J9999 was published in the Second Quarter 2001 *Medicare A Bulletin* on pages 75-82. Included in this policy is coverage for Doxorubicin HCL (J9000). Since the publication of this policy, the following changes have been made to the indications for Doxorubicin HCL:

- AIDs related Kaposi's sarcoma has been moved from an off-labeled indication to a labeled indication.
- Vaginal and Testicular carcinoma have been added as off-labeled indications.

The effective date for this revision is March 6, 2001. Refer to the complete policy in the Second Quarter 2001 *Medicare A Bulletin.*

Erythropoietin for Anemia of Chronic Disease

Anemia of chronic disease (ACD) is a condition that accompanies chronic inflammatory, infectious, or neoplastic disorders. ACD is associated with an underproduction of red cells, a decrease in iron utilization, and failure of the bone marrow to respond to increased erythropoietin (EPO) levels (blunted EPO response). Laboratory values of patients experiencing ACD usually include a low hemoglobin, reticulocyte count, serum iron with normal or increased iron stores (ferritin level).

Several articles were received from the manufacturer which date back to 1990. Many of these articles focused on patients with rheumatoid arthritis, the critically ill, and a few on patients with neoplastic disease. The articles pertaining to the critically ill encompassed a minimal number of patients in the ICU setting in which phlebotomy, inflammation, nutritional deficiencies, and blood loss contribute significantly to the development of anemia. The majority of these patients required immediate correction of anemia via blood transfusions and their anemia are not associated with ACD. Procrit® is not indicated for patients who require immediate correction of anemia. No studies were received regarding the use of Procrit® in infection and other inflammatory diseases with the exception of Rheumatoid Arthritis. Many additional studies were reviewed and some of them revealed that use of erythropoietin in anemic patients with cancer demonstrated some benefit but recommended further investigation.

Local Medical Review Policy Development Changes

Several changes have occurred in the local medical review policy (LMRP) development process. These changes are very positive and will make the development of LMRP's more open to comment and discussion prior to their finalization and implementation. The new procedures will not replace any of the longstanding Health Care Financing Administration (HCFA)-directed procedures of circulating draft LMRPs to associations, and societies, as well as interested parties throughout the state. What will occur is:

1. All draft LMRPs will be posted on our Internet Web site (*www.floridamedicare.com*) approximately three to four weeks prior to the draft LMRPs being published in the *Medicare Part A Bulletin.*
2. Our Web site also instructs readers on how to provide written comments pertaining to the draft LMRPs. Providers have 45 days from the start date of the comment period in which to provide comments. All written comments and supporting documentation can be sent to the Medical Policy and Procedures Department at P.O. Box 2078, Jacksonville, Florida 32231-0048 or, emailed to *Medical.Policy@FCSO.com.*
3. Prior to the beginning of the comment period, an open public meeting will be held, whereby interested parties will have the opportunity to present scientific evidence regarding draft LMRPs to First Coast Service Options, Inc. Interested parties must notify us in advance of their attendance and the designated topic that they will be addressing. Interested parties should contact the Medical Policy and Procedures Department at (904) 791-8292 to request a time for their presentation.
4. The same interested parties should summarize their comments, issues, or clinical information in a one-page summary to First Coast Service Options, Inc., which will be shared with all Carrier Advisory Committee (CAC) members at the scheduled CAC meetings.
5. Posted on our Web site is a summary of the comments received on each new draft LMRP with the contractor's response.
6. Also posted on our Web site is a draft LMRP status page. The purpose of this page is to inform providers at what stage a particular draft LMRP is in (e.g., the draft is under development, the draft has been released for comment, the comment period has ended and comments are now being considered, or the final LMRP has been issued).
7. Providers without access to the Web site can request a hard copy of draft, final, or retired LMRPs by contacting the Medical Policy and Procedures Department at P.O. Box 2078, Jacksonville, Florida 32231-0048, or by emailing your request to *Medical.Policy@FCSO.com.*

These are some of the recent additions to our LMRP development process. We strongly believe that these new changes will make our LMRP process more open for discussion and comment, while continuing our current objectives of maintaining a sound, evidenced-based clinical focus, preserving integrity, and satisfying all HCFA directives.

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Devices Eligible for Transitional Pass-Through Payments Under the Hospital Outpatient Prospective Payment System

Section 402 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), makes changes in the provision for transitional pass-through payments for devices under the hospital outpatient prospective payment system. Section 402 requires the use of categories of devices for which Medicare will make transitional pass-through payments for certain devices, including those that had not previously been determined eligible for such payments because Medicare was paying for them in outpatient departments prior to 1997. Until categories are established, the previously applicable rule limiting transitional pass-through payments to devices specifically identified in previous notifications continues to apply. That is, hospitals may bill for transitional pass-through payments only for specified devices, not for similar or related devices that are not specified.

This article contains information on pre-1997 devices as well as devices that were submitted for pass-through status for the April 2001 update. Devices listed in this article are eligible for transitional pass-through payments **effective January 20, 2001.**

The following HCPCS codes and descriptors contain:

- A list of pre-1997 devices with assigned HCPCS C-codes that were submitted for the August, October, and January updates but initially did not meet the criteria for a "new device technology" ambulatory payment classification (APC). As a result of BIPA, HCFA has determined these devices to be eligible for transitional pass-through payments, effective for services delivered on or after January 20, 2001.
- A list of items that were submitted to HCFA by December 1, 2000 and that HCFA has determined eligible for transitional pass-through payments. These items were initially submitted for the April 1, 2001 update, but as a result of BIPA HCFA has determined they are eligible effective January 20, 2001. Each of the devices listed in this section has been assigned a pass-through C-code, and hospitals may use these codes when billing for transitional pass-through payments for these specific devices.
- A list of devices that were previously assigned to "new device technology" APCs. (Certain pre-1997 devices were placed in "new device technology" APCs if they met both the pass-through criteria (other than the post-1996 requirement) and a test of cost relative to the payment for the procedure with which they are associated.) These devices were assigned C-codes C8500 through C8891. Effective January 20, 2001, these devices are no longer classified in "new device technology" APCs, but as devices eligible for transitional pass-through payments. Accordingly, HCFA has designated additional C-codes for these devices that will result in payment on a pass-through basis.

HCPCS CODE	Long Descriptor
C1000	Closure, arterial vascular device, Perclose Closer Arterial Vascular Closure Device, Prostar Arterial Vascular Closure Device, **Closer S Arterial Vascular Closure Device**
C1003	Catheter, Livewire TC Ablation Catheter 402132, 402133, 402134, 402135, 402136, 402137, 402145, 402146, 402147, 402148, 402149, 402150, 402151, 402152, 402153, 402154, 402155, 402156, **7 Fr CSM Livewire EP Catheter (model 401935), 5FR Decapolar (models 401938, 401939, 401940, 401941**), **Livewire TC Compass Ablation Catheter (models 402205, 402006, 402207, 402208)**
C1007	Prosthesis, penile, AMS 700 Penile Prosthesis, AMS Ambicor Penile Prosthesis, **Dura II Penile Prosthesis, AMS Malleable 650 Penile Prosthesis**
C1008	Stent, UroLume, **Cook Harrison Fetal Bladder Stent**
C1029	Catheter, balloon dilatation, Controlled Radial Expansion Balloon Dilatation Catheter Wire-Guided and Fixed Wire, **Quantum Dilation Balloon, MS Classique Balloon Dilation Catheter**
C1030	Catheter, balloon dilatation, Marshal, Blue Max 20, Ultra-Thin Diamond, **Ultra-Thin Balloon Dilatation Catheter, Ultra-Thin ST Balloon Dilatation Catheter, Ultra-Thin Balloon Dilatation Catheter with Glidex Hydrophilic Coated Balloon, Ultra-Thin ST Balloon Dilatation Catheter with Glidex Hydrophilic Coated Balloon**
C1033	Catheter, imaging, Sonicath Ultra Model 37-410 Ultrasound Imaging Catheter, **Sonicath Ultra 9 MHz Ultrasound Imaging Catheter**
C1036	Port/reservoir, venous access device, Vaxcel Implantable Vascular Access System, R Port Premier Vascular Access System (model 45-100), **Bard Port Implanted Port, Bard Rosenblatt Lumen Port, Bard Ultra Low Profile Port, BardPort Titanium Implanted Port, BardPort X-Port Implanted Port, BardPort M.R.I. Dual Implanted Port, BardPort M.R.I. Hard-Base Implanted Port**

Devices Eligible for Transitional Pass-Through Payments Under the HO PPS (continued)

C1037 Catheter, Vaxcel Chronic Dialysis Catheter, Medcomp Bio Flex Tesio Catheter, **Medcomp Silicone Tesio Catheter, Medcomp Hemo-cath Long Term Silicone Catheter, Bard Niagara Dual Lumen Catheter, Bard Opti-Flow Dual Lumen Catheter, Medcomp Ash Split Catheter**

C1043 Atherectomy system, coronary, RotablatorRotaLink Atherectomy Catheter and Burr, Rotablator RotaLink Rotational Atherectomy System Advancer and Guide Wire, **Atherocath-GTO Atherectomy Catheter, Interventional Technologies Transluminal Extraction Coronary (TEC) Atherectomy System**

C1051 Catheter, thrombectomy, Oasis Thrombectomy Catheter, **Fogarty Adherent Clot Catheter (4 Fr, 5 Fr, 6Fr), 6 Fr Thrombex PMT Catheter (60cm, 120cm)**

C1055 Catheter, Transesophageal 210 Atrial Pacing Catheter, Transesophageal 210-S Atrial Pacing Catheter, **Flex-EZ Balloon Dilato**r, **EZ Resolution Balloon Dilator (models 3802, 3804, 3806)**

C1056 Catheter, Gynecare Thermachoice II Catheter, **Cook Intrauterine Insemination Catheter, Cook Jansen-Anderson Insemination Set, Cook OB/GYN Suprapubic Balloons, Cook Urological O'Brien Suprapubic Access Set, Cook Urological Suprapubic Balloons, Product Health Induct Breast Microcatheter, Cook Chorionic Villus Sampling Set**

C1061 Catheter, coronary guide, ACS Viking Guiding Catheter, **Cardima Vueport Balloon Occlusion Guiding Catheter, Merit Medical Systems Performa Vessel Sizing Catheter, Merit Medical Systems Pediatric/Adult Pigtail Catheter**

C1067 Stent, biliary, Megalink Biliary Stent, **PALMAZ Balloon Expandable Stent and Delivery System, Spiral Z Biliary Metal Expandable Stent, Za Biliary Metal Expandable Stent, Wallstent Transhepatic Biliary Endoprosthesis**

C1068 Pacemaker, dual chamber, Pulsar DDD , **Unity VDDR (model 292-07)**

C1071 Pacemaker, single chamber, Pulsar Max SR, Pulsar SR , **Vigor SSI**

C1100 Guide wire, percutaneous transluminal coronary angioplasty, Medtronic AVE GT1Guide Wire, Medtronic AVE GT2 Fusion Guide Wire, **Interventional Technologies TrackWire, Interventional Technologies TrackWire Support, Interventional Technologies TrackWire Extra Support**

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, **Medtronic AVE Vector Guide Catheter, Medtronic AVE Vector X Guide Catheter**

C1107 Catheter, diagnostic, electrophysiology, Torqr, Soloist, **Dynamic XT Decapolar Catheter**

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, **Biomet 3.5mm Cortical Screw, Biomet 4.5mm Cortical Screw (fully threaded), Biomet 6.5mm Cancellous Lag Screw (32mm thread length), Biomet 6.5mm Cannulated Cancellous Screw (20mm thread length)**

C1115 Lead, pacemaker, 5038S, 5038, 5038L, **2188 Coronary Sinus Lead, 4057M, 4058M, 4557M, 4558M, 5058, 6416 Pacemaker Lead, Innomedica Sutureless Myocardial (models 4045, 4046, 4047, 4058), Unipass (models 425-02, 425-04, 425-06)**

C1118 Pacemaker, dual chamber, Sigma 300 DR, Legacy II DR, **Legacy II S**

C1123 Defibrillator, implantable, GEM II VR, **GEM III VR (model 7231)**

C1125 Pacemaker, single chamber, Kappa 400 SR, Topaz II SR, **Topaz 3/Topaz SR (model 540)**

C1126 Pacemaker, dual chamber, Kappa 700 DR (all models), **Clarity DR (models 860, 862, 865), Diamond 3/Diamond DR (model 840)**

C1127 Pacemaker, single chamber, Kappa 700 SR, **Clarity SR (models 560, 562, 565)**

C1128 Pacemaker, dual chamber, Kappa 700 D, Ruby II D, **Ruby 3/Ruby 3 D (model 740), Vita 2 DR (model 830)**

C1133 Pacemaker, single chamber, Sigma 300 SR, Vita SR, **Vita 2 SR (model 530)**

C1137 Septal defect implant system, CardioSEAL Septal Occlusion System, CardioSEAL Occluder Delivery Catheter, **AGA Medical Amplatzer PFO Occluder**

C1143 Pacemaker, dual chamber, AddVent 2060BL, **Paragon III (models 2314L, 2315 M/S)**

C1144 Pacemaker, single chamber, rate-responsive, Affinity SR 5130, Affinity SR 5130L, Affinity 5130R, Integrity SR 5142, **Integrity U SR 5136**

C1145 Vascular closure device, Angio-Seal 6 French Vascular Closure Device (model 610091), Angio-Seal 8 French Vascular Closure Device (models 610089, 610097), **Angio-seal 6 Fr EV Vascular Closure Device, Angio-seal 8 Fr EV Vascular Closure Device (models 610099, 610101)**

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, **Contour II (models V-185AC, V-185B, V-185C)**

C1151 Lead, pacemaker, Passive Plus DX 1343K/46, Passive Plus DX 1343K/52, Passive Plus DX

Devices Eligible for Transitional Pass-Through Payments Under the HO PPS (continued)

	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, **Passive Plus TiN (model 1242T)**
C1154	Lead, defibrillator, SPL SP01, SPL SP02, SPL SP04, **6721L, 6721M, 6721S, 6939 Oval Patch Lead, CapSure 4965, DP-3238, EndoTak DSP,** Transvene 6933, Transvene 6937
C1156	Pacemaker, single chamber, Affinity SR 5131M/S, Tempo VR 1102, Trilogy SR+ 2260L, Trilogy SR+ 2264L, **Solus II (models 2006L, 2007 M/S)**
C1157	Pacemaker, dual chamber, Trilogy DC+ 2318L, **Synchrony III (models 2028L, 2029 M/S)**
C1183	Pacemaker, single chamber, Jade II S, Sigma 300 S, **Jade 3/Jade 3S (model 340)**
C1184	Pacemaker, single chamber, Sigma 200 S, **Sigma 100 S**
C1306	Lead, neurostimulator, Cyberonics NeuroCybernetic Prosthesis Lead, **Octad Lead 3898-33/389861, On-Point Model 3987, Pisces—Quad Plus Model 3888, Resume TL Model 3986, Pisces—Quad Model 3487a, Resume II Model 3587a, SymMix Lead 3982**
C1315	Pacemaker, dual chamber, Vigor DR, Meridian DR, **Vigor DDD, Vista DDD**
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 andDuodenal Endoprosthesis with Unistep Plus Delivery System (60mm in length), **Esophageal Z Metal Expandable Stent with Dua Anti-reflux Valve, Esophageal Z Metal Expandable Stent with Uncoated Flanges, Ultraflex Esophageal Stent System, Wallstent Esophageal Prosthesis (Double), Wallstent Esophageal Prosthesis with Delivery System, Wilson-Cook Esophageal Z Metal Expandable Stent, Bard Memotherm Esophageal Stent**
C1333	Stent, biliary, PALMAZ Corinthian Transhepatic Biliary Stent and Delivery System, **Cook Oasis One Action Stent Introductory System, Cook Z Stent Gianturco-Rosch Biliary Design, Cordis Palmaz XL Transhepatic Biliary Stent, Large Palmaz Balloon Expandable Stent with Delivery System**
C1334	Stent, coronary, PALMAZ-Schatz Crown Stent, Mini-Crown Stent, CrossFlex LC Stent, **Cook Gianturco-Roubin Flex-Stent Coronary Stent**
C1335	Mesh, hernia, Prolene Polypropylene Hernia System, **Prolene Soft Mesh (Polypropylene), Trelex Natural Mesh**
C1353	Neurostimulator, implantable, Itrel II/Soletra Implantable Neurostimulator and Extension, Itrel III Implantable Neurostimulator and Extension, InterStim Neurostimulator (implantable) and Extension, **NeuroControl Stim System**
C1363	Defibrillator, implantable, dual chamber, Gem DR, **GEM III DR (model 7275)**
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, **Doc Wire, Hi-Torque Extra Balance, Hi-Torque Extra S'port, Hi-Torque Extra Support, Hi-Torque Floppy II, Hi-Torque Intermediate, Hi-Torque Standard, Hi-Torque Traverse, TAD II Guide Wire System (145cm, 200cm, 260cm, 260cm, 300cm), TAD Guide Wire System (145cm), Wholey Hi-Torque Modified J Guide Wire System (145cm, 175cm, 260cm, 300cm), Wholey Hi-Torque Floppy Guide Wire System (145cm, 175cm, 260cm), Wholey Hi-Torque Standard Guide Wire System (145cm, 300cm), LOC Guide Wire Extension (115cm), Hobbs Medical Flex-EZ Guide Wire (models 3406, 3408, 3410, 3412, 3413)**
C1369	Internal receiver, neurostimulation system, ANS Renew Spinal Cord Stimulator System, **Medtronic Mattrix Receiver/Transmitter**
C1371	Stent, biliary, Symphony Nitinol Stent Transhepatic Biliary System, **Nir Biliary Stent System**
C1372	Stent, biliary, Smart Cordis Nitinol Stent and Delivery System, **Cordis Smart .018 Nitinol Transhepatic Biliary Stent**
C1420	Anchor system, TransFix Bone Anchor System with Dermis, StapleTac2 Bone Anchor System with Dermis, **BioSorb FX System**
C1700	Needle, brachytherapy, Authentic Mick TP Brachytherapy Needle, **Cook Urological Brachytherapy Needle**
C1701	Needle, brachytherapy, Medtec MT-BT-5201-25 Brachytherapy Needle , **AVID Medical Metal Hub Pre-Load Style Brachytherapy Seeding Insertion Needle, Mick Style Bracytherapy Seeding Insertion Needle**
C1702	Needle, brachytherapy, WWMT Brachytherapy Needle, **Nucletron Pancreas Flexible Brachytherapy Needle**
C1705	Needle, brachytherapy, Best Flexi Needle brachytherapy seed implantation, **Nycomed Amersham Mick Applicator Style Brachytherapy Needle, Nycomed Amersham Brachytherapy Needle** C1790 Brachytherapy seed, Nucletron Iridium 192 HDR, **MDS Nordion TheraSphere (Yttrium-90) Brachytherapy Seed, MDS Nordion Gamma Med Iridium-192 HDR Brachytherapy Seed**
C1793	Brachytherapy seed, Bard InterSource-103 Palladium Seed, 1031L, 1031C, **International Brachytherapy Intersource-103 (Palladium 103)**
C1795	Brachytherapy seed, Bard BrachySource-125 Iodine Seed, 1251L, 1251C, **International Brachytherapy InterSource-125**
C1802	Brachytherapy seed, Best Iridium 192, **Best Dummy Ribbon Brachytherapy Seed (model 3 DR, 4 DR series)**

Devices Eligible for Transitional Pass-Through Payments Under the HO PPS (continued)

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 3.0, **Biomet Bone Mulch Screw, Biomet WasherLoc Screw and WasherLoc Washer, Wright Medical Technology Hammertoe Implant (Swanson Type) Weil Design, Wright Medical Technology Swanson Titanium Great Toe Implant, Wright Medical Technology STA – PEG (Subtalar Arthrosis Implant - Smith Design), Wright Medical Technology Spin Snap-off Screw, Wright Medical Technology Bold Cannulated Titanium Compression Screw, Wright Medical Technology I.C.O.S. Ideal Compression Screw, Wright Medical Technology Swanson Finger Joint Implant with Grommets, Wright Medical Technology Swanson Basal Thumb Implant, Wright Medical Technology Swanson Titanium Carpal Scaphoid Implant, Wright Medical Technology Swanson Trapezium Implant, Biomet Becton Colles' Fracture Plate, Biomet Repicci II Unicondylar Knee System, Wright Medical Technology OsteoSet Bone Graft Substitute (5cc, 10cc, 20cc, 50cc), Wright Medical Technology Uni-Clip Compression Staple**

C1812 Anchor, OBL 2.0mm Mini Tac Anchor, OBL 2.8mm HS Anchor, OBL 2.8mm S Anchor, OBL 3.5mm Ti Anchor, OBL RC5 Anchor, OBL PRC5 Anchor, **Arthrex Anterior Cruciate Ligament (ACL) Avulsion Lag Screw with Sheath, Arthrex Chrondral Dart, Arthrex Bio-Absorbable Corkscrew, Arthrex Bio-Fastak Suture Anchor, Arthrex Headed Bio-Absorbable Corkscrew, Arthrex Bio-Interference Screw, Arthrex Cannulated Interference Screw, Arthrex Suture Anchor Screw, Arthrex Fastak Suture Anchor, Arthrex Parachute Corkscrew Anchor, Arthrex TissueTak, Bionx Bankart Tack PLLA Implant, Bionx Cannulated SmartScrew PLLA Implant, Bionx Contour Labral Nail PLLA Implant, Bionx SmartNail PLLA Implant, Bionx SmartScrew PLLA Implant, Bionx SmartPin PLLA and PGA Implant, Bionx Wedge PLA Implant, Bionx Biocuff PLA Implant, Bionx Meniscus Arrow PLA Implant, Bionx SmartScrew ACL Interference Screw PLA Implant, DePuy Neuflex PIP Finger, Medtronic XOMed EpiDisc Otologic Lamina (model 14-17000)**

C1932 Catheter, SciMed Remedy Coronary Balloon Dilatation Infusion Catheter (20mm), **Dispatch Coronary Infusion Catheter, Ultra Fuse 4mm, Ultra Fuse 8mm, Ultra Fuse-X, AngioDynamics Pulse Spray Infusion Catheter, AngioDynamics Unifuse Infusion Catheter, Cordis Commodore Temporary Occlusion Balloon Catheter, Cordis RapidTransit Infusion Catheter, Cordis Regatta Flow Guided Infusion Catheter, Cordis Prowler Plus Microcatheter, Cordis Prowler Small Profile Infusion Microcatheter, Cordis Plus Microcatheter, Cordis MassTransit Max ID Microcatheter, Cordis Transit Microcatheter , Merit Medical Systems Mistique Infusion Catheter**

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), **Opti-Plast PTA Catheter (5.5 Fr), Tru Trac 5Fr Percutaneous Transluminal Angioplasty Balloon Dilatation Catheter, OptiPlast XT 5 Fr Percutaneous Transluminal Angioplasty Catheter (various sizes)**

C1934 Catheter, Ultraverse 3.5F Balloon Dilatation Catheter, **Interventional Technologies Cutting Balloon**

C1936 Catheter, Uromax Ultra High Pressure Balloon Dilatation Catheters with Hydroplus Coating, **UrethraMax High Pressure Urethral Balloon Dilatation Catheter, Carson Zero Tip Balloon Dilatation Catheters with HydroPlus Coating, Passport Balloon on a Wire Dilatation Catheters with HydroPlus Coating, Tandem Thin-Shaft Transureteroscopic Balloon Dilatation Catheter with Hydro Plus Coating, Trilogy Low Profile Balloon Dilatation Catheters with HydroPlus Coating, Ureteral Dilators with Hydro Plus Coating and Procedural Sheath, Amplatz Renal Dilator Set**

C1937 Catheter, Synergy Balloon Dilatation Catheter, Explorer ST (6 Fr), **Explorer 360 Jr., Explorer 360, Explorer ST, Symmetry Small Vessel Balloon Dilatation Catheter with Glidex Hydrophilic Coating, Symmetry Stiff Shaft Small Vessel Balloon Dilatation Catheter with Glidex Hydrophilic Coating, XXL Large Balloon Dilatation Catheter**

C1938 Catheter, Bard UroForce Balloon Dilatation Catheter, **Cook Urological Urodynamic 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, **Cordis PowerFlex P3 PTA Balloon Catheter**

C1941 Catheter, Jupiter PTA Balloon Dilatation Catheter, **Cordis OPTA ProPTA Dilatation Catheter, Cordis SLALOM PTA Dilatation Catheter**

C1944 Catheter, Rapid Exchange Single-Use Biliary Balloon Dilatation Catheter, **Maxforce Single-Use Biliary Balloon Dilatation Catheter**

C1948 Catheter, Pursuit Balloon Angioplasty Catheter, **Cook Accent Balloon Angioplasty Catheter**

C1981 Catheter, coronary angioplasty balloon, Adante, Bonnie, Bonnie 15mm, Bonnie Monorail 30mm

Devices Eligible for Transitional Pass-Through Payments Under the HO PPS (continued)

or 40mm, Bonnie Sliding Rail, Bypass Speedy, Chubby, Chubby Sliding Rail, Coyote 20mm, Coyote 9/15/25mm, Maxxum, NC Ranger, NC Ranger 9mm, Ranger 20mm, Long Ranger 30mm or 40mm, 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, **ACE—1cm, ACE—2 cm, ACE Graft, Long ACE, Pivot, Cobra (10, 14, 18, 30, 40mm in lengths)**

C2002 Catheter, Irvine Inquiry Steerable Electrophysiology 5F Catheter, **Livewire Steerable Electrophysiology Catheter, Livewire EP Catheter, 7 Fr Duo-Decapolar (model 401932), Marinr, RF Marinr MC**

C2004 Catheter, electrophysiology, **BioSense Webster Deflectable Tip Electrophysiology Catheter**

C2007 Catheter, electrophysiology, Irvine Luma-Cath 6F Fixed Curve Electrophysiology Catheter, **IBI-1000 Inquiry Fixed Curve EP Catheter (5 Fr), IBI-1000 Inquiry Fixed Curve EP Catheter (6 Fr, Bipolar), IBI-1000 Inquiry Fixed Curve EP Catheter (6 Fr, Decapolar), IBI-1000 Inquiry Fixed Curve EP Catheter (6 Fr, Octapolar), IBI-1000 Inquiry Fixed Curve EP Catheter (6 Fr, Quadrapolar), Santoro Fixed Curve Catheter, Ismus Cath Deflectable 20-Pole Catheter/Crista Cath II Deflectable 20-Pole Catheter**

C2010 Catheter, diagnostic, electrophysiology, **Response Fixed Curve Catheter, Supreme Fixed Curve Catheter, Torqr CS, BioSense Webster Fixed Curve Diagnostic Electrophysiology Catheter**

C2018 Catheter, ablation, Polaris T Ablation Catheter, **MECA Ablation Catheter, SteeroCath-A, SteeroCath-T, Polaris LE (7 Fr), Polaris Dx**

C2019 Catheter, EP Medsystems Deflectable Electrophysiology Catheter, **EP Medsystems Non-Deflectable Platinum Electrophysiology Catheter, Cardima Naviport Deflectable Tip Guiding Catheter, Cardima Venaport Guiding Catheter,**

C2020 Catheter, ablation, Blazer II XP, Blazer II 6F, Blazer II High Torque Distal (HTD), **Blazer II (7 Fr)**

C2100 Catheter, electrophysiology, Cardiac Pathways CS Reference Catheter, **Boston Scientific Special Procedure Steero Dx Octa, Boston Scientific Map Pacing Catheter**

C2101 Catheter, electrophysiology, Cardiac Pathways RV Reference Catheter, **Boston Scientific EPT-Dx Steerable**

C2103 Catheter, electrophysiology, Cardiac Pathways 7F Radii Catheter with Tracking, **Boston Scientific Valve Mapper SteeroDx**

C2104 Catheter, electrophysiology, Lasso Deflectable Circular Tip Mapping Catheter, **Cardima Tracer Over-the-Wire Mapping Microcatheter, Cardima PathFinder Microcatheter, Cardima Revelation Microcatheter**

C2152 Catheter, Cordis 5F, 6F, 7F, 8F, 9F, 10F Vista Brite Tip Guiding Catheter, **Cordis 0.056 Vista Brite Tip Guiding Catheter (5 Fr), Cordis Vista Brite Tip IG Introducer Guiding Catheter (7 Fr), Cordis Vista Brite Tip IG Introducer Guiding Catheter (8 Fr), Cordis Vista Brite Tip Supra-Aortic Guiding Catheter (8 Fr), Cordis Vista Brite Tip Supra-Aortic Guiding Catheter (9 Fr), Cordis Envoy Large Lumen Guiding Catheter (5 Fr), Cordis Envoy Large Lumen Guiding Catheter (6 Fr)**

C2300 Catheter, Varisource Standard Catheter, **Nucletron Nasopharyngeal Brachytherapy Catheter**

C2597 Clinicath Peripherally Inserted Midline Catheter (PICC) Dual Lumen PolyFlow Polyurethane Catheter 18G (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 16G (includes catheter and introducer), **BD First MidCath Catheter (3 Fr, 4 Fr, 5 Fr, 20cm/4 Fr, 20cm/5 Fr), Dual Lumen Silicone Midline Catheter Dual Lumen Silicone Midline Catheter (5 Fr/5Fr, 20 cm), BDL Single-Lumen Polyurethane PICC, BDL Single-Lumen Polyurethane Midline Catheter (catheter and introducer only), Bard Per-Q-Cath, Bard Per-Q-Cath Plus, Bard RadPICC, Bard Groshong Peripherally Inserted Central Catheter (PICC), Ethicon Endo-Surgery 18G/ 20G *Single Lumen* BIOVUE Midline Catheter Starter Set (catheter and introducer only), Ethicon Endo-Surgery 18G *Dual Lumen* BIOVUE Midline Catheter Starter Set (catheter and introducer only)**

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), **BD First PICC Catheter, 5Fr Dual Lumen Silicone PICC (catheter and introducer only), BDL 16G/ 18G/20G Dual-Lumen Cath Catheter (catheter and introducer only)**

C2599 Clinicath Peripherally Inserted Central Catheter (PICC) Single-Lumen PolyFlow Polyurethane Catheter 16G/18G/19G (includes catheter and introducer), **BD First PICC Catheter, 1.9 Fr,**

Devices Eligible for Transitional Pass-Through Payments Under the HO PPS (continued)

2.8 Fr, 3 Fr, 4 Fr, 5 Fr Single-Lumen Silicone PICC (catheter and introducer only), Boston Scientific Vaxcel Peripherally Inserted Central Catheter (PICC), Cook Peripherally Inserted Central Venous Catheter, Ethicon Endo-surgery 18G/20G/24G *Single Lumen* BIOVUE Peripherally Inserted Central Catheter Starter Set (catheter and introducer only), Ethicon Endo- surgery 16G/18G *Dual Lumen* BIOVUE Peripherally Inserted Central Catheter Starter Set (catheter and introducer only)

C2601 Catheter, Bard Dual Lumen Ureteral Catheter**, Cook Urological Ureteral Dilatation Balloon, Flexima Ureteral Catheter, Axxcess Ureteral Catheter (6 Fr), C-Flex Ureteral Catheter, Dual Lumen Ureteral Catheter**

C2602 Catheter, Spectranetics 1.4/1.7mm Vitesse Concentric Laser Catheter, **Spectranetics 0.9 mm Vitesse C Concentric Laser Catheter (model 110-003)**

C2605 Catheter, Spectranetics Extreme Laser Catheter, **Spectranetics Extreme 0.9mm Coronary Angioplasty Catheter (model 110-001)**

C2608 Catheter, Scimed 6F Wiseguide Guide Catheter, **Cyber Guide Catheter, Merit Medical Systems Trax Interventional Guide Catheter (7 Fr), Merit Medical Systems Trax Cavern Interventional Guide Catheter (8 Fr), Mighty Max Guide Catheter (7 Fr), Triguide-Flex Guide Catheter (10 Fr)**

C2612 Catheter, InDura Intraspinal Catheter, **EBI VueCath Steerable Spinal Cathet**er, Synchromed Vascular Catheter (models 8702, 8700A, 8700V)

C2803 Defibrillator, dual chamber, implantable, Ventak Prizm DR HE Models 1853, 1858, **Biotronik Tachos DR**

C3003 Lead, defibrillator, implantable**, Endotak SQ Array XP (Model 0085), Endotak SQ Array (models 0048, 0049), Endotak SQ Patch (models 0047, 0063) Endotak Reliance (models 0147, 0148, 0149, S-0127, S-0128, S-0129)**

C3400 Prosthesis, breast, Mentor Saline-Filled Contour Profile, Mentor Siltex Spectrum Mammary Prosthesis, **Mentor Siltex Gel-Filled Mammary Prosthesis, Smooth-Surface Gel-Filled Mammary Prosthesis, Mcghan Biodimensional Anatomical Tissue Expander Saline-Filled (BioSpan Textured, Style 133, 133FV, 133MV, 133LV), Mentor Tissue Expander, Mentor Contour Profile Tissue Expander, Mentor Siltex Becker Expander/ Mammary Prosthesis**

C3401 Prosthesis, breast, Mentor Saline-Filled Spectrum, **Mcghan BioCurve Round, BioCell Textured, Saline-Filled Moderate Profile (Style 168), Mcghan BioCurve Round, Smooth Saline-Filled Moderate Profile (Style 68), Mcghan Biodimensional BioCurve Shaped (BioCell Textured Full Height, Saline Filled, Style 163), Mcghan Breast Implant Smooth Silicone-Filled Intrashiel Barrier (Moderate Profile, Round, Style 110), Mcghan BioCell Textured Silicone-Filled Intrashiel Barrier (Standard Profile, Round, Style 40)**

C3500 Prosthesis, penile, Mentor Alpha I Inflatable Penile Prosthesis, Mentor Alpha I Narrow-Base Inflatable Penile Prosthesis**, Mentor Acu-Form Malleable Penile Prosthesis, Mentor Malleable Penile Prosthesis**

C3551 Guide wire, percutaneous transluminal coronary angioplasty, Choice, Luge, Patriot, PT Graphix Intermediate, Trooper, Mailman 182/300 cm, **Glidewire Gold Guidewire, Platinum Plus Guidewire, Platinum Plus Guidewire with Glidex Hydrophilic Coating, Jagwire Single-Use High Performance Guide Wire, Merit Medical Systems Extender Guidewire, Merit Medical Systems Tomcat PTCA Guidewire, Platinum Plus Guide Wire (0.014 and 0.018 in diameters)**

C3552 Guide wire, Hi-Torque Whisper, **Zebra Single-Use Exchange Guidewire**

C3553 Guide wire, Cordis Stabilizer Marker Wire Steerable Guidewire, Cordis Wizdom Marker Wire Steerable Guidewire, Cordis ATW Marker Wire Steerable Guidewire, Cordis Shinobi Steerable Guidewire, **Cordis ATW Steerable Guidewire, Cordis Cinch QR Steerable Guidewire Extension, Cordis Stor Q Guidewire, Cordis Essence Steerable Guidewire, Cordis Instinct Steerable Guidewire, Cordis Agility 10 Hydrophilic Steerable Guidewire, Cordis Agility 14 Hydrophilic Steerable Guidewire, Cordis Stabilizer Balanced Performance Guidewire, Cordis Stabilizer Plus Steerable Guidewire, Cordis Shinobi Plus Steerable Guidewire (models 547-214, 547-214X), Cordis Stabilizer XS Steerable Guidewire (models 527-914, 527-914J, 527-914X, 527-914Y), Cordis SV Guidewire—5cm Distal Taper Configuration (models 503-558, 503-558X), 8cm Distal Taper Configuration (models 503-658, 503-658X), 14cm Distal Taper Configuration (models 503-758, 503-758X), Cordis Wisdom ST Steerable Guidewire (models 537-114, 537-114J, 537-114X, 537-114Y)**

C3557 Guidewire, HyTek Guidewire, **Biotronik Galeo Hydro Guide Wire, Microvena Ultra Select Nitinol Guidewire, Wilson-Cook Axcess 21 Wire Guide, Wilson-Cook Roadrunner Extra Support Wire Guide, Wilson-Cook Tracer Wire Guide, Wilson-Cook Tracer Hybrid**

Devices Eligible for Transitional Pass-Through Payments Under the HO PPS (continued)

Wire Guide, Wilson-Cook Tracer Metro Wire Guide, Wilson-Cook Protector Wire Guides

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

C4300 Pacemaker, dual chamber, Integrity AFx DR Model 5342, **Integrity U DR 5336**

C4600 Lead, pacemaker, Synox, Polyrox, Elox, Retrox, SL-BP, ELC, **PR-B Permanent Implantable Pacing Lead (models PR 44 B, PR 48 B, PR 52 B, PR 58 B), PR-S Permanent Implantable Pacing Lead (models PR 44 S, PR 48 S, PR 52 S, PR 58 S), PY-PSBV Permanent Implantable Pacing Lead (models PY 44 PSBV, PY 48 PSBV, PY 52 PSBV, PY 58 PSBV), PY-PV Permanent Implantable Pacing Lead (models PY 48 PV, PY 52 PV, PY 58 PV), ZY-PBV Permanent Implantable Pacing Lead (models ZY 52 PBV, ZY 58 PBV), ZY-PJBV Permanent Implantable Pacing Lead (models ZY 48 PJBV, ZY 52 PJBV), ZY-PJUSBV Permanent Implantable Pacing Lead (models ZY 44 PJUSBV, ZY 48 PJUSBV, ZY 52 PJUSBV), ZY-PJUV Permanent Implantable Pacing Lead (models ZY 48 PJUV, ZY 52 PJUV), ZY-PJV Permanent Implantable Pacing Lead (models ZY 48 PJV, ZY 52 PJV), ZY-PUSBV Permanent Implantable Pacing Lead (models ZY 52 PUSBV, ZY 58 PUSBV), ZY-PUV Permanent Implantable Pacing Lead (models ZY 52 PUV, ZY 58 PUV), ZY-PV Permanent Implantable Pacing Lead (models ZY 52 PV, ZY 58 PV)**

C4603 Lead, pacemaker, Oscor PR 4015, 4016, 4017, 4018, Flexion 4015, 4016, 4017, 4018, **ELA Medical Stela Pacing Lead (models BJ44, BJ45), ELA Medical Stelid II Pacing Lead (model BTFR26D), ELA Medical Stelix Pacing Lead (model BR45D), HT-PB Permanent Implantable Pacing Lead (models HT 48 PB, HT 52 PB, HT 58 PB), HT-PB Permanent Implantable Pacing Lead (models HT 48 PB, HT 52 PB, HT 58 PB), Oscor PY (models 4439, 4440, 4441), Oscor ZY (models 4036, 4037, 4038, 4039, 4042, 4056, 4057), RT-TJV Permanent Implantable Pacing Lead (models RT 48 TJV, RT 52 TJV), RT-TV Permanent Implantable Pacing Lead (models RT 52 TV, RT 58 TV), RU-TBV Permanent Implantable Pacing Lead (models RU 52 TBV, TU 58 TBV, RU 70 TBV), RU-TJSBV Permanent Implantable Pacing Lead (models RU 44 TJSBV, RU 48 TJSBV, RU 52 TJSBV), RU-TJV Permanent Implantable Pacing Lead (models RU 48 TJV, RU 52 TJV), RU-TSBV Permanent Implantable Pacing Lead (models RU 52 TSBV, RU 58 TSBV, RU 70 TSBV), RU-TV Permanent Implantable Pacing Lead (models RU 52 TV, RU 58 TV)**

C4607 Lead, pacemaker, Fineline II 4452, 4453, 4454, 4455, 4477, 4478, Fineline II EZ 4463, 4464, 4465, 4466, 4467, 4468, Thinline II 430-25, 430-35, 432-35, Thinline II EZ 438-25, 438-35, **Fineline II EZ Sterol (models 4469, 4470, 4471, 4472, 4473, 4474), Fineline II Sterox (models 4456, 4457, 4459, 4479, 4480), Thinline II EZ Sterox (models 438-25S, 438-35S), Thinline II Sterox (models 430-25S, 430-35S, 432-35S)**

C5001 Stent, biliary, Bard Memotherm-Flex Biliary Stent (small/medium diameter)

C5011 Stent, biliary, IntraStent, IntraStent LP, **Wilson-Cook ST2 Soehendra Tannenbaum**

C5012 Stent, biliary, IntraStent DoubleStrut LD, **IntraStent Double Strut Para Mount Biliary Stent, Olympus Double Layer Biliary Stent**

C5016 Stent, biliary, Wallstent Single-Use Covered Biliary Endoprosthesis with Unistep Plus Delivery System, **Gore Biliary Endoprosthesis**

C5027 Stent, coronary, BX Velocity with Hepacoat on Raptor Stent System (8 or 13mm in length), **BX Velocity e.5/5.0 Balloon Expandable Stent with RAPTOR Over-the-Wire Delivery System**

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), **BiodivYsio AS PC Coated Coronary Stent Delivery System (11mm)**

C5031 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), **BiodivYsio AS PC Coated Coronary Stent Delivery System (15mm)**

C5033 Stent, coronary, Niroyal Advance Premounted Stent System (9mm), **Tenax-XR Stent and Delivery system**

C5039 Stent, peripheral, IntraCoil Peripheral Stent (40mm stent length), **Dynalink Peripheral Self-Expanding Stent System**

C5041 Stent, coronary, Medtronic BeStent 2 Over-the-Wire Coronary Stent System (24mm, 30mm), **Medtronic BeStent 2 Rapid Exchange Coronary Stent System (24mm, 30mm)**

C5042 Stent, coronary, Medtronic BeStent 2 Over-the-Wire Coronary Stent System (18mm), **Medtronic BeStent 2 Rapid Exchange (18mm)**

C5043 Stent, coronary, Medtronic BeStent 2 Over-the-Wire Coronary Stent System (15mm), **Medtronic BeStent 2 Rapid Exchange (15mm)**

C5044 Stent, coronary, Medtronic BeStent 2 Over-the-Wire Coronary Stent System (9mm, 12mm), **Medtronic BeStent 2 Rapid Exchange**

Devices Eligible for Transitional Pass-Through Payments Under the HO PPS (continued)

Coronary Stent System (9mm, 12mm)

C5279 Stent, ureteral, Boston Scientific Contour Soft Percuflex Stent with Hydroplus Coating (Braided), Contour Soft Percuflex Stent with Hydroplus Coating, Contour VL Variable Length Percuflex Stent with Hydroplus Coating, Percuflex Plus Stent with Hydroplus Coating, Percuflex Stent (Braided), Contour Closed Soft Percuflex Stent with HydroPlus Coating, Contour Injection Soft Percuflex Stent with HydroPlus Coating, Soft Percuflex Stent, Percuflex Tail Plus Tapered Ureteral Stent, **Contour Polaris Ureteral Stent with Hydroplus Coating, Mardis Firm Stent with HydroPlus Coating, Mardis Soft Stent with HydroPlus Coating, Mardis Soft Variable Length Stent with HydroPlus Coating, Nottingham One-Step Tapered Dilators with HydroPlus Coating, Stretch VL Variable Length Flexima Stent with HydroPlus Coating, Percuflex Urinary Diversion Stent**

C5280 Stent, ureteral, Bard Inlay Double Pigtail Ureteral Stent, **Cook Klein Rectal Tamponade Balloon, Cook Urological Cystostomy Catheter, Cook Urological Ureteral Dilator Set, Cook Urological Fascial Dilator Set, Circon Surgitek Classic Double Pigtail Ureteral Stent, Circon Surgitek Classic Double Pigtail Hydrophilic Coated Ureteral Stent, Circon Surgitek QuadraCoil Ureteral Stent, Circon Surgitek Double J II Ureteral Stent, Circon Surgitek Lithostent Ureteral Stent, Circon Surgitek Soft-Curl Ureteral Stent, Cook Urological LSe Double Pigtail Ureteral Stent, Cook Urological LSe Multi Length Ureteral Stent, Cook Urological Multi Length Ureteral Stent, Cook Urological Double Pigtail Ureteral Stent, Cook Urological Double Pigtail Ureteral Stent with AQ (Hydrophilic) Coating, Cook Urological Mazer Antegrade Double Pigtail Ureteral Stent Set**

C6001 Mesh, hernia, Bard Composix Mesh, per 8 or 21 inches, **Atrium Hernia/Surgical Mesh, Bard Composix E/X Mesh, Bard Kugel Hernia Patch (large circle, 12 cm x 12 cm), Bard Kugel Hernia Patch (small circle, 8 cm x 8 cm), Bard Kugel Hernia Patch (large oval, 14 cm x 18 cm), Bard Kugel Hernia Patch (medium oval, 11 cm x 14 cm), Bard Kugel Hernia Patch (small oval, 8 cm x 12 cm), Bard Mesh PerFix Plug, Bard Visilex Mesh (3 in x 6 in), Bard Visilex Mesh (4.5 in x 6 in)**

C6012 Pelvicol Acellular Collagen Matrix, per 8 or 14 square centimeter**s, Contigen Bard Collagen Implant (Contigen Implant)**

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, **Advanced UroScience Acyst**

C6200 Vascular graft, Exxcel Soft ePTFE Vascular Graft, **Exxcel ePTFE Vascular Graft (6mm or greater in diameter), B. Braun Vena Tech LGM Vena Cava Filter (Dual Approach—model # 31328, Jugular Approach—model # 31326, Femoral Approach—model # 31327), Cordis TrapEase Permanent Vena Cava Filter, Stainless Steel Green Field Vena Cava Filter with 12 Fr Introducer System**

C6201 Vascular graft, Impra Venaflo Vascular Graft with Carbon (Straight Graft, 10cm or 20cm in length), **Atrium Hybrid PTFE Vascular Graft**

C6205 Vascular graft, Impra Carboflo Vascular Graft (Straight Graft, 10 cm in length), **Atrium Advanta PTFE Vascular Graft**

C6210 Exxcel ePTFE Vascular Graft (less than 6mm in diameter), **Hemashield Woven Double Velour Fabric, Hemashield Finesse Ultra-thin, Knitted Cardiovascular Patch**

C6650 Introducer, guiding, Fast-Cath Two-Piece Guiding Introducer (models 406869, 406892, 406893, 406904), **AccuStick II with RO Marker Introducer System, Cook Extra Large Check-Flo Introducer, Cook Keller-Timmermans Introducer, Fast-Cath Hemostasis Introducer, Maximum Hemostasis Introducer, Fast-Cath Duo SL1 Guiding Introducer, Fast-Cath Duo SL2 Guiding Introducer**

C6652 Introducer, Bard Safety Excalibur Introducer, **Bard Radstic Microintroducer, Bard Universal Microintroducer**

C6700 Synthetic absorbable sealant, Focal Seal-L, **PerFluoron (per 2ml vial, 5ml vial, or 7ml vial)**

C8099 Spectranetics Lead Locking Device (models 518-018, 518-019, 518-020), **Oscor C/VS Permanent Implantable Pacing Lead Adaptor (models C/VS-10, C/VS-40), Oscor M/VS Permanent Implantable Pacing Lead Adaptor (models M/VS-10, M/VS-40), Oscor VS/M Permanent Implantable Pacing Lead Adaptor (model VS/M-10), Oscor VV Permanent Implantable Pacing Lead Extension (models VV-10, VV-40)**

L8614 Cochlear device/system

Devices Eligible for Transitional Pass-Through Payments Under the HO PPS (continued)

Devices Previously Assigned to "New Device Technology"

The following device list is for reference purposes only. These devices were previously designated as "new device technology" APCs. These devices were assigned C-codes C8500 through C8891. Effective January 20, 2001, these devices are reclassified as devices eligible for transitional pass-through payments. After April 1, 2001, each device may be reported under the pass-through code indicated in the left column of the device list.

Pass-Through C-codes	Long Descriptor	Previous C-code Listing
C1003	Catheter, 7 Fr CSM Livewire EP Catheter (model 401935), 5FR Decapolar (models 401938, 401939, 401940, 401941)	C8550
C1007	Prosthesis, penile, Dura II Penile Prosthesis	C8514
C1007	AMS Malleable 650 Penile Prosthesis	C8534
C1029	MS Classique Balloon Dilation Catheter	C8528
C1029	Catheter, Quantum Dilation Balloon	C8539
C1043	Catheter, atherectomy, Atherocath-GTO Atherectomy Catheter	C8500
C1055	Balloon dilator, esophageal, Flex-EZ Balloon Dilator	C8540
C1067	Stent, biliary, PALMAZ Balloon Expandable Stent and Delivery System	C8522
C1067	Stent, biliary, Wallstent Transhepatic Biliary Endoprosthesis	C8523
C1067	Stent, biliary, Spiral Z Biliary Metal Expandable Stent, Za Biliary Metal Expandable Stent	C8535
C1068	Pacemaker, dual chamber, Unity VDDR (model 292-07)	C8750
C1071	Pacemaker, single chamber, Vigor SSI	C8501
C1115	Lead, pacemaker, 4057M, 4058M, 4557M, 4558M, 5058	C8506
C1115	Lead, pacemaker, 2188 Coronary Sinus Lead	C8775
C1115	Lead, pacemaker, Innomedica Sutureless Myocardial (models 4045, 4046, 4047, 4058)	C8776
C1115	Lead, pacemaker, Unipass (models 425-02, 425-04, 425-06)	C8777
C1118	Pacemaker, single chamber, Legacy II S C8520	
C1154	Lead, defibrillator, 6721L, 6721M, 6721S, 6939 Oval Patch Lead	C8507
C1154	Lead, defibrillator, CapSure 4965	C8508
C1154	Lead, defibrillator, Transvene 6933, Transvene 6937	C8509
C1154	Lead, defibrillator, DP-3238	C8510
C1154	Lead, defibrillator, EndoTak DSP	C8511
C1306	Lead, neurostimulation, On-Point Model 3987, Pisces—Quad Plus Model 3888, Resume TL Model 3986	C8512
C1306	Lead, neurostimulation, Pisces—Quad Model 3487a, Resume II Model 3587a	C8513
C1306	Lead, neurostimulation, Octad Lead 3898-33/389861	C8724
C1306	Lead, neurostimulation, SymMix Lead 3982	C8725
C1315	Pacemaker, dual chamber, Vigor DDD	C8518
C1315	Pacemaker, dual chamber, Vista DDD	C8519
C1319	Stent, esophageal, Wallstent Esophageal Prosthesis with Delivery System	C8524
C1319	Stent, esophageal, Wallstent Esophageal Prosthesis (Double)	C8525
C1319	Wilson-Cook Esophageal Z Metal Expandable Stent	C8531
C1319	Stent, esophageal, Ultraflex Esophageal Stent System	C8532
C1319	Stent, esophageal, Esophageal Z Metal Expandable Stent with Dua Anti-reflux Valve, Esophageal Z Metal Expandable Stent with Uncoated Flanges	C8536
C1333	Stent, biliary, Large Palmaz Balloon Expandable Stent with Delivery System	C8800

Devices Eligible for Transitional Pass-Through Payments Under the HO PPS (continued)

Pass-Through C-codes	Long Descriptor	Previous C-code Listing
C1333	Stent, biliary, Cook Z Stent Gianturco-Rosch Biliary Design	C8801
C1333	Stent, biliary, Cook Oasis One Action Stent Introductory System	C8802
C1334	Stent, coronary, Cook Gianturco-Roubin Flex-Stent Coronary Stent	C8830
C1369	Receiver/transmitter, neurostimulator, Medtronic Mattrix	C8521
C1933	OptiPlast XT 5 Fr Percutaneous Transluminal Angioplasty Catheter (various sizes)	C8526
C1936	Balloon dilator, ureteral, Carson Zero Tip Balloon Dilatation Catheters with HydroPlus Coating, Passport Balloon on a Wire Dilatation Catheters with HydroPlus Coating	C8541
C1936	Balloon dilator, urethra, UrethaMax High Pressure Urethral Balloon Dilatation Catheter	C8542
C1936	Amplatz Renal Dilator Set	C8543
C2002	Catheter, diagnostic, electrophysiology, Livewire Steerable Electrophysiology Catheter	C8502
C2002	Catheter, Livewire EP Catheter, 7 Fr Duo-Decapolar (model 401932)	C8551
C2007	Ismus Cath deflectable 20-Pole Catheter/Crista Cath II Deflectable 20-Pole Catheter	C8529
C2007	Catheter, Santoro Fixed Curve Catheter	C8552
C2612	Catheter, Synchromed Vascular Catheter (model 8702)	C8503
C2612	Catheter, Synchromed Vascular Catheter (models 8700A, 8700V)	C8533
C3003	Lead, defibrillator, Endotak SQ Patch 0047, 0063	C8748
C3003	Lead, defibrillator, Endotak SQ Array 0048, 0049	C8749
C3400	Mentor Siltex Gel-Filled Mammary Prosthesis, Smooth-Surface Gel-Filled Mammary Prosthesis	C8530
C3500	Prosthesis, penile, Mentor Acu-Form Malleable Penile Prosthesis, Mentor Malleable Penile Prosthesis	C8516
C3553	Guide wire, Cordis Wisdom ST Steerable Guidewire (models 537-114, 537-114J, 537-114X, 537-114Y)	C8597
C3553	Guide wire, Cordis SV Guidewire—5cm Distal Taper Configuration (models 503-558, 503-558X), 8cm Distal Taper Configuration (models 503-658, 503-658X), 14cm Distal Taper Configuration (models 503-758, 503-758X)	C8598
C3553	Guide wire, Cordis Stabilizer XS Steerable Guidewire (models 527-914, 527-914J, 527-914X, 527-914Y)	C8599
C3553	Guide wire, Cordis Shinobi Plus Steerable Guidewire (models 547-214, 547-214X)	C8600
C3800	Infusion pump, implantable, programmable, SynchroMed Infusion Pump	C8505
C6650	Introducer, Cook Extra Large Check-Flo Introducer	C8650
C6700	PerFluoron, per 2ml	C8890
C6700	PerFluoron, per 5ml vial or 7ml vial	C8891

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, even if it is the same type of device.

The outpatient code editor and PRICER systems currently contain the codes included in this article. 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.

The listing of HCPCS codes contained in this article 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 article must be considered reasonable and necessary.

Additional Information on Transitional Pass-Through Devices and Drugs

The Health Care Financing Administration has issued additional information addressing devices and drugs that qualify for transitional pass-through payments under the hospital outpatient prospective payment system (OPPS).

The Outpatient Code Editor and PRICER systems currently contain the codes included in this document.

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

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

Pass-Through Devices Effective January 20, 2001

This section contains a list of items that were approved effective January 20, 2001, however, they were inadvertently omitted from the list of items that were submitted for the April 2001 update and approved for pass-through status. Therefore, these devices must be added to the long descriptors for each assigned C-codes.

C-Code **Long Descriptor**

C1036 R Port Premier Vascular Access System (model 45-155), Sims Deltec Pro Port Single Lumen Low Profile Implantable Venous Access System, Sims Deltec Port-A-Cath II Dual Lumen Low Profile Implantable Venous Access System, Sims Deltec Port-A-Cath II Fluoro-Free Implantable Venous Access System, Sims Deltec P.A.S. Port Fluoro-Free Implantable Peripheral Venous Access System, Sims Deltec P.A.S. Port T2 Implantable Peripheral Venous Access System, Sims Deltec P.A.S. Port T2 Fluoro-Free Implantable Peripheral Venous Access System, Sims Deltec P.A.S. Port T2 Elite Implantable Peripheral Venous Acces System, Sims Deltec P.A.S. Port Elite Implantable Peripheral Venous Access System, Sims Deltec Port-A-Cath II Implantable Epidural System Low Profile Venous Access System, Cook Vital Port Access Set, Horizon Medical MicroPort 2 Peripheral Access System

C1104 Catheter, ablation, RF Conductr MC—EXT (with stiffer tip) 07864447, 078754447

C1811 Depuy Neuflex MCP Finger Joint Prosthesis, Depuy Ace Timax Calcaneal Peri-articular Plate, Depuy Ace Timax Pilon Plate, Depuy Ace Timax Meta Plate, Depuy Spider Plate, Depuy Total Elbow (Acclaim Elbow), Wright Medical Technology Swanson Titanium Carpal Lunate Implant

C1812 Depuy Scarf Threaded-head Screw, Depuy Twist Off Screw, Depuy Rockwood Clavicle Pin, Depuy Scarf Threaded-head Screw (Millenium Screw) C4603 KY-SBV Oscor Permanent Implantable Pacing Lead (KY-48 SBV, KY 52 SBV, KY 58 SBV), KY-USBV Oscor Permanent Implantable Pacing Lead (KY 48 USBV, KY 52 USBV, KY 58 USBV, KY 70 USBV), KY-UV Oscor Permanent Implantable Pacing Lead (KY 48 UV, KY 52 UV, KY 58 UV, KY 70 UV), KY-V Oscor Permanent Implantable Pacing Lead (KY 48 V, KY 52 V, KY 58 V, KY 70 V)

C4607 Lead, pacemaker, Fineline II Sterox 4458

C6051 DePuy Orthotech Restore

C8099 Oscor C/VS Permanent Implantable Pacing Lead Extension (VKU-10V, VKU-20V, VKU-40V, VKU-10M, VKU-20M, VKU-40M), Oscor C/VS Permanent Implantable Pacing Lead Adaptor (BVS/VS-15, B/VS-15, B/VS-20)

Pass-Through Drugs Effective April 1, 2001

This section contains a list of transitional pass-through drugs that were submitted for the April 2001 update that have been approved for transitional pass-through status.

C-Code	SI	APC	Long Descriptor	Payment Rate	Minimun Unadjustted Co-insurance
C9012	G	9012	Injection, arsenic trioxide, per ampule	$237.50	$34.00
C9013	G	9013	Supply of Co 57 cobaltous chloride, radiopharmaceutical diagnostic imaging agent, per ml	$10.03	$1.44
C9017	G	9017	Lomustine, 10 mg	$109.80	$15.72

Pass-Through Items No Longer Eligible for Pass-Through Payments Effective April 1, 2001

This section contains a list of items that were previously approved for pass-through status but **will not be approved** for pass-through status effective April 1, 2001. The items in this section were mistakenly approved for transitional pass-through payments.

C-Code **Long Descriptor**

C1056* Cook Chorionic Villus Sampling Set, Cook Intrauterine Insemination Catheter, Cook Jansen- Anderson Insemination Set, Product Health Induct Breast Microcatheter

C1111[#] Stent graft system, AneuRx Aorto-Uni-Iliac-Stent Graft System

C1112[#] 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

C1117[#] Endograft system, Ancure Endograft Delivery System

C1852[*] TransCyte, per 247 square centimeters

C1872[*] Dermagraft, per 37.5 square centimeters

C5280[*] Cook Klein Rectal Tamponade Balloon

C6300[#] Stent graft system, Vanguard III Bifurcated Endovascular Aortic Graft

C6600[*] Probe, Microvasive Swiss F/G Lithoclast Flexible Probe .89mm, Microvasive Swiss F/G Lithoclast Flexible Probe II .89mm

J1650[**] Enoxaparin sodium 10 mg

[*]Items are not eligible for pass-through status because they are not surgically implanted or inserted into the patient.
[**]Drug is not eligible for pass-through status under the hospital OPPS effective April 1, 2001.
[#]Devices not eligible for pass-through status because the associated procedures are listed in the "inpatient only" list.

Pass-Through Item Redesignated as a "New Technology" APC Effective April 1, 2001

This section redesignates PROSORBA Column (extracorporeal immunoadsorption Protein A column) from transitional pass-through status to a "new technology procedure/service" status. This item should not have been approved for transitional pass-through payment as a device but rather should have been approved as a "new technology procedure/service."

C-Code	Long Descriptor	Old SI	New SI	Old APC	New APC
C1050	Protein A immunoadsorption, PROSORBA Column	H	S	1410	0976

C-Codes Replaced With Designated National HCPCS Codes Effective April 1, 2001

This section contains a list of three C-codes that are no longer reportable under the hospital OPPS.

These C-codes have been replaced with designated national HCPCS codes. For reporting purposes under the hospital OPPS, the national HCFA Common Procedure Coding System (HCPCS) codes must be reported rather than the C-codes.

C-Code	Long Descriptor	Replacement HCPCS Code	Long Descriptor
C1045	Supply of radiopharmaceutical diagnostic imaging agent, I-131 MIBG [iobenguane sulfate I-131], per 0.5 mCi	A9508	Supply of radiopharmaceutical diagnostic imaging agent, iobenguane sulfate I-131, per 0.5 mCi
C1089	Supply of radiopharmaceutical diagnostic imaging agent, cyanocobalamin Co 57, 0.5 mCi, capsule	Q3012	Supply of oral radiopharmaceutical diagnostic imaging agent, cyanocobalamin cobalt Co57, per 0.5 mCi
C1360	Ocular photodynamic therapy	67221	Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion)

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.

Categories for Use in Coding Devices Eligible for Transitional Pass-Through Payments Under the Hospital Outpatient Prospective Payment System

The Health Care Financing Administration (HCFA) has issued instructions for the implementation of **category** codes for use in making transitional pass-through payments for devices under Medicare's outpatient prospective payment system (OPPS). These instructions apply to medical devices, including devices of brachytherapy and cryoablation. Transitional pass-through payments for drugs or biologicals are **not** affected by the changes discussed in this article and the three subsequent articles in this publication.

Overview

Since the inception of OPPS, transitional pass-through payments have been made on the basis of codes [C-codes of the HCFA Common Procedure Coding System (HCPCS)] defined for individual devices (e.g., Acme dual chamber pacemaker). C-codes have been assigned by HCFA exclusively for this purpose. Only devices specifically identified in the long descriptions associated with the codes have been qualified for transitional pass-through payments. In some instances, the same code has been used for several similar devices, each specifically identified. This coding practice has been referred to as "item specific."

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 requires the establishment of categories for purposes of determining transitional pass-through payment for devices, effective April 1, 2001. For items furnished **on or after April 1, 2001,** hospitals should bill using the new defined category C-codes when furnishing devices that qualify for transitional pass-through payment. (See pages 85-86) These new codes are also in the C series of HCPCS and are exclusively for use in billing for transitional pass-through payments. Each item previously determined to qualify fits in one of these categories. Other items may be billed using the category codes, even though HCFA has not qualified them on an item-specific basis, as long as they:

A. Meet the definition of a device that qualifies for transitional pass-through payments and other requirements and definitions put forth below under "Devices Eligible for Transitional Pass-through Payments" section;
B. Are described by the long descriptor associated with an active category code assigned by HCFA in this or in subsequent publications; and
C. Accord with definitions of terms and other general explanations issued by HCFA to accompany coding assignments in this or subsequent publications.

The categories presented in this publication are based only on devices previously qualified for transitional pass-through payment on an item-specific basis. As is explained below, other devices not previously qualified will also fit in these categories if they meet the applicable descriptors and instructions. If a device does not meet the description of any established category and the other coding instructions, even though it appears to meet the other requirements, it may not be billed for transitional pass-through payments until an applicable category is established by HCFA. Additional categories created by HCFA will be published in subsequent publications.

This instruction addresses how devices that qualify for transitional pass-through payments are to be coded. The introduction of categories makes no changes with respect to how payment amounts are calculated. The transitional pass-through payment for a device will continue to be based on the charge on the individual bill, reduced to cost, and subject (in some instances) to a deduction that represents the cost of similar devices already included in the ambulatory payment classification (APC) payment rate. The PRICER software makes such deductions in processing the claim.

The qualification of a device for transitional pass-through payments is temporary. Most of the categories established here will expire on January 1, 2003. (The underlying provision is permanent, and categories established later will expire in successive years.) At that time, APC payment rates will be adjusted to reflect the costs of devices (and drugs and biologicals) that received transitional pass-through payments. These adjustments will be based on claim data that reflect the use of codes for transitional pass-through devices, drugs and biologicals in conjunction with the CPT codes for the associated procedures. While some of the categories established here include devices that vary significantly in cost, claim data that shows use of CPT and device together will allow HCFA to insure appropriate assignment of these costs to relevant APCs.

The Outpatient Code Editor (OCE) and PRICER system currently contain the codes included in this document. Because of time constraints, several short descriptors have not been updated in the OCE for the April 2001 update. However, the correct short descriptors will be shown on remittance advice, crossover claims, and Medicare summary notices. The short descriptors will be modified to be consistent with the long descriptors in the July 2001 update.

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.

Roles of Hospitals, Manufacturers, and HCFA

In general, hospitals are ultimately responsible for the content of the bills they present to Medicare. Determining which category code is applicable for a specific item will be the responsibility of the billing hospital. Hospitals are expected to make these determinations in accord with these instructions and with usual coding and billing practices. They may rely on information presented here and in subsequent HCFA issuances noted below. Claims for outpatient prospective payment services are subject to the same review process as other hospital claims.

Many device manufacturers routinely provide hospital customers with information about appropriate coding of their devices. This information provided by manufacturers in this manner can significantly simplify the hospitals' task in determining how to bill transitional pass-through payments. Accordingly, HCFA, in reviewing for appropriate billing of transitional pass-through items, will regard such information as, in general, reasonable support for a coding decision with respect to whether payment was appropriate. If hospitals have questions about appropriate

Categories for Use in Coding Devices Eligible for Transitional Pass-Through Payments (continued)

coding that they cannot resolve on their own, the appropriate first step would be to seek information from the manufacturer.

While HCFA expects hospitals, with the assistance of manufacturers, to be able to make the vast majority of coding decisions appropriately on the basis of information in this and subsequent instructions, a few problematic cases may nonetheless emerge. To help address such cases, HCFA will provide information on whether a particular device may be billed for transitional pass-through payments and/or which category would be applicable. HCFA does not expect that such information will be needed except in a very few ambiguous cases. To make such a judgment, HCFA will need information that is readily available only from the manufacturer. In some instances, consideration of such questions may reveal the need for an application from a manufacturer for a new category. Accordingly, a hospital wishing to secure such clarification is encouraged to first work with and through the manufacturer, rather than contacting HCFA directly. HCFA will post on its Web page the results of any requests received for such decisions. HCFA does not have to have qualified a particular device for transitional pass-through payment before a hospital can bill for the device. In general, hospitals are expected to make appropriate coding decisions based on these instructions and other information available to them.

Devices Eligible for Transitional Pass-through Payments

The definition of devices was elaborated in an Interim Final Rule with Comment Period published in the *Federal Register* on August 3, 2000 (65 FR 47670; the regulatory changes in that rule are compiled at 42 CFR 419.43). HCFA's implementation of BIPA will necessitate changes in certain aspects of this definition of devices. In particular, one aspect of that definition, dealing with whether Medicare paid for a device in outpatient departments as of December 31, 1996, no longer apply effective April 1, 2001. BIPA also requires the test of whether the cost of a device is "not insignificant" to be applied on the basis of the average cost of devices in a category, not an individual item. (HCFA will make determinations about whether a category passes the "not insignificant" test when it establishes new categories. Hospitals do not make these determinations and should assume any category established by HCFA meets this test.) HCFA will revise the regulations as soon as possible to reflect the changes made by BIPA. In the meantime, for coding purposes on or after April 1, 2001, hospitals and others must rely on the following information regarding which devices are eligible for transitional pass-through payments:

A. They are described by the long descriptor of a C code issued by HCFA for this purpose and meet other definitions and general coding instructions in this or subsequent instructions.
B. They have been approved or cleared for use by the Food and Drug Administration (FDA), if such approval or clearance is required and subject to the exception for certain investigational devices noted in C.
C. They are considered to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part, as required by section 1862(a)(1)(A) of the Social Security Act ("the Act"0. Some investigational devices are refinements or replications of existing technologies and may be considered reasonable and necessary. Such devices that have received an FDA investigational device exemption (IDE) and are classified by the FDA as Category B devices are eligible for transitional pass-through payments if all other requirements are met.
D. They are an integral and subordinate part of the procedure performed, are used for one patient only, are single use, come in contact with human tissue, and are surgically implanted or inserted whether or not they remain with the patient when the patient is released from the hospital outpatient department.
E. They are not equipment, instruments, apparatuses, implements, or such items for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (HCFA Pub. 15-1).
F. They are not materials and supplies (such as sutures, customized surgical kits, or clips, other than radiological site makers) furnished incident to a service or procedure. Supplies include pharmacological imaging and stressing agents other than radiopharmaceutical or contrast agents (for which transitional pass-through payments are authorized under section 1833(t)(6)(A) of the Act).
G. They are not materials such as biologicals or synthetics that may be used to replace human skin.

To qualify for a transitional pass-through payment, a device must meet all of these requirements, and in addition it must be medically necessary in a particular case. Medicare only makes transitional pass-through payments for a device in conjunction with a procedure for its implantation or insertion. Consequently, a device will only be considered medically necessary and eligible for a transitional pass-through payment if the associated procedure is also medically necessary and payable under the outpatient prospective payment system.

In coding devices for transitional pass-through payments, an important concern is to ensure that the items in fact meet the requirements for transitional pass-through payments. These payments are not available for supplies or for capital equipment, and HCFA is concerned that transitional pass-through payments not be inadvertently made for such items. Thus, for example, scalpels and coagulators are considered supplies because they are neither implanted (like a pacemaker) nor surgically inserted (like an ablation catheter) in a patient. The cost of these and other supplies are "packaged" into the APC payment rates for surgeries, and they do not qualify for separate transitional pass-through payments. Similarly, monitors or EKG machines that are used on multiple patients are treated as capital equipment. Costs of these items are amortized and packaged in the payments for applicable APCs. In making determinations of which individual devices qualify for transitional pass-through payments, HCFA excluded both supplies and capital equipment, and the need to do so is not changed by the introduction of categories. Hospitals should be vigilant in not billing for transitional pass-through payments for either supplies or capital equipment.

General Coding, Billing Instructions and Explanations for Categories Used in Coding Devices Eligible for Transitional Pass-Through Payments

The following article is the first release (Release 2001-01) issued by the Health Care Financing Administration on general coding, billing instructions and explanations for categories used in coding devices elegible for transitional pass-through payments. Subsequent releases will be posted on HCFA's Web site (**www.hcfa.gov**) for ready reference, and published in future bulletins as they become available.

Kits: Manufacturers frequently package a number of individual items used in a particular procedure in a kit. Generally, to avoid complicating the category list unnecessarily and to avoid the possibility of double coding, HCFA has not established codes for such kits. However, hospitals are free to purchase and use such kits. If the kits contain individual items that separately qualify for transitional pass-through payments, these items may be separately billed using applicable codes. **Hospitals may not bill for transitional pass-through payments for supplies that may be contained in kits.**

Multiple units: Hospitals must bill for multiple units of items that qualify for transitional pass-through payments when such items are used with a single procedure by entering the number of units used on the bill.

Old codes and grace period: The previous item-specific C-codes will remain active for a 90-day grace period. Hospitals may use these codes for services delivered up until June 30, 2001, when they will be retired. During this period, hospitals may bill an item under either an item-specific code, if one has been specified by HCFA as applicable for that item, or an appropriate category code, but not both.

Reporting of multiple categories: For items with multiple component devices that fall in more than one category (e.g., kits or systems other than those explicitly identified in the long descriptors), hospitals should code the appropriate category separately for each component. For example, the "Rotablator Rotational Angioplasty System (with catheter and advancer)" consists of both a catheter as well as an advancer/sheath. Report category C1724 for the catheter and C1894 for the advancer/sheath.

Also, for items packaged as kits that contain a catheter and an introducer, report both appropriate categories. For example, the "Clinicath 16G Peripherally Inserted Central Catheter (PICC) Dual-Lumen PolyFlow Polyurethane" contains a catheter and an introducer. To appropriately bill for this item, report category C1751 for the catheter and C1894 for the introducer.

Reprocessed devices: Hospitals may bill for transitional pass-through payments only for those devices that are "single use." Reprocessed devices may be considered "single use" if they are reprocessed in compliance with enforcement guidance of the Food and Drug Administration (FDA) relating to the reprocessing of devices applicable at the time the service is delivered. The FDA is phasing in new enforcement guidance relating to reprocessing during 2001 and 2002. For further information, see FDA's guidance document entitled "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals," published August 14, 2000.

Explanations of Terms

3D mapping catheter – Refers to a catheter used for mapping the electrophysiologic properties of the heart. Signals are identified by a specialized catheter and changed into a 3-dimensional map of a specific region of the heart.

Ablation catheter – Used to obliterate or necrose tissues in an effort to restore normal anatomic and physiologic function.

Adaptor for a pacing lead – Interposed between an existing pacemaker lead and a new generator. The end of the adaptor lead has the appropriate connector pin that will enable utilization of the existing pacemaker lead with a new generator that has a different receptacle. These are required when a generator is replaced or when two leads are connected to the same port in the connector block.

Anchor for opposing bone-to-bone or soft tissue-to-bone – Implantable pins and/or screws that are used to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone. Screws oppose tissues via drilling as follows: soft tissue-to-bone, tendon-to-bone, or bone-to-bone fixation. Pins are inserted or drilled into bone, principally with the intent to facilitate stabilization or oppose bone-to-bone. Anchors do not include screws used for anchoring plates to bone.

Balloon dilatation catheter, non-vascular – Catheter used to dilate strictures or stenoses through the insertion of an uninflated balloon affixed to the end of a flexible catheter, followed by the inflation of the balloon at the specified site (e.g., common bile duct, ureter, small or large intestine). [For the reporting of vascular balloon dilatation catheters, see category "Transluminal angioplasty catheter."]

Balloon tissue dissector catheter (insertable) – Balloon tipped catheter used to separate tissue planes, used in procedures such as hernia repairs.

Coated stent – Refers to a stent bonded with drugs (e.g., heparin) or layered with biocompatible substances (e.g., phosphorylcholine).

Connective tissue, human – These tissues include a natural, cellular collagen or extracellular matrix obtained from autologous rectus fascia, decellularized cadaveric fascia lata, or decellularized dermal tissue. They are intended to repair or support damaged or inadequate soft tissue. They are used to treat urinary incontinence resulting from hypermobility or Intrinsic Sphincter Deficiency (ISD), pelvic floor repair, or for implantation to reinforce soft tissues where weakness exists in the urological anatomy. [This excludes those items that are used to replace skin.] [For reporting mesh when used to treat urinary incontinence, see the category "Mesh."] [For reporting urinary incontinence repair device when

General Coding, Billing Instructions... Devices Eligible for Transitional Pass-Through Payments (continued)

used to treat urinary incontinence, see the category "Urinary incontinence repair device."]

Connective tissue, non-human (includes synthetic) – These tissues include a natural, acellular collagen matrix typically obtained from porcine or bovine small intestinal submucosa, or pericardium. This bio-material is intended to repair or support damaged or inadequate soft tissue. They are used to treat urinary incontinence resulting from hypermobility or Intrinsic Sphincter Deficiency (ISD), pelvic floor repair, or for implantation to reinforce soft tissues where weakness exists in the urological or musculoskeletal anatomy. [This excludes those items that are used to replace skin.] [For reporting mesh when used to treat urinary incontinence, see the category "Mesh."] [For reporting urinary incontinence repair device when used to treat urinary incontinence, see the category "Urinary incontinence repair device."]

Covered stent – Refers to a stent layered with silicone or a silicone derivative (e.g., PTFE, polyurethane).

Electrophysiology (EP) catheter – Assists in providing anatomic and physiologic information about the cardiac electrical conduction system. Electrophysiology catheters are categorized into two main groups: (1) diagnostic catheters that are used for mapping, pacing, and/or recording only, and (2) ablation (therapeutic) catheters that also have diagnostic capability. The electrophysiology ablation catheters are distinct from non-cardiac ablation catheters.

Extension for a pacing lead – Provides additional length to an existing pacing lead but does not have the capability of an adaptor.

Extension for a neurostimulator lead – Conducts electrical pulses from the power source (generator or neurostimulator) to the lead. The terms neurostimulator and generator are used interchangeably.

Guiding catheter – Intended for the introduction of interventional/diagnostic devices into the coronary or peripheral vascular systems. It can be used to inject contrast material, function as a conduit through which other devices pass, and/or provide a mechanism for measuring arterial pressure, and maintain a pathway created by the guide wire during the performance of a procedure.

Insertable retrieval device – A device designed to retrieve other devices or portions thereof (e.g., fractured catheters, leads) lodged within the vascular system.

Intraocular lens (new technology) – Refers to the intraocular lenses approved by HCFA as "new technology." A list of these lenses is published annually in the *Federal Register*.

Intraoperative ocular device for detached retina – A perfluorocarbon substance instilled during a vitreoretinal procedure to treat retinal detachment.

Joint device – An artificial joint such as a finger or toe that is implanted in a patient. Typically, a joint device functions as a substitute to its natural counterpart and is not used (as are anchors) to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone.

Liquid pulmonary sealant – An absorbable, synthetic solution that forms a seal utilizing a photochemical polymerization process. It is used to seal visceral pleural air leaks incurred during pulmonary resection.

Material for vocal cord medialization, synthetic – Synthetic material that is composed of a non-absorbable substance such as silicone and can be injected or implanted to result in vocal cord medialization.

Mesh – A mesh implant or synthetic patch composed of absorbable or non-absorbable material that is used to repair hernias, support weakened or attenuated tissue, cover tissue defects, etc. [For reporting connective tissue (human or non-human) when used to treat urinary incontinence, see the category "Connective tissue, human" or "Connective tissue, non-human."] [For reporting urinary incontinence repair device when used to treat urinary incontinence, see the category "Urinary incontinence repair device."]

Morcellator – Used for cutting, coring, and extracting tissue in laparoscopic procedures. These are distinct from biopsy devices because morcellators are used for the laparoscopic removal of tissue.

Patient programmer – Programmer that allows the patient to operate their neurostimulator, for example, programming the amplitude and rate of stimulation of a neurostimulator system. Only a non-console patient programmer is eligible for transitional pass-through payments.

Peel-away introducer/sheath – A non-absorbable sheath or introducer that separates into two pieces. This device is used primarily when removal of the sheath is required after a catheter or lead is in the desired position.

Septal defect implant system – An intracardiac metallic implant used for closure of various septal defects within the heart. The septal defect implant system includes a delivery catheter. The category code for the septal defect implant system (C1817) includes the delivery catheter; therefore, the delivery catheter should not be reported separately.

Stents with delivery system – Stents packaged with delivery systems generally include the following components: stent mounted or unmounted on a balloon angioplasty catheter, introducer, and sheath. These components should not be reported separately.

Temperature-controlled electrophysiology catheter – Ablation catheter that contains a cooling mechanism and has temperature sensing capability.

Temporary non-coronary stent – Usually composed of a substance, such as plastic or other non-absorbable material, designed to permit removal. Typically, this type of stent is placed for a period of less than one year.

Tissue marker – A material that is placed in subcutaneous or parenchymal tissue for radiopaque identification of an anatomic site. These markers are distinct from topical skin markers, which are positioned on the surface of the skin to serve as anatomical landmarks.

General Coding, Billing Instructions... Devices Eligible for Transitional Pass-Through Payments (continued)

Transluminal angioplasty catheter – Designed to dilate stenotic blood vessels (arteries and veins). For vascular use, the terms "balloon dilatation catheter" and "transluminal angioplasty catheter" are frequently used interchangeably. [For the reporting of non-vascular balloon dilatation catheters, see the category "Balloon dilatation catheter."]

Transvenous VDD single pass pacemaker lead – A transvenous pacemaker lead that paces and senses in the ventricle and senses in the atrium.

Urinary incontinence repair device –- Used to attach or insert a sling graft for the purpose of strengthening the pelvic floor. It consists of the device components used to deliver (suprapubically or transvaginally) and/or fixate (via permanent sutures or bone anchors) the sling graft. The device may or may not be packaged with a sling graft. Report the appropriate category for a device with or without a sling graft. [For reporting connective tissue (human or non-human) when used to treat urinary incontinence, see the category "Connective tissue, human" or "Connective tissue, non-human."] [For reporting mesh when used to treat urinary incontinence, see the category "Mesh."]

Vascular closure device (implantable/insertable) – Used to achieve hemostasis at arterial puncture sites following invasive or interventional procedures using biologic substances (e.g., collagen) or suture through the tissue tract.

Vector mapping catheter – Refers to an electrophysiology catheter with an "in-plane" orthogonal array of electrodes. This catheter is used to locate the source of a focal arrhythmia.

C-Codes for Categories Used in Coding Devices Eligible for Transitional Pass-Through Payments

The following categories are effective for services delivered **on or after April 1, 2001**. They are expected to remain in effect until January 1, 2003. These new C-codes are exclusively for use in billing for transitional pass-through payments.

HCPCS Codes	Category Long Descriptor
C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)
C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)
C1715	Brachytherapy needle
C1716	Brachytherapy seed, Gold 198
C1717	Brachytherapy seed, High Dose Rate Iridium 192
C1718	Brachytherapy seed, Iodine 125
C1719	Brachytherapy seed, Non-High Dose Rate Iridium 192
C1720	Brachytherapy seed, Palladium 103
C2616	Brachytherapy seed, Yttrium-90
C1721	Cardioverter-defibrillator, dual chamber (implantable)
C1882	Cardioverter-defibrillator, other than single or dual chamber (implantable)
C1722	Cardioverter-defibrillator, single chamber (implantable)
C1723	Catheter, ablation, non-cardiac
C1726	Catheter, balloon dilatation, non-vascular
C1727	Catheter, balloon tissue dissector, non-vascular (insertable)
C1728	Catheter, brachytherapy seed administration
C1729	Catheter, drainage, biliary
C1730	Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes)
C1731	Catheter, electrophysiology, diagnostic, other than 3D mapping (20 or more electrodes)
C1732	Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping
C1733	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than temperature-controlled
C2630	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, temperature-controlled
C1887	Catheter, guiding (may include infusion/ perfusion capability)
C1750	Catheter, hemodialysis, long-term
C1752	Catheter, hemodialysis, short-term
C1751	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)
C1759	Catheter, intracardiac echocardiography
C1754	Catheter, intradiscal
C1755	Catheter, intraspinal
C1753	Catheter, intravascular ultrasound
C2628	Catheter, occlusion
C1756	Catheter, pacing, transesophageal
C2627	Catheter, suprapubic/cystoscopic
C1757	Catheter, thrombectomy/embolectomy
C1885	Catheter, transluminal angioplasty, laser
C1725	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)
C1714	Catheter, transluminal atherectomy, directional
C1724	Catheter, transluminal atherectomy, rotational
C1758	Catheter, ureteral
C1760	Closure device, vascular (implantable/insertable)
L8614	Cochlear implant system
C1762	Connective tissue, human (includes fascia lata)
C1763	Connective tissue, non-human (includes synthetic)
C1881	Dialysis access system (implantable)
C1764	Event recorder, cardiac (implantable)
C1767	Generator, neurostimulator (implantable)
C1768	Graft, vascular
C1769	Guide wire
C1770	Imaging coil, magnetic resonance (insertable)
C1891	Infusion pump, non-programmable, permanent (implantable)
C2626	Infusion pump, non-programmable, temporary (implantable)

Categories Used in Coding Devices Eligible for Transitional Pass-Through Payments (continued)

C1772	Infusion pump, programmable (implantable)
C1893	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away
C1892	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away
C1894	Introducer/sheath, other than guiding, intracardiac electrophysiological, non-laser
C2629	Introducer/sheath, other than guiding, intracardiac electrophysiological, laser
C1776	Joint device (implantable)
C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)
C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)
C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)
C1778	Lead, neurostimulator (implantable)
C1897	Lead, neurostimulator test kit (implantable)
C1898	Lead, pacemaker, other than transvenous VDD single pass
C1779	Lead, pacemaker, transvenous VDD single pass
C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)
C1780	Lens, intraocular (new technology)
C1878	Material for vocal cord medialization, synthetic (implantable)
C1781	Mesh (implantable)
C1782	Morcellator
C1784	Ocular device, intraoperative, detached retina
C2619	Pacemaker, dual chamber, non rate-responsive (implantable)
C1785	Pacemaker, dual chamber, rate-responsive (implantable)
C2621	Pacemaker, other than single or dual chamber (implantable)
C2620	Pacemaker, single chamber, non rate-responsive (implantable)
C1786	Pacemaker, single chamber, rate-responsive (implantable)
C1787	Patient programmer, neurostimulator
C1788	Port, indwelling (implantable)
C2618	Probe, cryoablation
C1789	Prosthesis, breast (implantable)
C1813	Prosthesis, penile, inflatable
C2622	Prosthesis, penile, non-inflatable
C1815	Prosthesis, urinary sphincter (implantable)
C1816	Receiver and/or transmitter, neurostimulator (implantable)
C1771	Repair device, urinary, incontinence, with sling graft
C2631	Repair device, urinary, incontinence, without sling graft
C1773	Retrieval device, insertable (used to retrieve fractured medical devices)
C2615	Sealant, pulmonary, liquid (Implantable)
C1817	Septal defect implant system, intracardiac
C1874	Stent, coated/covered, with delivery system
C1875	Stent, coated/covered, without delivery system
C2625	Stent, non-coronary, temporary, with delivery system
C2617	Stent, non-coronary, temporary, without delivery system
C1876	Stent, non-coated/non-covered, with delivery system
C1877	Stent, non-coated/non-covered, without delivery system
C1879	Tissue marker (implantable)
C1880	Vena cava filter

Crosswalk to New Category C-codes Used in Coding Devices Eligible for Transitional Pass-Through Payments

The following table has been developed to assist providers with transition to the new categories C-codes. The table contains a crosswalk from item-specific C-codes to new category C-codes used in coding devices eligible for transitional pass-through payments. Hospitals may continue to use the old codes during the grace period ending June 30, 2001. This crosswalk covers only those items previously determined eligible. Some other items that have not previously been determined eligible will be eligible to be included in categories and to receive transitional pass-through payments. In other words, if a device appears on this cross-walk, it is eligible while its category is effective, but other devices that do not appear will also be eligible. In general, HCFA does not expect to make item-specific determinations of such items as it has been done previously. Consequently, this crosswalk table will not be updated in the future.

Current C-Code	Long Descriptor	New Category C-Code
C1000	Closure, arterial vascular device, Perclose Closer Arterial Vascular Closure Device, Prostar Arterial Vascular Closure Device, Closer S Arterial Vascular Closure Device	C1760
C1001	Catheter, diagnostic ultrasound, AcuNav Diagnostic Ultrasound Catheter	C1759
C1003	Catheter, 7 Fr CSM Livewire EP Catheter (model 401935), 5FR Decapolar (models 401938, 401939, 401940, 401941)	C1730
C1003	Catheter, Livewire TC Ablation Catheter 402132, 402133, 402134, 402135, 402136, 402137, 402145, 402146, 402147, 402148, 402149, 402150, 402151, 402152, 402153, 402154, 402155, 402156, Livewire TC Compass Ablation Catheter (models 402205, 402006, 402207, 402208)	C1733

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C1004	Introducer, guiding, Fast-Cath, Swartz, SAFL, CSTA, SEPT, RAMP	C1893
C1006	Intraocular lens, Array Multifocal Silicone Posterior Chamber Intraocular Lens	C1780
C1007	Prosthesis, penile, AMS 700 Penile Prosthesis, AMS Ambicor Penile Prosthesis, Dura II Penile Prosthesis	C1813
C1007	Prosthesis, penile, AMS Malleable 650 Penile Prosthesis	C2622
C1008	Stent, urethral, UroLume	C1877
C1008	Cook Harrison Fetal Bladder Stent	C2617
C1025	Catheter, Marinr CS	C1733
C1026	Catheter, ablation, RF Performr, 5F RF Marinr	C1733
C1027	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	C1876
C1028	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, Capio Suture Capturing Device, Standard or Open Access	C2631
C1029	Catheter, balloon dilatation, MS Classique Balloon Dilation Catheter	C1725
C1029	Catheter, balloon dilatation, Controlled Radial Expansion Balloon Dilatation Catheter Wire-Guided and Fixed Wire, Wilson-Cook Quantum Dilation Balloon	C1726
C1030	Catheter, balloon dilatation, Marshal, Blue Max 20, Ultra-Thin Diamond, Ultra-Thin Balloon Dilatation Catheter, Ultra-Thin ST Balloon Dilatation Catheter, Ultra-Thin Balloon Dilatation Catheter with Glidex Hydrophilic Coated Balloon, Ultra-Thin ST Balloon Dilatation Catheter with Glidex Hydrophilic Coated Balloon	C1725
C1033	Catheter, imaging, Sonicath Ultra Model 37-410 Ultrasound Imaging Catheter, Sonicath Ultra 9 MHz Ultrasound Imaging Catheter	C1753
C1034	Catheter, coronary angioplasty, SURPASS Superfusion Catheter, Long 30 SURPASS Superfusion Catheter	C1725
C1035	Catheter, intracardiac echocardiography, Ultra ICE 6F, 12.5 MHz Catheter with Disposable Sheath, Ultra ICE 9F, 9 MHz Catheter with Disposable Sheath **NOTE:** To appropriately bill for these pass-through devices, report two categories. The catheter should be reported with category code C1759 and the introducer/sheath should be reported with category code C1894.	C1759/ C1894
C1036	Port/reservoir, venous access device, Vaxcel Implantable Vascular Access System, R Port Premier Vascular Access System (models 45-100, 45-155), Sims Deltec Pro Port Single Lumen Low Profile Implantable Venous Access System, Sims Deltec Port-A-Cath II Dual Lumen Low Profile Implantable Venous Access System, Sims Deltec Port-A-Cath II Fluoro-Free Implantable Venous Access System, Sims Deltec P.A.S. Port Fluoro-Free Implantable Peripheral Venous Access System, Sims Deltec P.A.S. Port T2 Implantable Peripheral Venous Access System, Sims Deltec P.A.S. Port T2 Fluoro-Free Implantable Peripheral Venous Access System, Sims Deltec P.A.S. Port T2 Elite Implantable Peripheral Venous Access System, Sims Deltec P.A.S. Port Elite Implantable Peripheral Venous Access System, Sims Deltec Port-A-Cath II Implantable Epidural System Low Profile Venous Access System, Cook Vital Port Access Set, Horizon Medical MicroPort 2 Peripheral Access System	C1788
C1037	Catheter, Vaxcel Chronic Dialysis Catheter, Medcomp Bio Flex Tesio Catheter, Medcomp Silicone Tesio Catheter, Medcomp Hemo-Cath Long Term Silicone Catheter, Bard Opti-Flow Dual Lumen Catheter, Medcomp Ash Split Catheter	C1750
C1037	Catheter, Bard Niagara Dual Lumen Catheter	C1752
C1038	Catheter, imagining, UltraCross 2.9 F 30 MHz Coronary Imaging Catheter, UltraCross 3.2 F MHz Coronary Imaging Catheter	C1753
C1039	Stent, tracheobronchial, Wallstent Tracheobronchial Endoprosthesis (covered)	C1875
C1039	Stent, tracheobronchial, Wallstent Tracheobronchial Endoprosthesis with Permalume Covering and Unistep Plus Delivery System	C1874

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C1039	Stent, tracheobronchial, Wallstent RP Tracheobronchial Endoprosthesis with Unistep Plus Delivery System	C1876
C1040	Stent, self-expandable for creation of intrahepatic shunts, Wallstent Transjugular Intrahepatic Portosystemic Shunt (TIPS) with Unistep Plus Delivery System (40/42/60/68mm in length), Wallstent RP TIPS Endoprosthesis with Unistep Plus Delivery System (42/68) mm in length)	C1876
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	C1876
C1043	Catheter, atherectomy, Atherocath-GTO Atherectomy Catheter	C1714
C1043	Atherectomy system, coronary, Interventional Technologies Transluminal Extraction Coronary (TEC) Atherectomy System	C1724
C1043	Atherectomy system, peripheral, Rotablator RotaLink Rotational Atherectomy System (includes burr, catheter, advancer, and guide wire) **NOTE**: To appropriately bill for these pass-through devices, report three categories. The catheter should be reported with category code C1724, the advancer (sheath) with C1894, and the guide wire with C1769.	C1724/ C1894/ C1769
C1047	Catheter, diagnostic, Navi-Star Diagnostic Deflectable Tip Catheter, NOGA-STAR Diagnostic Deflectable Tip Catheter	C1732
C1048	Generator, bipolar pulse, Cyberonics NeuroCybernetic Prosthesis Generator	C1767
C1051	Catheter, thrombectomy, Oasis Thrombectomy Catheter, Fogarty Adherent Clot Catheter (4 Fr, 5 Fr, 6Fr), 6 Fr Thrombex PMT Catheter (60cm, 120cm)	C1757
C1053	Catheter, diagnostic, EnSite 3000 Catheter	C1732
C1054	Catheter, thrombectomy, Hydrolyser 6F Mechanical Thrombectomy Catheter, Hydrolyser 7F Mechanical Thrombectomy Catheter, Microvena Helix Clot Buster Thrombectomy Device, 7F (60cm, 120cm)	C1757
C1055	Catheter, Flex-EZ Balloon Dilator, EZ Resolution Balloon Dilator (models 3802, 3804, 3806)	C1726
C1055	Catheter, Transesophageal 210 Atrial Pacing Catheter, Transesophageal 210-S Atrial Pacing Catheter	C1756
C1056	Catheter, Gynecare Thermachoice II Catheter	C1723
C1056	Cook OB/GYN Suprapubic Balloons, Cook Urological O'Brien Suprapubic Access Set, Cook Urological Suprapubic Balloons	C2627
C1057	Tissue marker, 11-Gauge MicroMark II Tissue Marker	C1879
C1060	Stent, coronary, ACS Multi-Link Tristar Coronary Stent System and Delivery System, ACS Multi-Link Ultra Coronary Stent System	C1876
C1061	Merit Medical Systems Performa Vessel Sizing Catheter, Merit Medical Systems Pediatric/ Adult Pigtail Catheter	C1751
C1061	Catheter, coronary guide, ACS Viking Guiding Catheter, Cardima Vueport Balloon Occlusion Guiding Catheter	C1887
C1063	Lead, defibrillator, Endotak Endurance EZ, Endotak Endurance RX, Endotak Endurance 0134, 0135, 0136	C1895
C1067	Stent, biliary, PALMAZ Balloon Expandable Stent and Delivery System	C1876
C1067	Stent, biliary, Megalink Biliary Stent, Spiral Z Biliary Metal Expandable Stent, Za Biliary Metal Expandable Stent, Wallstent Transhepatic Biliary Endoprosthesis	C1877
C1068	Pacemaker, dual chamber, Unity VDDR (model 292-07)	C1785
C1068	Pacemaker, dual chamber, Pulsar DDD	C2619
C1069	Pacemaker, dual chamber, Discovery DR	C1785
C1071	Pacemaker, single chamber, Pulsar Max SR, Pulsar SR	C1786

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C1071	Pacemaker, single chamber, Vigor SSI	C2620
C1072	Catheter, balloon dilatation, coronary, RX Esprit, RX Gemini, RX Solaris, OTW Photon, OTW Solaris	C1725
C1073	Morcellator, laparascopic, Gynecare X-tract Laparascopic Morcellator	C1782
C1074	Catheter, peripheral dilatation, RX Viatrac 14 Peripheral Dilatation Catheter, OTW Viatrac 18 Peripheral Dilatation Catheter	C1725
C1075	Lead, pacemaker, Selute Picotip, Selute, Sweet Picotip Rx, Sweet Tip Rx, FineLine, FineLine EZ, ThinLine, ThinLine EZ	C1898
C1076	Defibrillator, single chamber, automatic, implantable, Ventak Mini IV, Ventak Mini III HE, Ventak Mini III HE+ (Model 1788, 1789), Ventak Mini III, Ventak Mini III+ (Model 1783, 1786)	C1722
C1077	Defibrillator, single chamber, automatic, implantable, Ventak Prizm VR, Ventak VR	C1722
C1078	Defibrillator, dual chamber, automatic, implantable, Ventak Prizm, Ventak AV III DR	C1721
C1100	Guide wire, percutaneous transluminal coronary angioplasty, Medtronic AVE GT1Guide Wire, Medtronic AVE GT2 Fusion Guide Wire, Interventional Technologies TrackWire, Interventional Technologies TrackWire Support, Interventional Technologies TrackWire Extra Support	C1769
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, Medtronic AVE Vector Guide Catheter, Medtronic AVE Vector X Guide Catheter	C1725
C1102	Generator, pulse, neurostimulator, Medtronic Synergy Neurostimulator Generator and Extension NOTE: To appropriately bill for these devices, report two categories. The pulse generator should be reported with category code C1767, and the neurostimulator extension with category code.	C1767/ C1883
C1103	Defibrillator, implantable, Micro Jewel, Micro Jewel II	C1882
C1104	Catheter, ablation, RF Conductr MC 4mm, RF Conductr MC 5mm (Model 6042, 7544), RF Conductr MC—EXT (with stiffer tip) 07864447, 078754447	C1733
C1105	Pacemaker, dual chamber, Sigma 300 VDD	C2619
C1106	Neurostimulator, patient programmer, Synergy EZ Patient Programmer	C1787
C1107	Catheter, diagnostic, electrophysiology, Torqr, Soloist, Dynamic XT Decapolar Catheter	C1730
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, Biomet 3.5mm Cortical Screw, Biomet 4.5mm Cortical Screw (fully threaded), Biomet 6.5mm Cancellous Lag Screw (32mm thread length), Biomet 6.5mm Cannulated Cancellous Screw (20mm thread length)	C1713
C1110	Catheter, diagnostic, electrophysiology, Stable Mapper	C1731
C1115	Lead, pacemaker, 5038S, 5038, 5038L, Unipass (models 425-02, 425-04, 425-06)	C1779
C1115	Lead, pacemaker, 4057M, 4058M, 4557M, 4558M, 5058, 6416 Pacemaker Lead, Innomedica Sutureless Myocardial (models 4045, 4046, 4047, 4058)	C1898
C1115	Lead, pacemaker 2188 Coronary Sinus Lead	C1899
C1116	Lead, pacemaker, CapSure SP Novus, CapSure SP, Capsure, Excellence +, S+, PS+, CapSure Z Novus, CapSure Z, Impulse	C1898
C1118	Pacemaker, dual chamber, Sigma 300 DR, Legacy II DR	C1785
C1119	Lead, defibrillator, Sprint 6932, Sprint 6943	C1777
C1120	Lead, defibrillator, Sprint 6942, Sprint 6945	C1895
C1121	Defibrillator, implantable, GEM	C1722
C1123	Defibrillator, implantable, GEM II VR, GEM III VR (model 7231)	C1722
C1124	Lead, neurostimulator, kit, InterStim Test Stimulation Lead Kit	C1897

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C1125	Pacemaker, single chamber, Kappa 400 SR, Topaz II SR, Topaz 3/Topaz SR (model 540), Legacy II S	C1786
C1126	Pacemaker, dual chamber, Kappa 700 DR (all models), Clarity DR (models 860, 862, 865), Diamond 3/Diamond DR (model 840)	C1785
C1127	Pacemaker, single chamber, Kappa 700 SR, Clarity SR (models 560, 562, 565)	C1786
C1128	Pacemaker, dual chamber, Vita 2 DR (model 830)	C1785
C1128	Pacemaker, dual chamber, Kappa 700 D, Ruby II D, Ruby 3/Ruby 3 D (model 740)	C2619
C1129	Pacemaker, Kappa 700 VDD	C2619
C1130	Pacemaker, dual chamber, Sigma 200 D, Legacy II D	C2619
C1131	Pacemaker, dual chamber, Sigma 200 DR	C1785
C1132	Pacemaker, single chamber, Sigma 200 SR, Legacy II SR, Legacy II S	C1786
C1133	Pacemaker, single chamber, Sigma 300 SR, Vita SR, Vita 2 SR (model 530)	C1786
C1134	Pacemaker, dual chamber, Sigma 300 D	C2619
C1135	Pacemaker, dual chamber, rate-responsive, Entity DR 5326, Entity DR 5326L, Entity DR 5326R	C1785
C1136	Pacemaker, dual chamber, rate-responsive, Affinity 5330, Affinity DR 5330L, Affinity DR 5330R	C1785
C1137	Septal defect implant system, CardioSEAL Septal Occlusion System, CardioSEAL Occluder Delivery Catheter, AGA Medical Amplatzer PFO Occluder	C1817
C1143	Pacemaker, dual chamber, AddVent 2060BL, Paragon III (models 2314L, 2315 M/S)	C1785
C1144	Pacemaker, single chamber, rate-responsive, Affinity SR 5130, Affinity SR 5130L, Affinity 5130R, Integrity SR 5142, Integrity U SR 5136	C1786
C1145	Vascular closure device, Angio-Seal 6 French Vascular Closure Device (model 610091), Angio-Seal 8 French Vascular Closure Device (models 610089, 610097), Angio-seal 6 Fr EV Vascular Closure Device, Angio-seal 8 Fr EV Vascular Closure Device (models 610099, 610101)	C1760
C1147	Lead, pacemaker, AV Plus DX 1368/52, AV Plus DX 1368/58, AV Plus DX 1368/65	C1779
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, Contour II (models V-185AC, V-185B, V-185C)	C1722
C1149	Pacemaker, dual chamber, non-rate responsive, Entity DC 5226R, Entity DC 5226	C2619
C1151	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, Passive Plus TiN (model 1242T)	C1898
C1152	Access system, dialysis, LifeSite Access System	C1881
C1153	Pacemaker, single chamber, Regency SC+ 2402L	C2620
C1154	Lead, defibrillator, SPL SP01, SPL SP02, SPL SP04, EndoTak DSP	C1895
C1154	Lead, defibrillator, 6721L, 6721M, 6721S, 6939 Oval Patch Lead, CapSure 4965, DP-3238, Transvene 6933, Transvene 6937	C1896
C1155	Repliform Tissue Regeneration Matrix, per 8 square centimeters	C1762
C1156	Pacemaker, single chamber, Affinity SR 5131M/S, Tempo VR 1102, Trilogy SR+ 2260L, Trilogy SR+ 2264L, Solus II (models 2006L, 2007 M/S)	C1786
C1157	Pacemaker, dual chamber, Synchrony III (models 2028L, 2029 M/S)	C1785
C1157	Pacemaker, dual chamber, Trilogy DC+ 2318L	C2619
C1158	Lead, defibrillator, TVL SV01, TVL SV02, TVL SV04	C1896
C1159	Lead, defibrillator, TVL RV02, TVL RV06, TVLRV07	C1777

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C1160	Lead, defibrillator, TVL-ADX 1559/65	C1777
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	C1898
C1162	Pacemaker, dual-chamber, Affinity DR 5331 M/S, Tempo DR 2102, Trilogy DR+ 2360L, Trilogy DR + 2364L	C1785
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	C1898
C1164	Brachytherapy seed, ImagynMedical Technologies I-125 seeds	C1718
C1171	Site marker device, disposable, Auto Suture SITE MARKER Device	C1879
C1172	Balloon, tissue dissector, Spacemaker Tissue Dissection Balloon, Spacemaker 1000cc Hernia Balloon Dissector	C1727
C1173	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	C1876
C1174	Needle, brachytherapy, Bard BrachyStar Brachytherapy Needle	C1715
C1180	Pacemaker, single chamber, Vigor SR	C1786
C1181	Pacemaker, single chamber, Meridian SSI	C2620
C1182	Pacemaker, single chamber, Pulsar SSI	C2620
C1183	Pacemaker, single chamber, Jade II S, Sigma 300 S, Jade 3/Jade 3S (model 340)	C2620
C1184	Pacemaker, single chamber, Sigma 200 S, Sigma 100 S	C2620
C1302	Lead, defibrillator, TVL SQ01	C1896
C1303	Lead, defibrillator, CapSure Fix 6940, CapSure Fix 4068-110	C1896
C1304	Catheter, imaging, Sonicath Ultra Model 37-416 Ultrasound Imaging Catheter, Sonicath Ultra Model 37-418 Ultrasound Imaging Catheter	C1753
C1306	Lead, neurostimulator, Cyberonics NeuroCybernetic Prosthesis Lead, Octad Lead 3898-33/389861, On-Point Model 3987, Pisces—Quad Plus Model 3888, Resume TL Model 3986, Pisces—Quad Model 3487a, Resume II Model 3587a, SymMix Lead 3982	C1778
C1311	Pacemaker, dual chamber, Trilogy DR+/DAO	C1785
C1312	Stent, coronary, Magic Wallstent Mini Coronary Self Expanding Stent with Delivery System	C1876
C1313	Stent, coronary, Magic Wallstent Medium Coronary Self Expanding Stent with Delivery System, Radius 31mm Self Expanding Stent with Over the Wire Delivery System	C1876
C1314	Stent, coronary, Magic Wallstent Long Coronary Self Expanding Stent with Delivery System	C1876
C1315	Pacemaker, dual chamber, Vigor DR, Meridian DR	C1785
C1315	Pacemaker, dual chamber, Vigor DDD, Vista DDD	C2619
C1316	Pacemaker, dual chamber, Meridian DDD	C2619
C1317	Pacemaker, single chamber, Discovery SR	C1786
C1318	Pacemaker, single chamber, Meridian SR	C1786

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
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), Ultraflex Esophageal Stent System, Wallstent Esophageal Prosthesis with Delivery System	C1876
C1319	Esophageal Z Metal Expandable Stent with Dua Anti-reflux Valve, Esophageal Z Metal Expandable Stent with Uncoated Flanges, Wallstent Esophageal Prosthesis (Double), Wilson-Cook Esophageal Z Metal Expandable Stent, Bard Memotherm Esophageal Stent	C1877
C1320	Stent, iliac, Wallstent Iliac Endoprosthesis with Unistep Plus Delivery System, Wallstent RP Iliac Endoprosthesis with Unistep Plus Delivery System	C1876
C1325	Brachytherapy seed, Theragenics Theraseed Palladium-103 seeds	C1720
C1326	Catheter, thrombectomy, AngioJet Rheolytic Thrombectomy Catheter	C1757
C1328	External transmitter, neurostimulation system, ANS Renew Spinal Cord Stimulator System	C1816
C1333	Stent, biliary, PALMAZ Corinthian Transhepatic Biliary Stent and Delivery System, Cook Oasis One Action Stent Introductory System, Large Palmaz Balloon Expandable Stent with Delivery System	C1876
C1333	Cook Z Stent Gianturco-Rosch Biliary Design, Cordis Palmaz XL Transhepatic Biliary Stent	C1877
C1334	Stent, coronary, PALMAZ-Schatz Crown Stent, Cook Gianturco-Roubin Flex-Stent Coronary Stent	C1877
C1334	Stent, coronary, Mini-Crown Stent, CrossFlex LC Stent	C1876
C1335	Mesh, hernia, Prolene Polypropylene Hernia System, Prolene Soft Mesh (Polypropylene), Trelex Natural Mesh	C1781
C1336	Infusion pump, implantable, non-programmable, Constant Flow Implantable Pump with Bolus Safety Valve Model 3000, Model 3000-16 (16ml), Model 3000-50 (50ml)	C1891
C1337	Infusion pump, implantable, non-programmable, IsoMed Infusion Pump Model 8472-20, 8472-35, 8472-60	C1891
C1350	Brachytherapy, per source, ProstaSeed I-125	C1718
C1351	Lead, pacemaker, CapSureFix, SureFix, Pirouet +, S+	C1898
C1352	Defibrillator, dual chamber, implantable, Gem II DR	C1721
C1353	Neurostimulator, implantable, Itrel II/Soletra Implantable Neurostimulator and Extension, Itrel III Implantable Neurostimulator and Extension, InterStim Neurostimulator (implantable) and Extension NOTE: To appropriately bill for these devices, report three categories. The pulse generator should be reported with category code C1767, the neurostimulator lead should be reported with category code C1778, and the neurostimulator extension with category code C1883.	C1767/ C1778/ C1883
C1353	NeuroControl Stim System NOTE: To appropriately bill for this device, report two categories. The pulse generator should be reported with category code C1767, and the neurostimulator lead should be reported with category code C1778.	C1767/ C1778
C1354	Pacemaker, dual chamber, Kappa 400 DR, Diamond II 820 DR	C1785
C1355	Pacemaker, dual chamber, Kappa 600 DR, Vita DR	C1785
C1356	Defibrillator, single chamber, implantable, Profile MD V-186HV3	C1722
C1357	Defibrillator, single chamber, implantable, Angstrom MD V-190HV3	C1722
C1358	Pacemaker, dual chamber, non-rate responsive, Affinity DC 5230R, Affinity DC 5230	C2619
C1359	Pacemaker, dual chamber, Pulsar DR, Pulsar Max DR	C1785
C1361	Recorder, cardiac event, implantable, Reveal, Reveal Plus	C1764
C1362	Stent, biliary, RX HERCULINK 14 Biliary Stent, OTW MEGALINK SDS Biliary Stent	C1877
C1363	Defibrillator, dual chamber, implantable, Gem DR, GEM III DR (model 7275)	C1721

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C1364	Defibrillator, dual chamber, Photon DR V-230HV	C1721
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, Doc Wire, Hi-Torque Extra Balance, Hi-Torque Extra S'port, Hi-Torque Extra Support, Hi-Torque Floppy II, Hi-Torque Intermediate, Hi-Torque Standard, Hi-Torque Traverse, TAD II Guide Wire System (145cm, 200cm, 260cm, 260cm, 300cm), TAD Guide Wire System (145cm), Wholey Hi-Torque Modified J Guide Wire System (145cm, 175cm, 260cm, 300cm), Wholey Hi-Torque Floppy Guide Wire System (145cm, 175cm, 260cm), Wholey Hi-Torque Standard Guide Wire System (145cm, 300cm), LOC Guide Wire Extension (115cm), Hobbs Medical Flex-EZ Guide Wire (models 3406, 3408, 3410, 3412, 3413)	C1769
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	C1769
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	C1769
C1369	Internal receiver, neurostimulation system, ANS Renew Spinal Cord Stimulator System, Medtronic Mattrix Receiver/Transmitter	C1816
C1370	Single use device for treatment of female stress urinary incontinence, Tension-Free Vaginal Tape Single Use Device	C2631
C1371	Stent, biliary, Symphony Nitinol Stent Transhepatic Biliary System, Nir Biliary Stent System	C1876
C1372	Stent, biliary, Smart Cordis Nitinol Stent and Delivery System	C1876
C1372	Stent, biliary, Cordis Smart .018 Nitinol Transhepatic Biliary Stent	C1877
C1375	Stent, coronary, NIR ON Ranger Stent Delivery System, NIR w/Sox Stent System, NIR Primo Premounted Stent System	C1876
C1376	Lead, neurostimulator, ANS Renew Spinal Cord Stimulation System Lead (with or without extension)	C1778
C1377	Lead, neurostimulator, Specify 3998 Lead	C1778
C1378	Lead, neurostimulator, InterStim Therapy 3080 Lead, InterStim Therapy 3886 Lead	C1778
C1379	Lead, neurostimulator, Pisces-Quad Compact 3887 Lead	C1778
C1420	Anchor system, TransFix Bone Anchor System with Dermis, StapleTac2 Bone Anchor System with Dermis, BioSorb FX System	C1713
C1421	Anchor system, TransFix Bone Anchor System without Dermis, Staple Tac2 Bone Anchor System without Dermis	C1713
C1450	Orthosphere Spherical Interpositional Arthroplasty	C1776
C1451	Orthosphere Spherical Interpositional Arthroplasty Kit	C1776
C1500	Atherectomy system, Rotablator Rotational Angioplasty System (with catheter, advancer, guide wire) NOTE: To appropriately bill for this system, report three categories. The catheter should be reported with category code C1724, the advancer (sheath) should be reported with category code C1894, and the guide wire with category code C1769.	C1724/ C1894/ C1769
C1700	Needle, brachytherapy, Authentic Mick TP Brachytherapy Needle, Cook Urological Brachytherapy Needle	C1715
C1701	Needle, brachytherapy, Medtec MT-BT-5201-25 Brachytherapy Needle , AVID Medical Metal Hub Pre-Load Style Brachytherapy Seeding Insertion Needle, AVID Medical Mick Style Bracytherapy Seeding Insertion Needle	C1715
C1702	Needle, brachytherapy, WWMT Brachytherapy Needle, Nucletron Pancreas Flexible Brachytherapy Needle	C1715
C1703	Needle, brachytherapy, Mentor Prostate Brachytherapy Needle	C1715
C1704	Needle, brachytherapy, Medtec MT-BT-5001-25, MT-BT-5051-25	C1715

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C1705	Needle, brachytherapy, Best Industries Flexi Needle Brachytherapy Seed Implantation (13G, 14G, 15G, 16G, 17G, 18G), Best Industries Prostate Brachytherapy Needle, Nycomed Amersham Mick Applicator Style Brachytherapy Needle, Nycomed Amersham Brachytherapy Needle	C1715
C1706	Needle, brachytherapy, Indigo Prostate Seeding Needle	C1715
C1707	Needle, brachytherapy, VariSource Interstitial Implant Needle	C1715
C1708	Needle, brachytherapy, UroMed Prostate Seeding Needle	C1715
C1709	Needle, brachytherapy, Remington Medical Brachytherapy Needle	C1715
C1710	Needle, brachytherapy, US Biopsy Prostate Seeding Needle	C1715
C1711	Needle, brachytherapy, MD Tech P.S.S. Prostate Seeding Set (needle)	C1715
C1712	Needle, brachytherapy, Imagyn Medical Technologies IsoStar Prostate Brachytherapy Needle	C1715
C1790	Brachytherapy seed, Nucletron Iridium 192 HDR, MDS Nordion Gamma Med Iridium-192 HDR Brachytherapy Seed	C1717
C1790	Brachytherapy Seed, MDS Nordion TheraSphere (Yttrium-90)	C2616
C1791	Brachytherapy seed, Nycomed Amersham I-125 (OncoSeed, Rapid Strand)	C1718
C1792	Brachytherapy seed, UroMed Symmetra I-125	C1718
C1793	Brachytherapy seed, Bard InterSource-103 Palladium Seed, 1031L, 1031C, International Brachytherapy Intersource-103 (Palladium 103)	C1720
C1794	Brachytherapy seed, Bard IsoSeed-103 Palladium Seed, Pd3S111L, Pd3S111P	C1720
C1795	Brachytherapy seed, Bard BrachySource-125 Iodine Seed, 1251L, 1251C, International Brachytherapy InterSource-125	C1718
C1796	Brachytherapy seed, Source Tech Medical I-125 Seed Model STM 1251	C1718
C1797	Brachytherapy seed, Draximage I-125 Seed Model LS-1	C1718
C1798	Brachytherapy seed, Syncor I-125 PharmaSeed Model BT-125-1	C1718
C1799	Brachytherapy seed, I-Plant Iodine 125 Model 3500	C1718
C1800	Brachytherapy seed, Mentor PdGold Pd-103	C1720
C1801	Brachytherapy seed, Mentor IoGold I-125	C1718
C1802	Brachytherapy seed, Best Iridium 192, Best Dummy Ribbon Brachytherapy Seed (model 3 DR, 4 DR series, Iridium 192)	C1719
C1803	Brachytherapy seed, Best Iodine 125	C1718
C1804	Brachytherapy seed, Best Palladium 103	C1720
C1805	Brachytherapy seed, IsoStar Iodine-125 Interstitial Brachytherapy Seed	C1718
C1806	Brachytherapy seed, Best Gold 198	C1716
C1810	Catheter, balloon dilatation, D114S Over-the-Wire Balloon Dilatation Catheter	C1725
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 3.0, Biomet Bone Mulch Screw, Biomet WasherLoc Screw and WasherLoc Washer, Wright Medical Technology Spin Snap-off Screw, Wright Medical Technology Bold Cannulated Titanium Compression Screw, Wright Medical Technology I.C.O.S. Ideal Compression Screw, Biomet Becton Colles' Fracture Plate, Biomet Repicci II Unicondylar Knee System, Wright Medical Technology OsteoSet Bone Graft Substitute (5cc, 10cc, 20cc, 50cc), Wright Medical Technology Uni-Clip Compression Staple, Depuy Ace Timax Calcaneal Peri-articular Plate, Depuy Ace Timax Pilon Plate, Depuy Ace Timax Meta Plate, Depuy Spider Plate, Depuy Total Elbow (Acclaim Elbow)	C1713
C1811	Wright Medical Technology Swanson Finger Joint Implant with Grommets, Swanson Titanium Carpal Lunate Implant, Wright Medical Technology Swanson Basal Thumb Implant, Wright Medical Technology Swanson Titanium Carpal Scaphoid Implant, Wright Medical Technology Swanson Trapezium Implant, Wright Medical Technology Swanson Titanium	C1776

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
	Great Toe Implant, DePuy Neuflex PIP Finger, Depuy Neuflex MCP Finger Joint Prosthesis, Wright Medical Technology Hammertoe Implant (Swanson Type) Weil Design, Wright Medical Technology STA – PEG (Subtalar Arthrosis Implant - Smith Design)	
C1812	Anchor, OBL 2.0mm Mini Tac Anchor, OBL 2.8mm HS Anchor, OBL 2.8mm S Anchor, OBL 3.5mm Ti Anchor, OBL RC5 Anchor, OBL PRC5 Anchor, Arthrex Anterior Cruciate Ligament (ACL) Avulsion Lag Screw with Sheath, Arthrex Chrondral Dart, Arthrex Bio-Absorbable Corkscrew, Arthrex Bio-Fastak Suture Anchor, Arthrex Headed Bio-Absorbable Corkscrew, Arthrex Bio-Interference Screw, Arthrex Cannulated Interference Screw, Arthrex Suture Anchor Screw, Arthrex Fastak Suture Anchor, Arthrex Parachute Corkscrew Anchor, Arthrex TissueTak, Bionx Bankart Tack PLLA Implant, Bionx Cannulated SmartScrew PLLA Implant, Bionx Contour Labral Nail PLLA Implant, Bionx SmartNail PLLA Implant, Bionx SmartScrew PLLA Implant, Bionx SmartPin PLLA and PGA Implant, Bionx Wedge PLA Implant, Bionx Biocuff PLA Implant, Bionx Meniscus Arrow PLA Implant, Bionx SmartScrew ACL Interference Screw PLA Implant, Depuy Scarf Threaded-head Screw, Depuy Twist Off Screw, Depuy Rockwood Clavicle Pin, Depuy Scarf Threaded-head Screw (Millenium Screw)	C1713
C1812	Medtronic XOMed EpiDisc Otologic Lamina (model 14-17000)	C1763
C1850	Repliform Tissue Regeneration Matrix, per 14 or 21 square centimeters	C1762
C1851	Repliform Tissue Regeneration Matrix, per 24 or 28 square centimeters	C1762
C1853	Suspend Tutoplast Processed Fascia Lata, per 8 or 14 square centimeters	C1762
C1854	Suspend Tutoplast Processed Fascia Lata, per 24 or 28 square centimeters	C1762
C1855	Suspend Tutoplast Processed Fascia Lata, per 36 square centimeters	C1762
C1856	Suspend Tutoplast Processed Fascia Lata, per 48 square centimeters	C1762
C1857	Suspend Tutoplast Processed Fascia Lata, per 84 square centimeters	C1762
C1858	DuraDerm Acellular Allograft, per 8 or 14 square centimeters	C2631
C1859	DuraDerm Acellular Allograft, per 21, 24, or 28 square centimeters	C2631
C1860	DuraDerm Acellular Allograft, per 48 square centimeters	C2631
C1861	DuraDerm Acellular Allograft, per 36 square centimeters	C2631
C1862	DuraDerm Acellular Allograft, per 72 square centimeters	C2631
C1863	DuraDerm Acellular Allograft, per 84 square centimeters	C2631
C1864	Bard Sperma Tex Mesh, per 13.44 square inches	C1781
C1865	Bard FasLata Allograft Tissue, per 8 or 14 square centimeters	C1762
C1866	Bard FasLata Allograft Tissue, per 24 or 28 square centimeters	C1762
C1867	Bard FasLata Allograft Tissue, per 36 or 48 square centimeters	C1762
C1868	Bard FasLata Allograft Tissue, per 96 square centimeters	C1762
C1869	Gore Thyroplasty Device, per 8, 12, 30, or 37.5 square centimeters (0.6mm)	C1878
C1870	DermMatrix Surgical Mesh, per 16 square centimeters	C1781
C1871	DermMatrix Surgical Mesh, per 32 or 64 square centimeters	C1781
C1873	Bard 3DMax Mesh, medium or large size	C1781
C1929	Catheter, Maverick Monorail PTCA Catheter, Maverick Over-the-Wire PTCA Catheter	C1725
C1930	Catheter, percutaneous transluminal coronary angioplasty, Coyote Dilatation Catheter 20mm/30mm/40mm	C1725
C1931	Catheter, Talon Balloon Dilatation Catheter	C1725
C1932	Catheter, SciMed Remedy Coronary Balloon Dilatation Infusion Catheter (20mm), Dispatch Coronary Infusion Catheter, Ultra Fuse 4mm, Ultra Fuse 8mm, Ultra Fuse-X, AngioDynamics Pulse Spray Infusion Catheter, AngioDynamics Unifuse Infusion Catheter, Merit Medical Systems Mistique Infusion Catheter	C1725

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C1932	Catheter, Cordis Regatta Flow Guided Infusion Catheter, Cordis Prowler Plus Microcatheter, Cordis Prowler Small Profile Infusion Microcatheter, Cordis MassTransit Max ID Microcatheter, Microcatheter Cordis Transit Microcatheter, Cordis RapidTransit Infusion Catheter, Cordis Plus Microcatheter	C1887
C1932	Catheter, Cordis Commodore Temporary Occlusion Balloon Catheter	C2628
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), Opti-Plast PTA Catheter (5.5 Fr), Tru Trac 5Fr Percutaneous Transluminal Angioplasty Balloon Dilatation Catheter, OptiPlast XT 5 Fr Percutaneous Transluminal Angioplasty Catheter (various sizes)	C1725
C1934	Catheter, Ultraverse 3.5F Balloon Dilatation Catheter, Interventional Technologies Cutting Balloon	C1725
C1935	Catheter, WorkHorse PTA Balloon Catheter	C1725
C1936	Catheter, Uromax Ultra High Pressure Balloon Dilatation Catheters with Hydroplus Coating, UrethraMax High Pressure Urethral Balloon Dilatation Catheter, Carson Zero Tip Balloon Dilatation Catheters with HydroPlus Coating, Passport Balloon on a Wire Dilatation Catheters with HydroPlus Coating, Tandem Thin-Shaft Transureteroscopic Balloon Dilatation Catheter with Hydro Plus Coating, Trilogy Low Profile Balloon Dilatation Catheters with HydroPlus Coating, Ureteral Dilators with Hydro Plus Coating and Procedural Sheath, Amplatz Renal Dilator Set	C1726
C1937	Catheter, Synergy Balloon Dilatation Catheter, Symmetry Small Vessel Balloon Dilatation Catheter with Glidex Hydrophilic Coating, Symmetry Stiff Shaft Small Vessel Balloon Dilatation Catheter with Glidex Hydrophilic Coating, XXL Large Balloon Dilatation Catheter	C1725
C1937	Catheter, Explorer ST (6 Fr), Explorer 360 Jr., Explorer 360, Explorer ST	C1730
C1938	Catheter, Bard UroForce Balloon Dilatation Catheter, Cook Urological Urodynamic Catheter	C1726
C1939	Catheter, NinjaFX PTCA Dilatation Catheter, Raptor PTCA Dilatation Catheter, Ninja, NC Raptor PTCA Dilatation Catheter, Charger PTCA Dilatation Catheter, Titan PTCA Dilatation Catheter, Titan Mega PTCA Dilatation Catheter	C1725
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, Cordis PowerFlex P3 PTA Balloon Catheter	C1725
C1941	Catheter, Jupiter PTA Balloon Dilatation Catheter, Cordis OPTA ProPTA Dilatation Catheter, Cordis SLALOM PTA Dilatation Catheter	C1725
C1942	Catheter, Cordis Maxi LD PTA Balloon Catheter	C1725
C1943	Catheter, RX CrossSail Coronary Dilatation Catheter, OTW OpenSail Coronary Dilatation Catheter	C1725
C1944	Catheter, Maxforce Single-Use Biliary Balloon Dilatation Catheter, Rapid Exchange Single-Use Biliary Balloon Dilatation Catheter	C1726
C1945	Catheter, Cordis Savvy PTA Dilatation Catheter	C1725
C1946	Catheter, R1s Rapid Exchange Pre-Dilatation Balloon Catheter	C1725
C1947	Catheter, Gazelle Balloon Dilatation Catheter	C1725
C1948	Catheter, Pursuit Balloon Angioplasty Catheter, Cook Accent Balloon Angioplasty Catheter	C1725
C1949	Catheter, Endosonics Oracle MegaSonics Five-64 F/X PTCA Catheter	C1725
C1979	Catheter, Endosonics Visions PV 8.2F Intravascular Ultrasound Imaging Catheter, Endosonics Avanar F/X Intravascular Ultrasound Imaging Catheter	C1753
C1980	Catheter, Atlantis SR Coronary Imaging Catheter	C1753
C1981	Catheter, coronary angioplasty balloon, Adante, Bonnie, Bonnie 15mm, Bonnie Monorail 30mm or 40mm, Bonnie Sliding Rail, Bypass Speedy, Chubby, Chubby Sliding Rail, Coyote 20mm, Coyote 9/15/25mm, Maxxum, NC Ranger, NC Ranger 9mm, Ranger 20mm, Long Ranger 30mm or 40mm, 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, ACE—1cm, ACE—2 cm, ACE Graft, Long ACE, Pivot, Cobra (10, 14, 18, 30, 40mm in lengths)	C1725

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C2000	Catheter, Orbiter ST Steerable Electrode Catheter	C1730
C2001	Catheter, Constellation Diagnostic Catheter	C1731
C2002	Catheter, Irvine Inquiry Steerable Electrophysiology 5F Catheter, Livewire Steerable Electrophysiology Catheter	C1730
C2002	Catheter, Livewire EP Catheter 7 Fr Duo-Decapolar (model 401932)	C1731
C2002	Catheter, Marinr, RF Marinr MC	C1733
C2003	Catheter, Irvine Inquiry Steerable Electrophysiology 6F Catheter	C1730
C2004	Catheter, electrophysiology, BioSense Webster EP Deflectable Tip (Octapolar)	C1730
C2005	Catheter, electrophysiology, BioSense Webster EP Deflectable Tip Catheter (Hexapolar)	C1730
C2006	Catheter, electrophysiology, BioSense Webster EP Deflectable Tip Catheter (Decapolar)	C1730
C2007	Catheter, electrophysiology, Irvine Luma-Cath 6F Fixed Curve Electrophysiology Catheter, IBI-1000 Inquiry Fixed Curve EP Catheter (5 Fr), IBI-1000 Inquiry Fixed Curve EP Catheter (6 Fr, Bipolar), IBI-1000 Inquiry Fixed Curve EP Catheter (6 Fr, Decapolar), IBI-1000 Inquiry Fixed Curve EP Catheter (6 Fr, Octapolar), IBI-1000 Inquiry Fixed Curve EP Catheter (6 Fr, Quadrapolar), Santoro Fixed Curve Catheter	C1730
C2007	Catheter, electrophysiology, Ismus Cath Deflectable 20-Pole Catheter/Crista Cath II Deflectable 20-Pole Catheter	C1731
C2008	Catheter, electrophysiology, Irvine Luma-Cath 7F Steerable Electrophysiology Catheter Model 81910, Model 81915, Model 81912	C1730
C2009	Catheter, electrophysiology, IrvineLuma-Cath 7F Steerable Electrophysiology Catheter Model 81920	C1730
C2010	Biosense Webster Fixed Curve Electrophysiology Catheter (Decapolar, Hexapolar, Octapolar, Quadrapolar)	C1730
C2011	Catheter, electrophysiology, Biosense Webster Deflectable Tip Catheter (Quadrapolar)	C1730
C2012	Catheter, ablation, Biosense Webster Celsius Braided Tip Ablation Catheter, Biosense Webster Celsius Long Reach Ablation Catheter	C1733
C2012	Catheter, ablation, Biosense Webster Celsius 5mm Temperature Ablation Catheter, Biosense Webster Celsius Temperature Sensing Diagnostic/Ablation Tip Catheter	C2630
C2013	Catheter, ablation, Biosense Webster Celsius Large Dome Ablation Catheter	C1733
C2014	Catheter, ablation, Biosense Webster Celsius II Asymmetrical Ablation Catheter	C1733
C2015	Catheter, ablation, Biosense Webster Celsius II Symmetrical Ablation Catheter	C1733
C2016	Catheter, ablation, Navi-Star DS Diagnostic/Ablation Catheter	C1732
C2016	Catheter, ablation, Navi-Star Thermo-Cool Temperature Diagnostic/Ablation Catheter	C1732
C2017	Catheter, ablation, Navi-Star Diagnostic/Ablation Deflectable Tip Catheter	C1732
C2018	Catheter, ablation, Polaris DX, Polaris LE (7 Fr)	C1730
C2018	Catheter, ablation, Polaris T Ablation Catheter, Steerocath-T, Steerocath-A, MECA Ablation Catheter	C1733
C2019	Catheter, EP Medsystems Deflectable Electrophysiology Catheter	C1730
C2020	Catheter, ablation, Blazer II XP, Blazer II 6F, Blazer II High Torque Distal (HTD), Blazer II (7 Fr)	C1733
C2021	Catheter, EP SilverFlex Electrophysiology Catheter	C1730
C2022	Catheter, ablation, Cardiac Pathways Chilli Cooled Ablation Catheter Model 41422, 41442, 45422, 45442, 43422, 43442	C2630
C2023	Catheter, ablation, Cardiac Pathways Chilli Cooled Ablation Catheter, Standard Curve (Model 3005), Large Curve (Model 3006)	C2630

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C2100	Catheter, electrophysiology, Cardiac Pathways CS Reference Catheter, Boston Scientific Special Procedure Steero Dx Octa, Boston Scientific Map Pacing Catheter	C1730
C2101	Catheter, electrophysiology, Cardiac Pathways RV Reference Catheter, Boston Scientific EPT-Dx Steerable	C1730
C2102	Catheter, electrophysiology, Cardiac Pathways 7F Radii Catheter	C1730
C2103	Catheter, electrophysiology, Cardiac Pathways 7F Radii Catheter with Tracking, Boston Scientific Valve Mapper SteeroDx	C1730
C2104	Catheter, electrophysiology, Lasso Deflectable Circular Tip Mapping Catheter, Cardima Tracer Over-the-Wire Mapping Microcatheter, Cardima PathFinder Microcatheter, Cardima Revelation Microcatheter	C1730
C2151	Catheter, Veripath Peripheral Guiding Catheter	C1887
C2152	Catheter, Cordis 5F, 6F, 7F, 8F, 9F, 10F Vista Brite Tip Guiding Catheter, Cordis 0.056 Vista Brite Tip Guiding Catheter (5 Fr), Cordis Vista Brite Tip IG Introducer Guiding Catheter (7 Fr), Cordis Vista Brite Tip IG Introducer Guiding Catheter (8 Fr), Cordis Vista Brite Tip Supra-Aortic Guiding Catheter (8 Fr), Cordis Vista Brite Tip Supra-Aortic Guiding Catheter (9 Fr), Cordis Envoy Large Lumen Guiding Catheter (5 Fr), Cordis Envoy Large Lumen Guiding Catheter (6 Fr)	C1887
C2153	Catheter, electrophysiology, Bard Viking Fixed Curve Catheter (Bipolar, Quadrapolar, ASP Models only)	C1730
C2200	Catheter, Arrow-Trerotola Percutaneous Thrombolytic Device Catheter	C1757
C2300	Catheter, Varisource Standard Catheter, Nucletron Nasopharyngeal Brachytherapy Catheter	C1728
C2597	Clinicath Peripherally Inserted Midline Catheter (PICC) Dual Lumen PolyFlow Polyurethane Catheter 18G (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 16G (includes catheter and introducer), BDL Single-Lumen Polyurethane Midline Catheter (catheter and introducer only), Ethicon Endo-Surgery 18G/20G *Single Lumen* BIOVUE Midline Catheter Starter Set (catheter and introducer only), Ethicon Endo-Surgery 18G *Dual Lumen* BIOVUE Midline Catheter Starter Set (catheter and introducer only) **NOTE**: To appropriately bill for the above pass-through devices, report two categories. The catheter should be reported with category code C1751 and the introducer/sheath should be reported with category code C1894.	C1751/ C1894
C2597	BD First MidCath Catheter (3 Fr, 4 Fr, 5 Fr, 20cm/4 Fr, 20cm/5 Fr), Dual Lumen Silicone Midline Catheter Dual Lumen Silicone Midline Catheter (5 Fr/5Fr, 20 cm), BDL Single-Lumen Polyurethane PICC, Bard Per-Q-Cath, Bard Per-Q-Cath Plus, Bard RadPICC, Bard Groshong Peripherally Inserted Central Catheter (PICC)	C1751
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), 5Fr Dual Lumen Silicone PICC (catheter and introducer only), BDL 16G/18G/20G Dual-Lumen Cath Catheter (catheter and introducer only) NOTE: To appropriately bill for the above pass-through devices, report two categories. The catheter should be reported with category code C1751 and the introducer/sheath should be reported with category code C1894.	C1751/ C1894
C2598	BD First PICC Catheter	C1751
C2599	Boston Scientific Vaxcel Peripherally Inserted Central Catheter (PICC), Cook Peripherally Inserted Central Venous Catheter	C1751
C2599	Clinicath Peripherally Inserted Central Catheter (PICC) Single-Lumen PolyFlow Polyurethane Catheter 16G/18G/19G (includes catheter and introducer), BD First PICC Catheter, 1.9 Fr, 2.8 Fr, 3 Fr, 4 Fr, 5 Fr Single-Lumen Silicone PICC (catheter and introducer only), Ethicon Endo-surgery 18G/20G/24G *Single Lumen* BIOVUE Peripherally Inserted Central Catheter Starter Set (catheter and introducer only), Ethicon Endo-surgery 16G/18G *Dual Lumen* BIOVUE Peripherally Inserted Central Catheter Starter Set (catheter and introducer only) NOTE: To appropriately bill for the above pass-through devices, report two categories. The catheter should be reported with category code C1751 and the introducer/sheath should be reported with category code C1894.	C1751/ C1894

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C2601	Catheter, Bard Dual Lumen Ureteral Catheter, Cook Urological Ureteral Dilatation Balloon, Flexima Ureteral Catheter, Axxcess Ureteral Catheter (6 Fr), C-Flex Ureteral Catheter, Dual Lumen Ureteral Catheter	C1758
C2602	Catheter, Spectranetics 1.4/1.7mm Vitesse C Concentric Laser Catheter, Spectranetics 0.9 mm Vitesse C Concentric Laser Catheter (model 110-003)	C1885
C2603	Catheter, Spectranetics 2.0mm Vitesse Concentric Laser Catheter	C1885
C2604	Catheter, Spectranetics 2.0mm Vitesse E Eccentric Laser Catheter	C1885
C2605	Catheter, Spectranetics Extreme Laser Catheter, Spectranetics Extreme 0.9mm Coronary Angioplasty Catheter (model 110-001)	C1885
C2605	Catheter, Spectranetics Extreme Laser Catheter	C1885
C2606	Catheter, Oratec SpineCath XL Intradiscal Catheter	C1754
C2607	Catheter, Oratec SpineCath Intradiscal Catheter	C1754
C2608	Catheter, Scimed 6F Wiseguide Guide Catheter, Cyber Guide Catheter, Merit Medical Systems Trax Interventional Guide Catheter (7 Fr), Merit Medical Systems Trax Cavern Interventional Guide Catheter (8 Fr), Mighty Max Guide Catheter (7 Fr), Triguide-Flex Guide Catheter (10 Fr)	C1887
C2609	Catheter, Flexima Biliary Drainage Catheter with Locking Pigtail, Flexima Biliary Drainage Catheter with Twist Loc Hub, Flexima Biliary Drainage Catheters with Temp Tip, AngioDynamics Abscession Biliary Drainage Catheter	C1729
C2610	Catheter, Arrow FlexTip Plus Intraspinal Catheter Kit	C1755
C2611	Catheter, Medtronic PS Medical AlgoLine Intraspinal Catheter System/Kit Models 81102, 81192	C1755
C2612	Catheter, Medtronic InDura Intraspinal Catheter, Myelotec Video Guided Catheter, EBI VueCath Steerable Spinal Catheter, Synchromed Vascular Catheter (models 8702, 8700A, 8700V)	C1755
C2700	Defibrillator, single chamber, implantable, MycroPhylax Plus	C1722
C2701	Defibrillator, single chamber, implantable, Phylax XM	C1722
C2702	Defibrillator, single chamber, implantable, Ventak Prizm 2 VR Model 1860	C1722
C2703	Defibrillator, single chamber, implantable, Ventak Prizm VR HE Models 1852, 1857	C1722
C2704	Defibrillator, single chamber, implantable, Ventak Mini IV+ Models 1793, 1796	C1722
C2801	Defibrillator, dual chamber, implantable, ELA Medical Defender IV DR Model 612	C1721
C2802	Defibrillator, dual chamber, implantable, Phylax AV	C1721
C2803	Defibrillator, dual chamber, implantable, Ventak Prizm DR HE Models 1853, 1858, Biotronik Tachos DR	C1721
C2804	Defibrillator, dual chamber, implantable, Ventak Prizm 2 DR Models 1861	C1721
C2805	Defibrillator, dual chamber, implantable, Jewel AF (Model 7250)	C1721
C2806	Defibrillator, implantable, Gem VR Model 7227	C1722
C2807	Defibrillator, implantable, Contak CD Model 1823	C1882
C2808	Pacemaker, implantable, Contak TR Model 1241 **NOTE**: Contak TR Model 1241 was previously listed as "Defibrillator, implantable, Contak TR Model 1241" in Transmittal A-01-17. New information from the manufacturer indicates this is a pacemaker. The above descriptor reflects this change.	C2621
C3001	Lead, defibrillator, implantable, Kainox RV	C1777
C3001	Lead, defibrillator, implantable, Kainox SL	C1895
C3002	Lead, defibrillator, implantable, EasyTrak (Models 4510, 4511, 4512, 4513)	C1899
C3003	Lead, defibrillator, implantable, Endotak Reliance S (models 0127, 0128, 0129)	C1777
C3003	Lead, defibrillator, implantable, Endotak Reliance (models 0147, 0148, 0149)	C1895

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C3003	Lead, defibrillator, implantable, Endotak SQ Array XP (Model 0085), Endotak SQ Array (models 0048, 0049), Endotak SQ Patch (models 0047, 0063)	C1896
C3004	Lead, defibrillator, implantable, Intervene (Models 497-23, 497-24)	C1777
C3400	Prosthesis, breast, Mentor Saline-Filled Contour Profile, Mentor Siltex Spectrum Mammary Prosthesis, Mentor Siltex Gel-Filled Mammary Prosthesis, Smooth-Surface Gel-Filled Mammary Prosthesis, Mcghan Biodimensional Anatomical Tissue Expander Saline-Filled (BioSpan Textured, Style 133, 133FV, 133MV, 133LV), Mentor Tissue Expander, Mentor Contour Profile Tissue Expander, Mentor Siltex Becker Expander/Mammary Prosthesis	C1789
C3401	Prosthesis, breast, Mentor Saline-Filled Spectrum, Mcghan BioCurve Round, BioCell Textured, Saline-Filled Moderate Profile (Style 168), Mcghan BioCurve Round, Smooth Saline-Filled Moderate Profile (Style 68), Mcghan Biodimensional BioCurve Shaped (BioCell Textured Full Height, Saline Filled, Style 163), Mcghan Breast Implant Smooth Silicone-Filled Intrashiel Barrier (Moderate Profile, Round, Style 110), Mcghan BioCell Textured Silicone-Filled Intrashiel Barrier (Standard Profile, Round, Style 40)	C1789
C3500	Prosthesis, penile, Mentor Alpha I Inflatable Penile Prosthesis, Mentor Alpha I Narrow-Base Inflatable Penile Prosthesis	C1813
C3500	Prosthesis, penile, Mentor Acu-Form Malleable Penile Prosthesis, Mentor Malleable Penile Prosthesis	C2622
C3510	Prosthesis, AMS Sphincter 800 Urinary Prosthesis	C1815
C3551	Guide wire, percutaneous transluminal coronary angioplasty, Choice, Luge, Patriot, PT Graphix Intermediate, Trooper, Mailman 182/300 cm, Glidewire Gold Guidewire, Platinum Plus Guidewire, Platinum Plus Guidewire with Glidex Hydrophilic Coating, Jagwire Single-Use High Performance Guide Wire, Merit Medical Systems Extender Guidewire, Merit Medical Systems Tomcat PTCA Guidewire, Platinum Plus Guide Wire (0.014 and 0.018 in diameters)	C1769
C3552	Guide wire, Hi-Torque Whisper, Zebra Single-Use Exchange Guidewire	C1769
C3553	Guide wire, Cordis Stabilizer Marker Wire Steerable Guidewire, Cordis Wizdom Marker Wire Steerable Guidewire, Cordis ATW Marker Wire Steerable Guidewire, Cordis Shinobi Steerable Guidewire, Cordis ATW Steerable Guidewire, Cordis Cinch QR Steerable Guidewire Extension, Cordis Stor Q Guidewire, Cordis Essence Steerable Guidewire, Cordis Instinct Steerable Guidewire, Cordis Agility 10 Hydrophilic Steerable Guidewire, Cordis Agility 14 Hydrophilic Steerable Guidewire, Cordis Stabilizer Balanced Performance Guidewire, Cordis Stabilizer Plus Steerable Guidewire, Cordis Shinobi Plus Steerable Guidewire (models 547-214, 547-214X), Cordis Stabilizer XS Steerable Guidewire (models 527-914, 527-914J, 527-914X, 527-914Y), Cordis SV Guidewire—5cm Distal Taper Configuration (models 503-558, 503-558X), 8cm Distal Taper Configuration (models 503-658, 503-658X), 14cm Distal Taper Configuration (models 503-758, 503-758X), Cordis Wisdom ST Steerable Guidewire (models 537-114, 537-114J, 537-114X, 537-114Y)	C1769
C3554	Guide wire, Jindo Tapered Peripheral Guidewire	C1769
C3555	Guide wire, Wholey Hi-Torque Plus Guide Wire System, 145cm, 190cm, 300cm	C1769
C3556	Guide wire, Endosonics Cardiometrics WaveWire Pressure Guide Wire, Cardiometrics FloWire Doppler Guide Wire, Radi Pressure Wire 3 Sensor	C1769
C3557	Guidewire, HyTek Guidewire, Biotronik Galeo Hydro Guide Wire, Microvena Ultra Select Nitinol Guidewire, Wilson-Cook Axcess 21 Wire Guide, Wilson-Cook Roadrunner Extra Support Wire Guide, Wilson-Cook Tracer Wire Guide, Wilson-Cook Tracer Hybrid Wire Guide, Wilson-Cook Tracer Metro Wire Guide, Wilson-Cook Protector Wire Guides	C1769
C3800	Infusion pump, implantable, programmable, SynchroMed EL Infusion Pump, SynchroMed Infusion Pump	C1772
C3801	Infusion pump, Arrow/MicroJect PCA System	C2626
C3851	Intraocular lens, Elastic Ultraviolet-Absorbing Silicone Posterior Chamber Intraocular Lens with Toric Optic Model AA-4203T, Model AA-4203TF, Model AA-4203TL	C1780
C4000	Pacemaker, single chamber, ELA Medical Opus G Model 4621, 4624	C1786
C4001	Pacemaker, single chamber, ELA Medical Opus S Model 4121, 4124	C1786

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C4002	Pacemaker, single chamber, ELA Medical Talent Model 113	C1786
C4003	Pacemaker, single chamber, Kairos SR	C1786
C4004	Pacemaker, single chamber, Actros SR+, Actros SR-B+	C1786
C4005	Pacemaker, single chamber, Philos SR, Philos SR-B	C1786
C4006	Pacemaker, single chamber, Pulsar Max II SR 1180, 1181	C1786
C4007	Pacemaker, single chamber, Marathon SR 291-09, 292-09R, 292-09X	C1786
C4008	Pacemaker, single chamber, Discovery II SSI 481	C2620
C4009	Pacemaker, single chamber, Discovery II SR 1184, 1185, 1186, 1187	C1786
C4300	Pacemaker, dual chamber, Integrity AFx DR Model 5342, Integrity U DR 5336	C1785
C4301	Pacemaker, dual chamber, Integrity AFx DR Model 5346	C1785
C4302	Pacemaker, dual chamber, Affinity VDR 5430	C1785
C4303	Pacemaker, dual chamber, ELA Brio Model 112 Pacemaker System	C1785
C4304	Pacemaker, dual chamber, ELA Medical Brio Model 212, Talent Model 213, Talent Model 223	C1785
C4305	Pacemaker, dual chamber, ELA Medical Brio Model 222	C1785
C4306	Pacemaker, dual chamber, ELA Medical Brio Model 220	C1785
C4307	Pacemaker, dual chamber, Kairos DR	C1785
C4308	Pacemaker, dual chamber, Inos^{2,} Inos $^{2+}$	C1785
C4309	Pacemaker, dual chamber, Actros DR+, Actros D+, Actros DR-A+, Actros SLR+	C1785
C4310	Pacemaker, dual chamber, Actros DR-B+	C1785
C4311	Pacemaker, dual chamber, Philos DR, Philos DR-B, Philos SLR	C1785
C4312	Pacemaker, dual chamber, Pulsar Max II DR 1280	C1785
C4313	Pacemaker, dual chamber, Marathon DR 293-09, 294-09, 294-09R, 294-10	C1785
C4314	Pacemaker, dual chamber, Momentum DR 294-23	C1785
C4315	Pacemaker, dual chamber, Selection AFm 902 SLC 902C	C1785
C4316	Pacemaker, dual chamber, Discovery II DR 1283, 1284, 1285, 1286	C1785
C4317	Pacemaker, dual chamber, Discovery II DDD 981	C2619
C4600	Lead, pacemaker, SL-BP	C1779
C4600	Lead, pacemaker, Synox, Polyrox, Elox, Retrox, ELC, PR-B Permanent Implantable Pacing Lead (models PR 44 B, PR 48 B, PR 52 B, PR 58 B), PR-S Permanent Implantable Pacing Lead (models PR 44 S, PR 48 S, PR 52 S, PR 58 S), PY-PSBV Permanent Implantable Pacing Lead (models PY 44 PSBV, PY 48 PSBV, PY 52 PSBV, PY 58 PSBV), PY-PV Permanent Implantable Pacing Lead (models PY 48 PV, PY 52 PV, PY 58 PV), ZY-PBV Permanent Implantable Pacing Lead (models ZY 52 PBV, ZY 58 PBV), ZY-PJBV Permanent Implantable Pacing Lead (models ZY 48 PJBV, ZY 52 PJBV), ZY-PJUSBV Permanent Implantable Pacing Lead (models ZY 44 PJUSBV, ZY 48 PJUSBV, ZY 52 PJUSBV), ZY-PJUV Permanent Implantable Pacing Lead (models ZY 48 PJUV, ZY 52 PJUV), ZY-PJV Permanent Implantable Pacing Lead (models ZY 48 PJV, ZY 52 PJV), ZY-PUSBV Permanent Implantable Pacing Lead (models ZY 52 PUSBV, ZY 58 PUSBV), ZY-PUV Permanent Implantable Pacing Lead (models ZY 52 PUV, ZY 58 PUV), ZY-PV Permanent Implantable Pacing Lead (models ZY 52 PV, ZY 58 PV)	C1898
C4602	Lead, pacemaker, Tendril SDX 1488K/46, Tendril SDX 1488K/52, Tendril SDX 1488K/58	C1898
C4603	Lead, pacemaker, Oscor PR 4015, 4016, 4017, 4018, Flexion 4015, 4016, 4017, 4018, ELA Medical Stela Pacing Lead (models BJ44, BJ45), ELA Medical Stelid II Pacing Lead (model BTFR26D), ELA Medical Stelix Pacing Lead (model BR45D), HT-PB Permanent Implantable Pacing Lead (models HT 48 PB, HT 52 PB, HT 58 PB), HT-PB Permanent Implantable Pacing Lead (models HT 48 PB, HT 52 PB, HT 58 PB), Oscor PY (models 4439, 4440, 4441), Oscor ZY	C1898

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
	(models 4036, 4037, 4038, 4039, 4042, 4056, 4057), RT-TJV Permanent Implantable Pacing Lead (models RT 48 TJV, RT 52 TJV), RT-TV Permanent Implantable Pacing Lead (models RT 52 TV, RT 58 TV), RU-TBV Permanent Implantable Pacing Lead (models RU 52 TBV, TU 58 TBV, RU 70 TBV), RU-TJSBV Permanent Implantable Pacing Lead (models RU 44 TJSBV, RU 48 TJSBV, RU 52 TJSBV), RU-TJV Permanent Implantable Pacing Lead (models RU 48 TJV, RU 52 TJV), RU-TSBV Permanent Implantable Pacing Lead (models RU 52 TSBV, RU 58 TSBV, RU 70 TSBV), RU-TV Permanent Implantable Pacing Lead (models RU 52 TV, RU 58 TV), KY-SBV Oscor Permanent Implantable Pacing Lead (KY-48 SBV, KY 52 SBV, KY 58 SBV), KY-USBV Oscor Permanent Implantable Pacing Lead (KY 48 USBV, KY 52 USBV, KY 58 USBV, KY 70 USBV), KY-UV Oscor Permanent Implantable Pacing Lead (KY 48 UV, KY 52 UV, KY 58 UV, KY 70 UV), KY-V Oscor Permanent Implantable Pacing Lead (KY 48 V, KY 52 V, KY 58 V, KY 70 V)	
C4604	Lead, pacemaker, Crystalline ActFix ICF09, CapsureFix Novus 5076	C1898
C4605	Lead, pacemaker, CapSure Epi 4968	C1898
C4606	Lead, pacemaker, Flextend 4080, 4081, 4082	C1898
C4607	Lead, pacemaker, Fineline II 4452, 4453, 4454, 4455, 4477, 4478, Fineline II EZ 4463, 4464, 4465, 4466, 4467, 4468, Thinline II 430-25, 430-35, 432-35, Thinline II EZ 438-25, 438-35, Fineline II EZ Sterox (models 4469, 4470, 4471, 4472, 4473, 4474), Fineline II Sterox (models 4456, 4457, 4458, 4459, 4479, 4480), Thinline II EZ Sterox (models 438-25S, 438-35S), Thinline II Sterox (models 430-25S, 430-35S, 432-35S)	C1898
C5000	Stent, coronary, BX Velocity with Hepacoat on Raptor Stent System (28 or 33mm in length)	C1874
C5001	Stent, biliary, Bard Memotherm-Flex Biliary Stent, small/medium diameter	C1877
C5002	Stent, biliary, Bard Memotherm-Flex Biliary Stent, large diameter	C1877
C5003	Stent, biliary, Bard Memotherm-Flex Biliary Stent, x-large diameter	C1877
C5004	Stent, biliary, Cordis Palmaz Corinthian IQ Transhepatic Biliary Stent	C1877
C5005	Stent, biliary, Cordis Palmaz Corinthian IQ Transhepatic Biliary Stent and Delivery System	C1876
C5006	Stent, biliary, Cordis Medium Palmaz Transhepatic Biliary Stent and Delivery System	C1876
C5007	Stent, biliary, Cordis Palmaz XL Transhepatic Biliary Stent (40mm length)	C1877
C5008	Stent, biliary, Cordis Palmaz XL Transhepatic Biliary Stent (50mm length)	C1877
C5009	Stent, biliary, Biliary VistaFlex Stent	C1877
C5010	Stent, biliary, Rapid Exchange Single-Use Biliary Stent System	C2625
C5011	Stent, biliary, IntraStent, IntraStent LP, Wilson-Cook ST2 Soehendra Tannenbaum	C1877
C5012	Stent, biliary, IntraStent DoubleStrut LD, IntraStent Double Strut Para Mount Biliary Stent, Olympus Double Layer Biliary Stent	C1877
C5013	Stent, biliary, IntraStent DoubleStrut, IntraStent DoubleStrut XS	C1877
C5014	Stent, biliary, Medtronic AVE Bridge Stent System—Biliary Indication (10mm, 17mm, 28mm)	C1876
C5015	Stent, biliary, Medtronic AVE Bridge Stent System—Biliary Indication (40mm-60mm, 80-100mm), Medtronic AVE Bridge X3 Biliary Stent System (17mm)	C1876
C5016	Stent, biliary, Wallstent Single-Use Covered Biliary Endoprosthesis with Unistep Plus Delivery System, Gore Biliary Endoprosthesis	C1876
C5017	Stent, biliary, Wallstent RP Biliary Endoprosthesis with Unistep Plus Delivery System (20/40/42/60/68 mm in length)	C1876
C5018	Stent, biliary, Wallstent RP Biliary Endoprosthesis with Unistep Plus Delivery System (80/94 mm in length)	C1876
C5019	Stent, biliary, Flexima Single Use Biliary Stent System	C2625
C5020	Stent, biliary, Cordis Smart Nitinol Stent Transhepatic Biliary System (20mm in length)	C1876
C5021	Stent, biliary, Cordis Smart Nitinol Stent Transhepatic Biliary System (40 or 60 mm in length)	C1876
C5022	Stent, biliary, Cordis Smart Nitinol Stent Transhepatic Biliary System (80mm in length)	C1876

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C5023	Stent, biliary, BX Velocity Transhepatic Biliary Stent and Delivery System (8 or 13mm in length)	C1876
C5024	Stent, biliary, BX Velocity Transhepatic Biliary Stent and Delivery System (18mm in length)	C1876
C5025	Stent, biliary, BX Velocity Transhepatic Biliary Stent and Delivery System (23mm in length)	C1876
C5026	Stent, biliary, BX Velocity Transhepatic Biliary Stent and Delivery System (28 or 33mm in length)	C1876
C5027	Stent, coronary, BX Velocity with Hepacoat on Raptor Stent System (8 or 13mm in length), BX Velocity e.5/5.0 Balloon Expandable Stent with RAPTOR Over-the-Wire Delivery System	C1874
C5028	Stent, coronary, BX Velocity with Hepacoat on Raptor Stent System (18mm in length)	C1874
C5029	Stent, coronary, BX Velocity with Hepacoat on Raptor Stent System (23mm in length)	C1874
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), BiodivYsio AS PC Coated Coronary Stent Delivery System (11mm)	C1876
C5031	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), BiodivYsio AS PC Coated Coronary Stent Delivery System (15mm)	C1876
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	C1876
C5033	Stent, coronary, Niroyal Advance Premounted Stent System (9mm), Tenax-XR Stent and Delivery system	C1876
C5034	Stent, coronary, Niroyal Advance Premounted Stent System (12mm, 15mm)	C1876
C5035	Stent, coronary, Niroyal Advance Premounted Stent System (18mm)	C1876
C5036	Stent, coronary, Niroyal Advance Premounted Stent System (25mm)	C1876
C5037	Stent, coronary, Niroyal Advance Premounted Stent System (31mm)	C1876
C5038	Stent, coronary, BX Velocity Balloon-Expandable Stent with Raptor Over-the-Wire Delivery System	C1876
C5039	Stent, peripheral, IntraCoil Peripheral Stent (40mm stent length	C1877
C5039	Stent, Dynalink Biliary Self-Expanding Stent System	C1876
C5040	Stent, peripheral, IntraCoil Peripheral Stent (60mm stent length)	C1877
C5041	Stent, coronary, Medtronic BeStent 2 Over-the-Wire Coronary Stent System (24mm, 30mm), Medtronic BeStent 2 Rapid Exchange Coronary Stent System (24mm, 30mm)	C1876
C5042	Stent, coronary, Medtronic BeStent 2 Over-the-Wire Coronary Stent System (18mm), Medtronic BeStent 2 Rapid Exchange (18mm)	C1876
C5042	Stent, coronary, Medtronic BeStent 2 Over-the-Wire Coronary Stent System (18mm)	C1876
C5043	Stent, coronary, Medtronic BeStent 2 Over-the-Wire Coronary Stent System (15mm), Medtronic BeStent 2 Rapid Exchange (15mm)	C1876
C5043	Stent, coronary, Medtronic BeStent 2 Over-the-Wire Coronary Stent System (15mm)	C1876
C5044	Stent, coronary, Medtronic BeStent 2 Over-the-Wire Coronary Stent System (9mm, 12mm), Medtronic BeStent 2 Rapid Exchange Coronary Stent System (9mm, 12mm)	C1876
C5044	Stent, coronary, Medtronic BeStent 2 Over-the-Wire Coronary Stent System (9mm, 12mm)	C1876
C5045	Stent, coronary, Multilink Tetra Coronary Stent System	C1876
C5046	Stent, coronary, Radius 20mm Self Expanding Stent with Over the Wire Delivery System	C1876
C5047	Stent, coronary, Niroyal Elite Premounted Stent System (15mm, 25mm, 31mm)	C1876
C5048	Stent, coronary, GR II Coronary Stent	C1877
C5130	Stent, colon, Wilson-Cook Colonic Z-Stent	C1877

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C5131	Stent, colorectal, Bard Memotherm Colorectal Stent Models30R060	C1877
C5132	Stent, colorectal, Bard Memotherm Colorectal Stent Models30R080	C1877
C5133	Stent, colorectal, Bard Memotherm Colorectal Stent Models30R100	C1877
C5134	Stent, enteral, Wallstent Enteral Endoprosthesis and Unistep Delivery System (90mm in length), Wallstent RP Enteral Endoprosthesis and Unistep Delivery System (90mm in length)	C1876
C5279	Stent, ureteral, Boston Scientific Contour Soft Percuflex Stent with Hydroplus Coating (Braided), Contour Soft Percuflex Stent with Hydroplus Coating, Contour VL Variable Length Percuflex Stent with Hydroplus Coating, Percuflex Plus Stent with Hydroplus Coating, Percuflex Stent (Braided), Contour Closed Soft Percuflex Stent with HydroPlus Coating, Contour Injection Soft Percuflex Stent with HydroPlus Coating, Soft Percuflex Stent, Percuflex Tail Plus Tapered Ureteral Stent, Contour Polaris Ureteral Stent with Hydroplus Coating, Mardis Firm Stent with HydroPlus Coating, Mardis Soft Stent with HydroPlus Coating, Mardis Soft Variable Length Stent with Hydro Plus Coating, Nottingham One-Step Tapered Dilators with HydroPlus Coating, Stretch VL Variable Length Flexima Stent with HydroPlus Coating, Percuflex Urinary Diversion Stent	C2617
C5280	Stent, ureteral, Bard Inlay Double Pigtail Ureteral Stent, Circon Surgitek Classic Double Pigtail Ureteral Stent, Circon Surgitek Classic Double Pigtail Hydrophilic Coated Ureteral Stent, Circon Surgitek QuadraCoil Ureteral Stent, Circon Surgitek Double J II Ureteral Stent, Circon Surgitek Lithostent Ureteral Stent, Circon Surgitek Soft-Curl Ureteral Stent, Cook Urological LSe Double Pigtail Ureteral Stent, Cook Urological LSe Multi Length Ureteral Stent, Cook Urological Multi Length Ureteral Stent, Cook Urological Double Pigtail Ureteral Stent, Cook Urological Double Pigtail Ureteral Stent with AQ (Hydrophilic) Coating, Cook Urological Mazer Antegrade Double Pigtail Ureteral Stent Set	C2617
C5280	Cook Urological Cystostomy Catheter, Cook Urological Ureteral Dilator Set, Cook Urological Fascial Dilator Set	C2627
C5281	Stent, tracheobronchial, Wallgraft Tracheobronchial Endoprosthesis with Unistep Delivery System (70mm in length)	C1876
C5282	Stent, tracheobronchial, Wallgraft Tracheobronchial Endoprosthesis with Unistep Delivery System (20mm, 30mm, 50mm in length)	C1876
C5283	Wallstent Transjugular Intrahepatic Portosystemic Shunt (TIPS) with Unistep Plus Delivery System (94 mm in length), Wallstent RP TIPS Endoprosthesis with Unistep Plus Delivery System (94 mm in length)	C1876
C5284	Stent, tracheobronchial, UltraFlex Tracheobronchial Endoprothesis (covered) and the Unistep Plus Delivery System	C1874
C5284	Stent, tracheobronchial, UltraFlex Tracheobronchial Endoprosthesis (non-covered) and the Unistep Plus Delivery System	C1876
C5600	Vascular Closure Device, VasoSeal ES (Extravascular Security) Device, VasoSeal Vascular Hemostasis Device	C1760
C5601	Vascular closure device, Vascular Solutions Duett Sealing Device 1000	C1760
C6001	Mesh, hernia, Bard Composix Mesh, per 8 or 21 inches, Atrium Hernia/Surgical Mesh, Bard Composix E/X Mesh, Bard Kugel Hernia Patch (large circle, 12 cm x 12 cm), Bard Kugel Hernia Patch (small circle, 8 cm x 8 cm), Bard Kugel Hernia Patch (large oval, 14 cm x 18 cm), Bard Kugel Hernia Patch (medium oval, 11 cm x 14 cm), Bard Kugel Hernia Patch (small oval, 8 cm x 12 cm), Bard Mesh PerFix Plug, Bard Visilex Mesh (3 in x 6 in), Bard Visilex Mesh (4.5 in x 6 in)	C1781
C6002	Mesh, hernia, Bard Composix Mesh, per 32 inches	C1781
C6003	Mesh, hernia, Bard Composix Mesh, per 48 inches	C1781
C6004	Mesh, hernia, Bard Composix Mesh, per 80 inches	C1781
C6005	Mesh, hernia, Bard Composix Mesh, per 140 inches	C1781
C6006	Mesh, hernia, Bard Composix Mesh, per 144 inches	C1781
C6012	Pelvicol Acellular Collagen Matrix, per 8 or 14 square centimeters	C1763
C6012	Contigen Bard Collagen Implant (Contigen Implant)	C2631

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C6013	Pelvicol Acellular Collagen Matrix, per 21, 24, or 28 square centimeters	C1763
C6014	Pelvicol Acellular Collagen Matrix, per 40square centimeters	C1763
C6015	Pelvicol Acellular Collagen Matrix, per 48 square centimeters	C1763
C6016	Pelvicol Acellular Collagen Matrix, per 96 square centimeters	C1763
C6017	Gore-Tex DualMesh Biomaterial, per 75 or 96 square centimeters (1mm thick)	C1781
C6018	Gore-Tex DualMesh Biomaterial, per 150 square centimeters oval shaped (1mm thick)	C1781
C6019	Gore-Tex DualMesh Biomaterial, per 285 square centimeters oval shaped (1mm thick)	C1781
C6020	Gore-Tex DualMesh Biomaterial, per 432 square centimeters (1mm thick)	C1781
C6021	Gore-Tex DualMesh Biomaterial, per 600 square centimeters (1mm thick)	C1781
C6022	Gore-Tex DualMesh Biomaterial, per 884 square centimeters oval shaped (1mm thick)	C1781
C6023	Gore-Tex DualMesh Plus Biomaterial, per 75 square centimeters (1mm thick), Gore-Tex DualMesh Plus Biomaterial, per 96 square centimeters (1mm thick)	C1781
C6024	Gore-Tex DualMesh Plus Biomaterial, per 150 square centimeters oval shaped (1mm thick)	C1781
C6025	Gore-Tex DualMesh Plus Biomaterial, per 285 square centimeters oval shaped (1mm thick)	C1781
C6026	Gore-Tex DualMesh Plus Biomaterial, per 432 square centimeters (1mm thick)	C1781
C6027	Gore-Tex DualMesh Plus Biomaterial, per 600 square centimeters (1mm thick)	C1781
C6028	Gore-Tex DualMesh Plus Biomaterial, per 884 square centimeters oval shaped (1mm thick)	C1781
C6029	Gore-Tex DualMesh Plus Biomaterial, per 150 square centimeters oval shaped (2mm thick)	C1781
C6030	Gore-Tex DualMesh Plus Biomaterial, per 285 square centimeters oval shaped (2mm thick)	C1781
C6031	Gore-Tex DualMesh Plus Biomaterial, per 432 square centimeters (2mm thick)	C1781
C6032	Gore-Tex DualMesh Plus Biomaterial, per 600 square centimeters (2mm thick)	C1781
C6033	Gore-Tex DualMesh Plus Biomaterial, per 884 square centimeters (2mm thick)	C1781
C6034	Bard Reconix ePTFE Reconstruction Patch 150 square centimeters (2mm thick)	C1781
C6035	Bard Reconix ePTFE Reconstruction Patch 150 square centimeters (1mm thick), 75 square centimeters (2mm thick)	C1781
C6036	Bard Reconix ePTFE Reconstruction Patch 50 or 75 square centimeters (1mm thick), 50 square centimeters (2mm thick)	C1781
C6037	Bard Reconix ePTFE Reconstruction Patch 300 square centimeters (1 mm thick)	C1781
C6038	Bard Reconix ePTFE Reconstruction Patch 600 square centimeters (1mm thick), 300 square centimeters (2mm thick)	C1781
C6039	Bard Reconix ePTFE Reconstruction Patch 884 square centimeters oval shaped (1mm thick)	C1781
C6040	Bard Reconix ePTFE Reconstruction Patch 600 square centimeters (2mm thick)	C1781
C6041	Bard Reconix ePTFE Reconstruction Patch 884 square centimeters oval shaped (2mm thick)	C1781
C6050	Sling fixation system for treatment of stress urinary incontinence, Female In-Fast Sling Fixation System with Electric Inserter with Sling Material	C1771
C6050	Sling fixation system for treatment of stress urinary incontinence, Female In-Fast Sling Fixation System with Electric Inserter without Sling Material, Advanced UroScience Acyst	C2631
C6051	DePuy Orthotech Restore, Stratasis Urethral Sling, 20/40 cm	C1763
C6052	Stratasis Urethral Sling, 60 cm	C1763
C6053	Surgisis Soft Tissue Graft, per 70cm, 105cm, 140cm	C1763
C6054	Surgisis Enhanced Strength Soft Tissue Graft, per 4.2cm, 20cm, 28cm, 40cm	C1763

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C6055	Surgisis Enhanced Strength Soft Tissue Graft, per 52.5cm, 60cm, 70cm	C1763
C6056	Surgisis Enhanced Strength Soft Tissue Graft, per 105cm, 140cm	C1763
C6057	Surgisis Hernia Graft, per 195cm	C1763
C6058	SurgiPro Hernia-Mate Plug, medium or large	C1781
C6080	Sling fixation system for treatment of stress urinary incontinence, AMS Male InVance Fixation System with Electric Inserter with Sling Material and Disposable Pressure Sensor, Male Straight-In Fixation System with Electric Inserter with Sling Material and Disposable Pressure Sensor	C1771
C6080	Sling fixation system for treatment of stress urinary incontinence, AMS Male InVance Fixation System with Electric Inserter without Sling Material and Disposable Pressure Sensor, Male Straight-In Fixation System with Electric Inserter without Sling Material and Disposable Pressure Sensor	C2631
C6200	Vascular graft, Exxcel Soft ePTFE Vascular Graft, Exxcel ePTFE Vascular Graft (6mm or greater in diameter)	C1768
C6200	Vena cava filter, B. Braun Vena Tech LGM Vena Cava Filter (Dual Approach—model # 31328, Jugular Approach—model # 31326, Femoral Approach—model # 31327), Cordis TrapEase Permanent Vena Cava Filter, Stainless Steel Green Field Vena Cava Filter with 12 Fr Introducer System	C1880
C6201	Vascular graft, Impra Venaflo Vascular Graft with Carbon (Straight Graft, 10cm or 20cm in length), Atrium Hybrid PTFE Vascular Graft	C1768
C6202	ascular graft, Impra Venaflo Vascular Graft with Carbon, Straight Graft, 30cm or 40cm in length	C1768
C6203	Vascular graft, Impra Venaflo Vascular Graft with Carbon, Straight Graft (50cm in length) or CenterFlex Venaflo Stepped Graft (45cm in length)	C1768
C6204	Vascular graft, Impra Venaflo Vascular Graft with Carbon, Stepped Graft, 20cm, 25cm, 30cm, 35cm, 40cm, or 45cm in length	C1768
C6205	Vascular graft, Impra Carboflo Vascular Graft (Straight Graft, 10 cm in length), Atrium Advanta PTFE Vascular Graft	C1768
C6206	Vascular graft, Impra Carboflo Vascular Graft, Straight Graft, 20 cm in length	C1768
C6207	Vascular graft, Impra Carboflo Vascular Graft, Straight Graft, 30 cm, 35cm, or 40cm in length	C1768
C6208	Vascular graft, Impra Carboflo Vascular Graft, Straight Graft (50cm in length), Access Tapered Graft (40cm in length), or Stepped Graft (45 or 50 cm in length)	C1768
C6209	Vascular graft, Impra Carboflo Vascular Graft, CenterFlex Straight Graft (40cm or 50cm in length) or CenterFlex Stepped Graft (40cm, 45cm or 50 cm in length)	C1768
C6210	Exxcel ePTFE Vascular Graft (less than 6mm in diameter), Hemashield Woven Double Velour Fabric, Hemashield Finesse Ultra-thin, Knitted Cardiovascular Patch	C1768
C6500	Sheath, guiding, Preface Braided Guiding Sheath (anterior curve, multipurpose curve, posterior curve)	C1893
C6501	Sheath, Soft Tip Sheaths	C1893
C6502	Sheath, electrophysiology, Perry Exchange Dilator	C1893
C6525	Sheath, Spectranetics Laser Sheath 500-001, 500-012, 500-013	C2629
C6650	Introducer, guiding, Fast-Cath Two-Piece Guiding Introducer (models 406869, 406892, 406893, 406904), Fast-Cath Duo SL1 Guiding Introducer, Fast-Cath Duo SL2 Guiding Introducer	C1893
C6650	Introducer, Fast-Cath Hemostasis Introducer, Maximum Hemostasis Introducer, AccuStick II with RO Marker Introducer System, Cook Extra Large Check-Flo Introducer, Cook Keller-Timmermans Introducer	C1894
C6651	Introducer, guiding, Seal-Away CS Guiding Introducer 407508, 407510	C1892
C6652	Introducer, Bard Safety Excalibur Introducer, Bard Radstic Microintroducer, Bard Universal Microintroducer	C1894

Crosswalk to New Category C-codes (continued)

Current C-Code	Long Descriptor	New Category C-Code
C6700	Perfluoron (per 2ml vial, 5ml vial, or 7ml vial)	C1784
C6700	Synthetic absorbable sealant, Focal Seal-L	C2615
C8099	Spectranetics Lead Locking Device (models 518-018, 518-019, 518-020)	C1773
C8099	Oscor C/VS Permanent Implantable Pacing Lead Adaptor (models C/VS-10, C/VS-40), Oscor M/VS Permanent Implantable Pacing Lead Adaptor (models M/VS-10, M/VS-40), Oscor VS/M Permanent Implantable Pacing Lead Adaptor (model VS/M-10), Oscor VV Permanent Implantable Pacing Lead Extension (models VV-10, VV-40), Oscor C/VS Permanent Implantable Pacing Lead Extension (VKU-10V, VKU-20V, VKU-40V, VKU-10M, VKU-20M, VKU-40M), Oscor C/VS Permanent Implantable Pacing Lead Adaptor (BVS/VS-15, B/VS-15, B/VS-20)	C1883
C8102	Surgi-Vision Esophageal Stylet Internal Coil	C1770
L8614	Cochlear device/system	

Further Guidance Regarding Billing Under the Outpatient Prospective Payment System (OPPS)

The Health Care Financing Administration (HCFA) has provided further guidance related to specific areas of billing under OPPS and to incorporate several Questions and Answers previously posted on the Internet.

Proper Billing for Blood Products and Blood Storage and Processing

When a hospital purchases blood or blood products from a community blood bank, or runs its own blood bank and assesses a charge for the blood or blood product, the hospital reports blood and blood products under revenue code series 38x – Blood, along with the appropriate blood HCFA Common Procedure Coding System (HCPCS) code. The amount billed should reflect the hospital's charge.

When a hospital does not pay for the blood or blood product, it often incurs an administrative cost from a community blood bank for the bank's processing, storage and related expenses. In this situation, the hospital bills the charge associated with these blood bank storage and processing costs under revenue code 390 – Blood Storage/ Processing, and reports the HCPCS code assigned to the blood or blood product and the number of units transfused. Payment is based on the ambulatory payment classification (APC) to which the HCPCS code is assigned, times the number of units transfused.

If a hospital purchases blood, or blood products, or runs its own blood bank, it is not appropriate to bill both the blood or blood product under revenue code series 38x and an additional blood bank storage and processing charge under revenue code 390.

A transfusion APC will be paid to the hospital for transfusing blood once per day, regardless of the number of units transfused. Hospitals should bill for transfusion services using revenue code 391 – Blood Administration, and HCPCS code 36430 through 36460. The hospital may also bill the laboratory revenue codes (30x or 31x) along with the HCPCS codes for blood typing and cross matching and other laboratory services related to the patient who receives the blood.

Proper Billing of Outpatient Surgical Procedures

When multiple surgical procedures are performed at the same session, it is not necessary to bill separate charges for each procedure. It is acceptable to bill a single charge under the revenue code that describes where the procedure was performed (e.g., operating room, treatment room, etc.) on the same line as one of the surgical procedure CPT/HCPCS codes and bill the other procedures using the appropriate CPT/HCPCS code and the same revenue code, but with "0" charges in the charge field.

In the past, some hospitals billed a single emergency room (ER) visit charge which included charges for any surgical procedures that were performed in the ER at the time of the ER visit. Under the OPPS, HCFA requires your hospitals to bill a separate charge for ER visits and surgical procedures effective with claims with dates of service on or after July 1, 2001. If a surgical procedure is performed in the ER, the charge for the procedure must be billed with the emergency room revenue code. If an ER visit occurs on the same day, a charge should be billed for the ER visit and a separate charge should be billed for the surgical procedure(s) performed. As described above, a single charge may be billed for all surgical procedures if more than one is performed in the ER during the same session.

The following is an example of how a claim should be completed under these new reporting requirements:

42 REV. CD.	44 HCPCS/RATES	45 SERV. DATE	47 TOTAL CHARGES
450	99283/25	7/5/2001	$150
450	12011	7/5/2001	$300
450	12035	7/5/2001	
250		7/5/2001	$70
270		7/5/2001	$85

The charge for both surgical procedures in this example is reflected in the $300 charge shown on the line with procedure code 12011.

Further Guidance Regarding Billing Under the Outpatient PPS (continued)

NOTE: This instruction was previously posted on the Internet as a question and answer with an effective date of January 1, 2001. Since many hospitals did not change their reporting requirements based on the question and answer, this notification reflects a new prospective date of July 1, 2001.

Inpatient Part B Services

Inpatient Part B services which are paid under OPPS include:

- Diagnostic X-ray tests, and other diagnostic tests (excluding clinical diagnostic laboratory tests).
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians.
- Surgical dressings applied during an encounter at the hospital and splints, casts, and other devices used for reduction of fractures and dislocations (splints and casts, etc., include dental splints).
- Implantable prosthetic devices.
- Pneumococcal vaccine and its administration, hepatitis B vaccine and its administration.
- Certain preventive screening services (pelvic exams, screening sigmoidoscopies, screening colonoscopies, bone mass measurements, prostate screening.).

NOTE: Payment for some of these services is packaged into the payment rate of other separately payable services.

Inpatient Part B services paid under other payment methods include:

- Clinical diagnostic laboratory tests, prosthetic devices other than implantable ones and other than dental which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.
- Leg, arm, back and neck braces, trusses, and artificial legs, arms, and eyes, including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.
- Take home surgical dressings, outpatient physical therapy, outpatient occupational therapy, and outpatient speech pathology services.
- Ambulance services.
- Screening pap smears, screening fecal occult blood tests, and screening mammography.

Appropriate Revenue Codes to Report Medical Devices that Have Been Granted Pass-Through Status

Hospitals must report all pass-through devices using HCPCS codes that begin with a "C" under any of the following revenue codes to bill implantable or medical devices of brachytherapy and cryoablation that have been granted pass- through status:

272 274 275 276 278 279 280
289 290 or 624

These devices should not be reported utilizing any other revenue code series or sub-categories.

For services furnished **on or after April 1, 2001,** devices that qualify for transitional pass-through payments are those that fit in one of the established active device categories. To qualify for pass-through payments, a device must meet the definition of a device and all of the requirements compiled in 42 CFR 419.43 and other established requirements. Refer to page XX for an initial and definition of an active device category. In particular, one aspect of that definition states that devices are "single use," come in contact with human tissue, and are surgically implanted or inserted.

HCPCS Clarification

The following revenue codes when billed without HCPCS are covered services. However, no separate payment is made under OPPS. The charge for these services is included in the transitional outpatient payment (TOP) and outlier calculations. The applicable revenue codes are:

250 251 252 254 255 257 258
259 260 262 263 264 269 270
271 272 274, 275 276 278 279
280 289 290 370 371 372 379
390 399 560 569 621 622 624
630 631 632 633 637 700 709
710 719 720 721 762 810 819
and 942

Any other revenue codes that are billable on a hospital outpatient claim must contain a HCPCS code in order to assure payment under OPPS. Claims containing revenue codes that require HCPCS will be return to provider (RTP), when no HCPCS is shown on the line.

HCPCS/Revenue Code Edits

The Fiscal Intermediary Standard System (FISS) maintainer will edit for HCPCS and revenue codes relationship on services billed for pass-through medical devices under OPPS.

Procedures Subject to Home Health Consolidated Billing

The Balance Budget Act of 1997 required consolidated billing of all home health services while a beneficiary in under a home health plan of care authorized by a physician. The Health Care Financing Administration (HCFA) has revised the previously released listing of procedures that were subject to home health consolidated billing effective October 1, 2000.

Services affected by the home health consolidated billing when billed by various types of providers submitting claims to either Medicare intermediaries or carriers at the same time as a home health episode are subject to denial because payment is provided to the home health agency creating the episode.

The services affected are:

- Non-routine supply
- Therapy codes

The new lists of procedures are effective for claims with dates of service January 1, 2001 through December 31, 2001 that are submitted to the carrier or intermediary July 1, 2001 and later.

Yearly updates to this list of procedures will be issued in conjunction with the release of the HCFA Common Procedure Coding System (HCPCS) annual update.

Non-Routine Supply Codes Affected

A4212	A4310	A4311	A4312	A4313
A4314	A4315	A4316	A4319	A4320
A4321	A4322	A4323	A4324	A4325
A4326	A4327	A4328	A4329	A4330
A4331	A4332	A4333	A4334	A4335
A4338	A4340	A4344	A4346	A4347
A4348	A4351	A4352	A4353	A4354
A4355	A4356	A4357	A4358	A4359
A4361	A4362	A4364	A4365	A4367
A4368	A4369	A4370	A4371	A4372
A4373	A4374	A4375	A4376	A4377
A4378	A4379	A4380	A4381	A4382
A4383	A4384	A4385	A4386	A4387
A4388	A4389	A4390	A4391	A4392
A4393	A4394	A4395	A4396	A4397
A4398	A4399	A4400	A4402	A4404
A4421	A4455	A4460	A4462	A4481
A4622	A4623	A4625	A4626	A4649
A5051	A5052	A5053	A5054	A5055
A5061	A5062	A5063	A5071	A5072
A5073	A5081	A5082	A5093	A5102
A5105	A5112	A5113	A5114	A5119
A5121	A5122	A5123	A5126	A5131
A6020	A6021	A6022	A6023	A6024
A6154	A6196	A6197	A6198	A6199
A6200	A6201	A6202	A6203	A6204
A6205	A6206	A6207	A6208	A6209
A6210	A6211	A6212	A6213	A6214
A6215	A6219	A6220	A6221	A6222
A6223	A6224	A6228	A6229	A6230
A6231	A6232	A6233	A6234	A6235
A6236	A6237	A6238	A6239	A6240
A6241	A6242	A6243	A6244	A6245
A6246	A6247	A6248	A6251	A6252
A6253	A6254	A6255	A6256	A6257
A6258	A6259	A6261	A6262	A6266
A6402	A6403	A6404	A6405	A6406
A7501	A7502	A7503	A7504	A7505
A7506	A7507	A7508	A7509	

Therapy Codes Affected

G0193	G0194	G0195	G0196	G0197	
G0198	G0199	G0200	G0201	64550	90901
90911	92506	92507	92508	92510	92525
92526	92597	92598	95831	95832	95833
95834	95851	95852	96105	97001	97002
97003	97004	97012	97014	97016	97018
97020	97022	97024	97026	97028	97032
97033	97034	97035	97036	97039	97110
97112	97113	97116	97124	97139	97140
97150	97504	97520	97530	97532	97533
97535	97537	97542	97545	97546	97601
97602	97703	97750	97799		

HCFA Announces Revised Fee Policy in Fiscal Year 2001 for Provider Education and Training Activities

As a Medicare contractor, First Coast Service Options, Inc. (FCSO) develops and delivers education and training seminars, publications, and resources stipulated and authorized by the Health Care Financing Administration (HCFA). Many activities identified and funded by HCFA as required curricula are provided free of charge to the provider and supplier communities.

In recent years, HCFA has supported significant expansions in provider education and training efforts that extend beyond the core curricula Medicare contractors have traditionally presented. This expansion has been in response to major program changes, and the need to educate providers and suppliers on specific Medicare regulations and procedures. This has allowed FCSO to present additional seminars, publications, and resources by assessing fees. The fees defray program expenses, and are never for profit. The topics are of significant interest, and have been well received by providers and suppliers.

Effective June 2000, HCFA advised Medicare contractors to discontinue charging fees for education and training activities, and initiated a review of its policies for such activities. FCSO conveyed this change in communications to key provider and supplier organizations, and through its customer service professionals. In announcing performance expectations for Fiscal Year 2001, HCFA has provided further guidelines. Medicare contractors are authorized to resume charging to recover expenses associated with performing provider training and education initiatives. Fair and reasonable costs are authorized for discretionary activities deemed supplemental or enhancements to core educational requirements. A variety of events and activities within the required curriculum will continue to be presented at no cost to providers and suppliers.

Presently, FCSO's education departments are developing enhanced and supplemental programs and resources to support improved Medicare education. These initiatives, many of which are customer requested, will be announced soon. FCSO will use the revenue generated to cover the cost of the education and training provided. Event information and registration forms are posted on the provider Web site - **www.floridamedicare.com** under the "Education & Training" page. Providers are invited and encouraged to visit this Web site regularly to access the latest event and resource information.

www.floridamedicare.com — Florida Medicare Provider Website

The following outlines information that is available on the First Coast Service Options, Inc. (FCSO) Florida Medicare provider Web site.

What's New

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

Part A

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

Part B

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

Shared (information shared by Part A and Part B)

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

EDI (Electronic Data Interchange)

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

Extra

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

Search

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

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

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904-905-8880

Medicare Websites

PROVIDERS

Florida Medicare Contractor
www.floridamedicare.com
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BENEFICIARIES

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