

Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

From the Intermediary Medical Director

Medical Review Progressive Corrective Action 3

General Information

Medical Review Process Revision to Medical Record Requests 5

General Coverage

New CLIA Waived Tests 8

Outpatient Hospital Services

Correction to the Outpatient Services Fee Schedule 9

Skilled Nursing Facility Services

Fee Schedule and Consolidated Billing for Skilled Nursing Facility (SNF) Services 12

Fraud and Abuse

Justice Recovers Record \$1.5 Billion in Fraud Payments - Highest Ever for One Year Period 20

Medical Policies

Use of the American Medical Association's (AMA's) Current Procedural Terminology (CPT) Codes on Contractors' Web Sites 21

Outpatient Prospective Payment System

January 2001 Update: Coding Information for Hospital Outpatient Prospective Payment System (OPPS) 93

Providers Will Be Asked to Register to Receive Medicare Bulletins and Newsletters

During this fiscal year, Medicare contractors will be required to register providers/suppliers to receive hard copy bulletins and newsletters. First Coast Service Options, Inc. is developing a process in accordance with the guidelines issued by the Health Care Financing Administration.

At this time there is no need to contact your Medicare contractor, you will be notified regarding this new registration requirement in the near future.



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
- _____

Table of Contents

In This Issue 1

**From the Intermediary Medical Director
A Physician's Focus**

Medical Review Progressive Corrective Action ... 3

Administrative

About The Medicare A Bulletin 4

General Information

Medical Review Process Revision to
Medical Record Requests 5

Medicare Appeals Workloads in FY 2001 5

Mandatory Assignment Now Required for
Drugs and Biologicals 5

Coordination of Benefits Trading Partners 6

General Coverage

Intravenous Iron Therapy 7

Replacement of Prosthetic Devices and Parts 7

New CLIA Waived Tests 8

Outpatient Hospital Services

Correction to the Outpatient Services
Fee Schedule 9

2001 Clinical Laboratory Fee Schedule—
Additions and Revisions 9

Inpatient Hospital Services

Payment for Method II Home Dialysis Supplies .. 9

Intestinal Transplantation 10

Changes in Payment of Swing-Bed
Facility Services 11

Skilled Nursing Facility Services

Fee Schedule and Consolidated Billing for
Skilled Nursing Facility (SNF) Services ... 12

**Comprehensive Outpatient
Rehabilitation Facility Services**

Payment of Drugs, Biologicals and Supplies in
a Comprehensive Outpatient Rehabilitation
Facility 19

Fraud and Abuse

Justice Recovers Record
\$1.5 Billion in Fraud Payments
Highest Ever for One Year Period 20

Medical Policies

General Information About Medical Policies .. 21

Medical Policy Table of Contents 21

Use of the American Medical Association's
(AMA's) Current Procedural Terminology
(CPT) Codes on Contractors' Web Sites .. 21

Final Medical Policies

33216: Implantation of Automatic Defibrillators . 22

55873: Cryosurgical Ablation of the Prostate 24

62263: Percutaneous Lysis of Epidural
Adhesions 26

70544: Magnetic Resonance Angiography
(MRA) 28

70551: Magnetic Resonance Imaging of the
Brain 31

72192: Computed Tomography of the Pelvis 33

80100: Qualitative Drug Screen 38

82105: Tumor Markers 40

82310: Total Calcium 43

82435: Chloride 46

84152: Complexed and Free Prostate Specific
Antigen 48

93000: Electrocardiography 50

93312: Transesophageal Echocardiogram ... 53

93724: Electronic Analysis of Pacemaker System
and Pacer Cardioverter-Defibrillator 56

93990: Duplex Scan of Hemodialysis Access .. 59

95115: Allergen Immunotherapy 61

95900: Nerve Conduction Studies 63

A0426: Ground Ambulance Services 66

C1203: Ocular Photodynamic Therapy (OPT)
with Verteporfin 70

DYSPHRT: Dysphagia/Swallowing Diagnosis
and Therapy 72

J9999: Antineoplastic Drugs 73

PHPPROG: Psychiatric Partial Hospitalization
Program 83

**Additions and Revisions to Previously
Published Medical Policy**

44388: Colonoscopy—Addition to Policy 91

82108: Aluminum—Addition to Policy 91

J1950: Leuprolide Acetate—Addition to Policy . 92

93965: Non-Invasive Evaluation of Extremity
Veins—Addition to Policy 92

G0108: Diabetes Outpatient Self-Management
Training—Revision to Policy 92

J7190: Hemophilia Clotting Factors—
Addition to Policy 92

Percutaneous Transluminal Angioplasty and
Carotid Stents 92

Outpatient Prospective Payment System

January 2001 Update: Coding Information for
Hospital Outpatient Prospective Payment
System (OPPS) 93

Technical Corrections to the January 2001
Update: Coding Information for Hospital
Outpatient Prospective Payment System .. 101

Hospital Outpatient Prospective Payment
System
Pass-Through Payment Corrections for Two
Radiopharmaceuticals 103

Educational Resources

www.floridamedicare.com—Florida Medicare's
Provider Web Site 104

Order Form - Part A Materials 105

Other Information

Index to *Medicare A Bulletin* 106

Addresses, Medicare Websites,
and Phone Numbers 111

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

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A PHYSICIAN'S FOCUS

Medical Review Progressive Corrective Action

No matter what your politics, the recent presidential election in Florida gave citizens an opportunity to gain a better understanding of data collection and its possible uses. All processes produce outcomes that vary. This is true of processes from making parts in a factory to counting votes in an election. It is also true of billing a CPT code on a health care claim. Data synthesis allows one to evaluate variation in outcomes and consider types of variation. A common cause type of variation can generally be attributed to random error. A special cause type of variation is generally attributed to something unique and requires an investigation into the origin of the special cause.

This fiscal year, the Health Care Financing Administration (HCFA) emphasized the approach contractors are to use in deploying resources and tools for medical review. This approach, known as Progressive Corrective Action, allows contractors to work with providers in correcting claims billing errors. Highlights include:

- the decision to conduct medical review will be data-driven,
- potential problems will be validated by conducting 'probe' reviews,
- Providers will only be subject to the amount of focused medical review necessary to address the nature and extent of the identified problem, and
- Provider feedback and education are essential parts of solving problems.

Through analysis of claims payment data and 'probe' reviews, contractors will direct resources at finding the origin of special cause type of variation. When appropriate, providers with special cause type of variation will require more extensive review and education. It is anticipated that common cause variation can be addressed with minimal review.

Medical review and data analysis is one of the strategies employed by contractors to meet HCFA's goal of paying the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers. Contractors recognize that the complexities of the Medicare Program put providers at risk for some claims billing errors. Most of these errors are not committed knowingly, willfully, or intentionally. The goal of Progressive Corrective Action is to identify errors and take the appropriate action to prevent or address the errors. By communicating directly with the provider or office staff in feedback sessions, First Coast Service Options, Inc. staff wants to make medical review and data analysis an improvement opportunity for providers and 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* will become a quarterly publication. In accordance with the Health Care Financing Administration's 45-day notification parameters, the approximate delivery dates for the coming year are:

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

Important notifications that require communication in between these dates will be published via additional unscheduled special issues and posted to the First Coast Service Option, Inc. (FCSO) website (www.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

GENERAL INFORMATION

Medical Review Process Revision to Medical Record Requests

The Health Care Financing Administration recently mandated that fiscal intermediaries revise their medical review processes to deny claims where providers fail to respond to requests for medical documentation on a timely basis as opposed to returning the claims to providers (RTPs).

Currently, Medicare returns claims to provider (RTPs) for reason code 56900 when medical documentation is not received within 38 days from the date of the request. Upon receipt of the medical documentation, Medicare reprocesses the RTP'd claim based on the medical review determination. However, based on this mandate, the current medical review process will be revised.

Effective April 1, 2001, all claims where medical documentation is not received within 45 days from the ADR request (for medical documentation) will be denied for reason code 56900. If a claim is denied for 56900 (medical documentation not provided within 45 days of request), the claim will **not** be reopened for medical review upon receipt of the medical documentation. The provider's only alternative would be to request an appeal.

Therefore, it is important that providers modify their processes to ensure they respond promptly to medical documentation requests (ADRs). The increase of denials due to a lack of medical documentation will increase the administrative costs of providers and the fiscal intermediary (with the increase of appeals). Therefore, FCSO will be monitoring the volume of 56900 denials as well as appeal requests for this denial and taking corrective actions on those providers that are impacting this denial rate and appeals receipts.

Medicare Appeals Workloads in FY 2001

In an effort to manage incoming appeals in fiscal year (FY) 2001 with the given resources, the Health Care Financing Administration (HCFA) has provided guidance relative to processing appeals. Incoming appeal requests submitted without necessary supporting documentation will be given secondary priority to appeal requests submitted with appropriate documentation. Consequently, determinations or decisions on appeal requests that are submitted without appropriate documentation to support the contention that the initial determination was incorrect could possibly be delayed.

Reconsideration is the first level of appeals for denied Part A claims. Providers are expected to have their files organized well enough to be able to file timely. Good cause for late filing will not be found for providers who submit documentation beyond the HCFA mandated deadline for filing requests for appeals. The deadline for Part A (inpatient skilled nursing facility) is 60 days after the initial determination by medical review. The deadline for Part A (outpatient claims) is six months after the initial deadline by medical review. Documentation should be complete and accompanied with a signed, dated request for reconsideration. The reconsideration mailing, address is:

Medicare Part A
Reconsiderations 17T
P. O. Box 45053
Jacksonville, FL 32203-5053

Mandatory Assignment Now Required for Drugs and Biologicals

Effective for claims processed on or after April 1, 2001 for items furnished on or after February 1, 2001, under section 114 of the Benefits Improvement and Protection Act of 2000 (BIPA), payment for any drug or biological covered under **Medicare Part B** may be made only on an assignment-related basis. No charge or bill may be rendered to anyone for these drugs and biologicals for any amount except for any applicable unmet Part B deductible and coinsurance amounts.

Florida Medicare will provide further information regarding this new requirement as it becomes available on our provider Web site, www.floridamedicare.com.

Coordination of Benefits Trading Partners

The following is a complete list of current trading partners active with First Coast Service Options, Inc. (FCSO) Medicare Part A, as it relates to electronic coordination of benefits (COB).

Trading Partner ID	Company Name	Transmission Frequency
A00031999	AFLAC	Weekly
A46254001	Anthem Insurance, Inc.	Weekly
A20904003	American Postal Workers Union	Weekly
B17177361	Capital Blue Cross	Daily
B20065001	CareFirst BCBS	Weekly
X32301999	Consultec Medicaid	Weekly
E10017303	Empire Blue Cross and Blue Shield	Daily
H68144001	Health Data Management Corp.	Weekly
	Aid Association for Lutherans	
	American Republic	
	North American	
	Celtic Life Insurance	
	Oxford Life Insurance	
	Savers Life Insurance	
	US Able Life Insurance	
	State Farm	
	Highmark Services	
	Continental General	
	Physicians Mutual	
	BCBS of Texas	
	Central Benefits	
	Mutual Protective (Medico Life)	
	Pacific Care Health Plan	
	Pyramids Life	
	Unified Life	
B60654030	Bankers Life & Casualty	Weekly
B35244001	BCBS of Alabama	Daily
DELW19899	BCBS of Delaware	Daily
BCNH03111	BCBS of New Hampshire	Weekly
M02110001	BCBS of Massachusetts	Daily
B32202001	BCBS of Florida	Daily
BSBSI4121	BCBS of Illinois	Daily
MN5512100	BCBS of Minnesota	Weekly
O98225001	Olympic Health Management	Weekly
P61101056	Pioneer Life Insurance Company	Weekly
UTAI78755	United Teachers Association	Weekly
	Humana, Inc.	
WELL50309	Wellmark, Inc.	Daily

The current COB process that was implemented March 23, 1995, produces a maximum number of crossover prospects because of the following features:

- The crossover file format is a standard format. Use of a standard format makes it possible for a greater number of insurers to receive claims from Medicare fiscal intermediaries since they do not have to accommodate individual proprietary formats.
- The enhanced process utilizes the supplemental insurers' eligibility file data, in addition to information furnished via claim submission, to determine crossover prospects and automatically forward appropriate claims payment data.

First Coast Service Options, Inc. will continue to actively pursue opportunities to contract with new trading partners. Any supplemental insurance entity interested in participating in this COB partnership can obtain more information by contacting the COB coordinator at (904) 791-6987.

GENERAL COVERAGE

Intravenous Iron Therapy

Iron deficiency is a common condition in end stage renal disease (ESRD) patients undergoing hemodialysis. Iron is a critical structural component of hemoglobin, a key protein found in normal red blood cells (RBCs) which transports oxygen. Without this important building block, anemic patients experience difficulty in restoring adequate, healthy RBCs that improve hemocrit levels. Clinical management of iron deficiency involves treating patients with iron replacement products while they undergo hemodialysis. Body iron stores can be supplemented with either oral or intravenous (IV) iron products.

The evidence suggests that there is little to distinguish various forms of IV iron therapy in terms of effectiveness. Rather, the medical literature indicates that the mode of intravenous administration is perhaps the most effective treatment for iron deficiency in hemodialysis patients. Unlike oral iron products which must be absorbed through the GI tract, IV iron products are infused directly into the bloodstream in a form that is readily available to the bone marrow for RBC synthesis, resulting in an earlier correction of iron deficiency and anemia. Review of medical literature indicated that the distinction among IV iron products lies within their safety profiles. The IV iron dextran products are associated with a small incidence of severe, life-threatening anaphylaxis. These type I hypersensitivity reactions, which are not dose-related, are immunoglobulin (Ig) E-mediated and are apparently exclusively associated with the dextran forms of injectable iron. In fact, clinical evidence indicates that the dextran component itself is what triggers the severe, life-threatening anaphylactic reactions. *Sodium ferric gluconate complex in sucrose injection* has demonstrated no life-threatening anaphylaxis and a less severe adverse-reaction rate when compared to iron dextran products.

Billing Guidelines

Effective for services furnished **on or after December 1, 2000**, Medicare covers sodium ferric gluconate complex in sucrose injection when used as a first line treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental erythropoietin therapy.

For services furnished **on or after January 1, 2001**, providers must use code J2915 to report sodium ferric gluconate complex in sucrose injection, 62.5 mg.

For services furnished **on or after December 1, 2000**, through **December 31, 2000**, providers must use code J3490 (unclassified drugs) to report sodium ferric gluconate complex in sucrose injection. When billing for an unclassified drug, the name, strength, and dosage of the drug must be indicated to ensure proper reimbursement.

Replacement of Prosthetic Devices and Parts

The Benefits Improvement and Protection Act of 2000 amended section 1834(h)(1) of the Social Security Act by adding a provision (1834 (h)(1)(G)(i)) that requires Medicare payment to be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if an ordering physician determines that the replacement device, or replacement part of such a device, is necessary.

Payment may be made for the replacement of a prosthetic device which is an artificial limb, or replacement part of a device if the ordering physician determines that the replacement device or part is necessary because of any of the following:

1. A change in the physiological condition of the patient;
2. An irreparable change in the condition of the device, or in a part of the device; or
3. The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

This provision supersedes any rule that as of the date of enactment of this Act, may have applied to a 5-year replacement rule with regard to prosthetic devices. In addition, this provision applies to items replaced **on or after April 1, 2001**.

Providers may contact the Region C DMERC, Palmetto GBA, for more information. Palmetto may be contacted at (866) 238-9650, at the address below, or online at <http://www.palmettogba.com>.

Palmetto GBA Medicare
DMERC Operations
P.O. Box 100141
Columbia, SC 29202-3141

New CLIA Waived Tests

Listed below are the latest tests approved by the Centers for Disease Control and Prevention (CDC) 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.

The following tests are effective for services rendered on or after September 15, 2000, processed on or after January 1, 2001:

TEST NAME	MANUFACTURER	CPT CODE(S)	USE
LifeSign Status H.pylori (for wholeblood)	Princeton BioMeditech	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to <i>Helicobacter pylori</i> in whole blood
Abbott Laboratories Medisense Products Precision™ Xtra™ Advanced Diabetes Management System	Abbott Laboratories, Inc.	82962 82010QW	Monitoring of blood glucose levels and measures ketones in whole blood
PTS Bioscanner Test Strips Cholesterol	Polymer Technology Systems, Inc.	82465QW	Cholesterol monitoring
Remel RIM7 A.R.C. H.pylori Test blood	Remel	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to <i>Helicobacter pylori</i> in whole
LifeSign LLC Status Strep A Princeton	BioMeditech	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection, which typically causes strep throat, tonsillitis, and scarlet fever
PTS, Inc. Bioscanner 2000 for Triglycerides	Polymer Technology Systems, Inc.	84478QW	Measures triglycerides in whole blood

The following tests are effective for services processed on or after April 1, 2001:

TEST NAME	MANUFACTURER	CPT CODE(S)	USE
Polymedco, Inc. Poly stat H.pylori	Applied Biotech, Inc.	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to <i>Helicobacter pylori</i> in whole blood
Polymedco, Inc. Poly stat Mono	Applied Biotech, Inc.	86308QW	Qualitative screening test for the presence of heterophile antibodies inhuman whole blood, which is used as an aid in the diagnosis of infectious mononucleosis
Polymedco, Inc. Poly stat A (II)	Applied Biotech, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection, which typically causes strep throat, tonsillitis, and scarlet fever
Trinity Uni-Gold™ H.pylori	Trinity BioTech	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to <i>Helicobacter pylori</i> in whole blood.
Lifestream Technologies Personal Cholesterol Monitor	Lifestream Technologies, Inc.	82465QW	Cholesterol monitoring
Teco Diagnostics URITEK TC-101 Urine Strip Reader	Teco Diagnostics	81003QW	Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
Quidel QuickVue® Influenza Test	Quidel Corporation	87899QW	Qualitative detection of influenza type A and type B antigens from nasal swab, nasal wash or nasal aspirate specimens

The complete list of waived tests is available on the Health Care Financing Administration's Website, <http://www.hcfa.gov/medicaid/cliia/cliahome.htm>.

OUTPATIENT HOSPITAL SERVICES

Correction to the Outpatient Services Fee Schedule

The 2001 Radiology and Other Diagnostic Services outpatient fee schedules published in the December 2000 Special Issue of the *Medicare A Bulletin* (pages 31-38) were printed incorrectly. The fee schedule for these outpatient services has not changed. Therefore, the 2000 update to the fee schedule for outpatient radiology and other diagnostic services published in the December 1999 Special Issue of *the Medicare A Bulletin* (pages 62-68) remain in effect.

2001 Clinical Laboratory Fee Schedule—Additions and Revisions

The 2001 Clinical Laboratory Fee Schedule allowances were provided in the December 2000 Special Issue *Medicare A Bulletin* (pages 17-23). Since the release of that publication, the following 2001 fee schedule allowances have been established or updated **effective for services rendered on and after January 1, 2001**.

The affected codes are:

G0123	\$27.90	P3000	\$14.60	88144	\$27.90	88153	\$14.60
G0143	\$27.90	82962	\$ 1.48	88145	\$27.90	88154	\$14.60
G0144	\$27.90	86294	\$16.91	88147	\$14.60	88164	\$14.60
G0145	\$27.90	87338	\$26.45	88148	\$14.60	88165	\$14.60
G0147	\$14.60	88142	\$27.90	88150	\$14.60	88166	\$14.60
G0148	\$14.60	88143	\$27.90	88152	\$14.60	88167	\$14.60

INPATIENT HOSPITAL SERVICES

Payment for Method II Home Dialysis Supplies

This article clarifies HCFA's policy with respect to billing and payment of Method II home dialysis supplies when an End Stage Renal Disease (ESRD) home dialysis patient is hospitalized as an inpatient. During an inpatient stay, the hospital is responsible for providing all supplies and equipment needed for dialysis. Therefore, the ESRD patient may not use his or her home dialysis supplies on the days that he or she is hospitalized.

Method II suppliers may bill only for the amount of supplies that the beneficiary actually used in the prior month. Home dialysis patients may retain 1 month's worth of emergency supplies. Therefore, in the month following a home dialysis patient's hospitalization, the supplier must reduce the monthly delivery of, and billing for, new supplies to account for the supplies the Method II beneficiary did not use during his or her hospitalization. The effect of this limitation on new supplies is that the home dialysis patient will have sufficient emergency supplies on hand to last for 1 month, but no more than 1 month.

The following HCPCS codes may be identified as Method II ESRD supplies:

A4650	A4655	A4660	A4663	A4670	A4680
A4690	A4700	A4705	A4712	A4714	A4730
A4735	A4740	A4750	A4755	A4760	A4765
A4770	A4771	A4772	A4773	A4774	A4780
A4790	A4800	A4820	A4850	A4860	A4870
A4880	A4890	A4900	A4901	A4905	A4910
A4912	A4913	A4914	A4918	A4919	A4920
A4921	A4927				

Hospitals submit inpatient claims for dialysis supplies on HCFA-1450 (UB-92) claim form or its electronic equivalent by using type of bill 11x.

If the beneficiary had a stay that lasted longer than 3 days, durable medical equipment regional carriers (DMERCs) and suppliers must not count the day of admission or the day of discharge when prorating supplies.

HCFA requires all Method II dialysis suppliers to have a written agreement with a backup renal facility, which maintains the beneficiary's medical records. DMERCs must encourage backup facilities to notify the appropriate supplier if the backup facility becomes aware that a beneficiary became an inpatient for part of a month. When the backup facility notifies the supplier of a beneficiary's inpatient stay, the supplier will know it must prorate its bills for the next month's supplies for that beneficiary. Similarly, suppliers should request that the beneficiaries that they service inform their supplier when they are in the hospital.

Intestinal Transplantation

Effective April 1, 2001, Medicare covers intestinal 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 both mortality and profound morbidity. This procedure is covered only when performed for patients who have failed total parenteral nutrition (TPN) and only when performed in centers 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 are 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 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 central nervous system with the development of multiple kidney stones, renal failure, and permanent brain damage.

Approved Transplant Facilities

Intestinal transplantation may be covered by Medicare 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 to 120 days before the fiducial date must be considered "lost to follow-up" if he or she 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 before the date we receive 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 1 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 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

Completed applications should be sent to:

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

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.

Reimbursement Guidelines

Medicare will not pay a separate cost for organ acquisition to transplant facilities. The DRG payment will be payment in full.

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 glands
- 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 the intestinal transplantation and the liver transplantation are performed simultaneously, the case would be

assigned to DRG 480 (Liver Transplant).

If the intestinal transplantation and the pancreas transplantation are performed simultaneously, 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).

The CPT codes for these services are:

- 44132* Donor enterectomy, open, with preparation and maintenance of allograft; from cadaver donor
- 44133 partial, from living donor
- 44135 Intestinal allotransplantation; from cadaver donor
- 44136 Intestinal allotransplantation; from living

*NOTE: CPT code 44132 is paid to the facility where the organ is procured.

Processing Guidelines

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

- A. Effective for discharges *on or after October 1, 2000*, ICD-9-CM procedure code 46.97 – Transplant of Intestine – was created. The Medicare code editor (MCE) lists this code as a noncovered procedure, no exceptions. The fiscal intermediary will override the MCE when this procedure code is listed and the above coverage criteria are met in an approved transplant facility.
- B. The system should generate an ADR for medical records.
- C. Upon receipt of medical records, the medical review staff must review the bill and the supporting documentation to determine if the coverage criteria are met.
- D. Charges for ICD-9-CM procedure code 46.97 must be billed under revenue code 360 – Operating Room Services.
- E. Bill the procedure used to obtain the donor's organ on the same claim, using appropriate ICD-9-CM procedure codes.
- F. Bill type 11x must be used when billing for intestinal transplants.
- G. Immunosuppressive therapy must be billed based on the established Medicare guidelines.

Changes in Payment of Swing-Bed Facility Services

Section 1883 of the Social Security Act (the Act) permits certain small rural hospitals and critical access hospitals (CAH) to enter into a swing-bed agreement, under which the hospital can use its beds to provide either acute or skilled nursing facility (SNF) care, as needed. Currently, Part A pays for extended care services furnished in Medicare swing-bed hospitals on a cost-related basis, with both calculated rate and retrospective reasonable cost-based rate components. Under Medicare payment principles set forth in section 1883(a)(2)(B) of the Act and regulations at 42 CFR 413.114, swing bed facilities receive payment for two major categories of costs: routine and ancillary.

Changes Based on BIPA 2000

Under section 203 of the Benefits Improvement and Protection Act of 2000 (BIPA 2000), swing beds in CAHs are exempt from section 1888(e)(7) of the Act (as enacted by section 4432(a) of the Balanced Budget Act of 1997),

that applies the SNF prospective payment system (PPS) to SNF services furnished by swing-bed hospitals generally. In addition, this provision establishes a new reimbursement system for CAHs that provides full reasonable cost payment for CAH swing-bed services. This provision is effective with cost reporting periods beginning on or after the date of the enactment of the BIPA 2000, **December 21, 2000**.

These changes apply solely to CAHs with swing beds. Other rural hospitals with swing beds are not affected by this provision and will continue to be reimbursed as described in section 1883 of the Act. CAHs will be contacted directly by the fiscal intermediary Provider Audit and Reimbursement Department with specific information and instructions on some of the changes affecting the cost reports to the swing-bed agreement provision. Should you have any questions, you may contact Star Ortiz, Supervisor at (904) 791-8691.

SKILLED NURSING FACILITY SERVICES

Fee Schedule and Consolidated Billing for Skilled Nursing Facility (SNF) Services

Part B physical, occupational and speech therapy services remain subject to consolidated billing regulations. Until further notice, consolidated billing will not be implemented for all other services and supplies. SNFs may choose to bill for all other Part B services and supplies, and will be paid in accordance with the provisions of this program memorandum. However, SNFs may elect to have suppliers continue to bill Medicare directly for these Part B services.

Effective for services provided **on or after April 1, 2001**, the following guidelines will be implemented:

- New common working file (CWF) edit requirements relating to consolidated billing for SNF Part A services, and related contractor resolution procedures
- New CWF edit requirements 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.

This implementation does not change current intermediary claim processing requirements, except that consolidated billing for Part B services other than therapies is rescinded.

There are no changes in program requirements not identified in this article, such as SNF demand bills, spell of illness requirements, MSP requirements, and basic coverage rules.

SNF instructions are being issued in SNF Manual sections 515-516.6, 529 - 544 and 595.

This instruction does not apply to Medicare beneficiaries enrolled in a Medicare managed care program. SNF Part A PPS and consolidated billing applies only to Medicare fee-for-service beneficiaries.

Fee Schedule for SNF Part B Services

Section 1888(e)(9) of the Social Security Act as modified by the Balanced Budget Act of 1997 requires that the payment amount for Part B services furnished to SNF Part B inpatients and outpatients (type of bill 22x and 23x) shall be the amount prescribed in the otherwise applicable fee schedule. Thus, where a fee schedule exists for the type of service, the fee amount (or charge if less than the applicable fee amount) will be paid.

This requirement will be implemented beginning with services provided **on and after April 1, 2001**.

Fee schedules currently exist for the following services:

- Outpatient rehabilitation services
- Clinical laboratory services
- Radiology and other diagnostic tests
- Prosthetic and orthotic devices
- Surgical dressings.

SNFs will continue to bill to intermediaries on HCFA-1450 (UB-92) claim form or its electronic equivalents.

Fee schedules will be based on either the locality of the provider or statewide (or carrier-wide within the state when multiple carriers exist within the state) depending upon the payment structure of the specific fee schedule.

Application of Part B Deductible and Coinsurance

Where payment for SNF Part B services (bill type 22x and 23x) is made under a fee schedule, any applicable beneficiary deductible and coinsurance are based on the approved amount. This includes situations where fee amounts for specific services are not included in the fee schedule but are determined on an individual basis.

Where payment is made on a reasonable cost basis, deductible and coinsurance continue to be based on SNF charges for the service.

Neither deductible nor coinsurance apply to clinical diagnostic laboratory services.

Neither deductible nor coinsurance apply to pneumococcal pneumonia vaccine (PPV), influenza virus vaccines, or to the administration of either.

Deductible does not apply to screening mammography services.

Services Not Covered by SNF Part B Fee Schedule

Fee schedules are not yet developed for the following services. All other services on bill type 22x and 23x are to be paid via fee schedule.

Medical Supplies

A4570 A4580 A4590

Dialysis Supplies & Equipment

A4650	A4655	A4660	A4663	A4680	A4690
A4700	A4705	A4712	A4714	A4730	A4735
A4740	A4750	A4755	A4760	A4765	A4770
A4771	A4772	A4773	A4774	A4780	A4790
A4820	A4850	A4860	A4870	A4880	A4900
A4901	A4905	A4910	A4912	A4914	A4918
A4919	A4920	A4921	A4927		

E1510	E1520	E1530	E1540	E1550	E1560
E1570	E1575	E1580	E1590	E1592	E1594
E1600	E1610	E1615	E1620	E1625	E1630
E1632	E1635	E1636	E1640		

Therapeutic Shoes

A5500	A5501	A5502	A5503	A5504	A5505
A5506	A5507				

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			

Blood Products

P9010	P9011	P9012	P9013	P9016	P9017	P9018
P9019	P9020	P9021	P9022			

Transfusion Medicine

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			

All Drugs

Drug payment methodology is not changed (reasonable cost for SNFs except where special rules apply).

Publication of Fee Schedules

SNF fee schedule prices and related installation instructions will be provided to intermediaries through the Mainframe Telecommunications System in the same manner that other fee schedule information is provided.

Analysis is not yet completed on whether SNF fee schedule data for intermediaries will be included with other data or whether a separate file will be released.

There will be some differences from current fee schedules in that:

- SNFs bill only the technical or facility component for most services, except where they furnish the complete service or obtain the complete service under arrangements;
- Some services cannot be paid to SNFs; and
- Some services for SNF Part A inpatients for which Part A benefits are payable, cannot be paid to anyone else.

Modifiers will be needed to determine the correct payment amount unless the related HCPCS code definition sufficiently describes the physician/facility component.

SNFs may not obtain physician services under arrangements except for services from physician therapists providing physical, occupational or speech language therapy services, which are required under consolidated billing. Services of physician employees of the SNF are not considered arranged for services, and related current Medicare Intermediary Manual (MIM) and SNF Manual provisions about billing for provider based physician services on Form HCFA-1500 continue to apply.

In addition to mainframe telecommunications system data, HCFA will publish a public use file on the Internet in HTML or PDF format for SNF inquiry and/or downloading and use as reference material. Complete details for this file have not been finalized, but it will contain the following data elements.

- Fee schedule year
- HCPCS code
- Applicable modifiers
- Narrative description of the HCPCS code
- Medicare coverage status (whether or not the item is a Medicare covered service)
- The professional or technical component (PC/TC) indicator for the service
- Whether the code is billable by SNFs.

For codes billable by SNFs:

- Whether included or excluded from Part A PPS
- Bundling requirements for billing if applicable
- Whether code for service considered technical (facility), professional or complete procedure.

SNFs will be expected to access this file for basic information about each HCPCS code. The file will not be included in the SNF Manual. Intermediaries may assist SNFs as appropriate. This file may also be used by intermediaries and carriers in resolving inquiries. Additional related instructions will be issued later.

Special Payment Rules Relating to Fee Schedules for SNFs

A SNF may provide many services to its inpatients either directly or under arrangement. Part A PPS rate includes all services rendered to a SNF inpatient except excluded services identified in section IV of this PM. Services excluded from the SNF PPS rate may not be billed by the SNF under Part B except preventive and screening services (pneumococcal pneumonia, influenza virus and, hepatitis B vaccines, screening mammography, etc.).

Where Part A PPS payment is not applicable to a resident, payment may be made for certain (MIM section 3626.1) services under Part B. The fee schedule payment methodology applies to those services as well as outpatient services.

Following are special payment for services provided directly or under arrangement billed by the SNF for patients with coverage under Part B.

Set Up Services in SNFs for Portable X-ray Equipment

Diagnostic portable X-ray services are covered under Part B when provided in participating SNFs and hospitals, under circumstances in which they cannot be covered under hospital insurance, i.e., the services are not furnished by the participating institution either directly or under arrangements that provide for the institution to bill for the services.

In order to avoid payment for services that are inadequate or hazardous to the patient, the scope of the covered portable X-ray benefit is defined as:

- Skeletal films involving arms and legs, pelvis, vertebral column, and skull;
- Chest films which do not involve the use of contrast media (except routine screening procedures and tests in connection with routine physical examinations); and
- Abdominal films that do not involve the use of contrast media.

Set up costs for portable X-ray equipment in the SNF is billed using HCPCS code Q0092. Set up costs are not applicable for lab or EKG services.

Specimen Collection

Specimen collection is allowed for SNF residents in circumstances such as drawing blood through venipuncture or collecting a urine sample by catheter. Applicable HCPCS codes are:

- G0001 Routine venipuncture for collection of specimen(s)
- P9615 Catheterization for collection of specimen(s)

A separate specimen collection is not paid for throat cultures, routine capillary puncture for clotting or bleeding time, stool specimens.

Costs for related supplies and items such as gloves and slides are also not separately billed.

The current fee amount for specimen collection under the lab fee schedule is paid to the SNF if it draws the blood.

Neither deductible nor coinsurance applies to specimen collection payments.

Travel Allowance

Travel allowance may be payable to the SNF in connection with the following services provided under arrangement with a supplier:

- Laboratory
- Radiology

Current HCFA rules for carriers for determining payment for travel/transportation will be used. These are described immediately below:

Where allocating miles or the flat rate between SNF patients and other supplier patients on a single trip is required, the supplier is expected to make all necessary calculations and bill the SNF only for the part of the travel allowed by Medicare. The SNF must bill only for the part of the travel allowed by Medicare.

a) **Travel Allowance to Collect Lab Specimen** - In addition to a specimen collection fee, a travel allowance is payable to the SNF to cover the costs of related travel to the SNF where the lab separately charges the SNF for travel. The allowance covers the estimated **travel** costs of collecting a specimen and reflects the technician's salary and travel costs. The following HCPCS codes are used for travel allowances:

P9603—Travel allowance - one way, in connection with medically necessary laboratory specimen collection drawn from a SNF resident; prorated miles actually traveled (intermediary allowance on per mile basis); or

P9604—Travel allowance - one way, in connection with medically necessary laboratory specimen collection drawn from a SNF resident; prorated trip charge (intermediary allowance on flat fee basis).

Per Mile Travel Allowance (P9603) – There is a minimum of 75 cents a mile. The per mile travel allowance is to be used in situations where the distance from the lab to the SNF is longer than 20

miles round trip. It may be paid to the SNF where the lab bills travel expense to the SNF. Payment is the lower of the SNFs charge or the allowance. Actual miles must be shown on the claim in the units field.

The per mile allowance was computed using the Federal mileage rate of 32.5 cents a mile plus an additional 44 cents a mile to cover the technician's time and travel costs. Contractors have the option of establishing a higher per mile rate in excess of the minimum of 75 cents a mile if local conditions warrant it. The minimum mileage rate will be reviewed and updated in conjunction with the clinical lab fee schedule as needed. At no time will the SNF be paid for more miles than are reasonable or for miles not actually traveled by the laboratory technician.

EXAMPLE 1: A laboratory technician travels 60 miles round trip from a lab in a city to a SNF in a remote rural location, and back to the lab to draw a single Medicare patient's blood. The total reimbursement would be \$45.00 (60 miles x .75 cents a mile), plus the specimen collection fee of \$3.00.

EXAMPLE 2: A laboratory technician travels 40 miles from the lab to a Medicare SNF to draw blood, then travels an additional 10 miles to a non-Medicare patient's home and then travels 30 miles to return to the lab. The total miles traveled would be 80 miles. The claim submitted would be for one half of the miles traveled or \$30.00 (40 x .75), plus the specimen collection fee of \$3.00.

Flat Rate (P9604) – There is a minimum of \$7.50 one way. The flat rate travel allowance is to be used in areas where the distance from the lab to the SNF is less than 20 miles round trip. The flat rate travel fee is to be pro-rated for more than one blood specimen drawn at the same SNF, and for stops at a SNF and another location. The SNF must obtain a proration from the laboratory for submission on the claim based on the number of patients seen on that trip, in order to bill Medicare properly.

This rate was based on an assumption that a trip is an average of 15 minutes and up to 10 miles one way. It uses the Federal mileage rate of 32.5 cents a mile and a laboratory technician's time of \$17.66 an hour, including overhead. Contractors have the option of establishing a flat rate in excess of the minimum of \$7.50, if local conditions warrant it. The minimum national flat rate will be reviewed and updated in conjunction with the clinical laboratory fee schedule, as necessitated by adjustments in the Federal travel allowance and salaries.

EXAMPLE 3: A laboratory technician travels from the laboratory to a single Medicare SNF and returns to the laboratory without making any other stops. The flat rate would be calculated as follows: 2 x \$7.50 for a total trip reimbursement of \$15.00, plus the \$3.00 specimen collection fee.

EXAMPLE 4: A laboratory technician travels from the laboratory to the homes of five patients to draw blood, four of the patients are Medicare patients and one is not. An additional flat rate would be charged to cover the five stops and the return trip to the lab (6 x \$7.50 = \$45.00). Each of the claims submitted would be for \$9.00 (\$45.00 / 5 = \$9.00). Since one of the patients is non-Medicare, four claims would be submitted for \$9.00 each, plus the \$3.00 specimen collection fee.

EXAMPLE 5: A laboratory technician travels from a laboratory to a SNF and draws blood from five patients and returns to the laboratory. Four of the patients are on Medicare and one is not. The \$7.50 flat rate is multiplied by two to cover the return trip to the laboratory (2 x \$7.50 = \$15.00) and then divided by five (1/5 of \$15.00 = \$3.00). Since one of the patients is non-Medicare, four claims would be submitted for \$3.00 each, plus the \$3.00 specimen collection fee.

HCFA has no requirement with respect to what the lab may bill the SNF or what the SNF may pay the lab. The requirements relate only to what the intermediary may pay the SNF.

b) Travel Allowance for Radiology – Pay the SNF for non-lab travel expenses only in connection with furnishing covered portable X-ray services under arrangements for Part B patients.

SNFs report travel related to portable X-rays services with the following HCPCS codes:

Q0092	Set-up portable X-ray equipment
R0070	For transportation of portable X-ray equipment where only one patient seen
R0075	For transportation of portable X-ray equipment where more than one patient seen (this code is billed for each patient)
99082	Unusual travel.

Intermediaries are now required to install an edit to allow payment for HCPCS codes Q0092, R0070, and R0075 to SNFs only in connection with CPT codes 70000 through 79999.

The intermediary will pay the SNF separately for unusual travel (CPT code 99082) only when the SNF submits documentation to demonstrate that the travel was very unusual. CPT 99082 is paid on individual consideration only.

UB 92 Bill Types, Frequency of Billing, and Late Charges

When billed by the SNF, bill type 22x is to be used for all services to Part B residents whether in a certified bed or otherwise, including services obtained from outside suppliers.

When billed by the SNF, bill type 23x is to be used for all Part B outpatient services furnished to those other than residents. The distinction between 22x and 23x is not

related to receipt of skilled care but is determined solely on the basis of being a resident.

The current requirements for monthly billing continue to apply. The SNF is expected to make a reasonable effort to include all services on the bill. However there will be situations in which the SNF receives billing data from suppliers after the billing cut off, just as internal billing data can be received in the SNF system after the cut off.

An adjustment bill is necessary to increase the units for the same HCPCS code on the same day. Adjustment bills remain necessary to delete charges. The adjustment bill must be completed in its entirety.

Services for different HCPCS codes not included on the original bill for the same dates of service may be submitted as a new bill.

Late charge bills remain unacceptable for Part A SNF bills.

There are no other changes in requirements for reporting data elements on the HCFA-1450 (UB-92) claim form.

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. Providers

Services rendered by the following providers are billed by the rendering provider to the carrier and paid separately; i.e., are not included in the PPS rate.

- Physician’s services other than physical, occupational, and speech-language therapy services furnished to SNF residents
- Physician assistant services not employed by the SNF, working under a physician’s supervision
- Nurse practitioner and clinical nurse specialist services not employed by the SNF, working in collaboration with a physician
- Certified mid-wife services
- Qualified psychologist services
- Certified registered nurse anesthetist services.

1. Professional (PC) and Technical Component (TC) Indicators

The PC/TC indicator in the Medicare Physician Fee Schedule (MPFS) will be used in the SNF fee schedule to identify the applicability of technical and/or physician component for the HCPCS codes. The following table describes intermediary processing for the PC/TC indicator when the SNF provides the service or receives the service under arrangement and bills for the service.

In summary, intermediary standard system requirements are to:

- Pay if PC/TC code is 3, 5, 7, or 9.
- Pay if PC/TC 1 and modifier TC is present, otherwise reject.
- Reject if PC/TC indicator is 0, 2, 6 or 8.
- Reject PC/TC code 4 unless the HCPCS code is for a service listed as an exception to Part A PPS in section IV.

PC/TC

Indicator SNF Consolidated Billing/Payment Policy for Intermediaries for MPFS Services

0	<p>Physician service code: Codes with a 0 indicator are not considered to have a separately identifiable professional or technical components. They will never be seen with a TC or 26 modifier.</p> <p>Intermediaries reject the service and notify the SNF to request the physician to bill the carrier.</p> <p>Physicians submit these services to the carrier for processing and reimbursement.</p>
1	<p>Diagnostic tests or radiology services: An indicator of 1 signifies a global code that when billed without a modifier includes both the PC and TC. The code can also be submitted using a 26 or TC modifier to bill just the PC or TC of that service (e.g., G0030, G003026 and G0030TC).</p> <p>Intermediaries pay the service when submitted with the TC modifier.</p> <p>If a global code is submitted, e.g., G0030 with no modifier, intermediaries reject the service and notify the SNF to resubmit only the TC.</p> <p>If modifier 26 is submitted, intermediaries reject the service and notify the SNF that the physician must bill the modifier 26 to the carrier.</p>
2	<p>Professional component only codes: Codes with an indicator of 2 signify services that only have a PC.</p> <p>Intermediaries reject these services and notify the SNF that the service must be billed to the carrier.</p>
3	<p>Technical component only codes: Codes with an indicator of 3 signify services that have only a TC.</p> <p>Intermediaries pay these without a modifier.</p>
4	<p>Global test only codes: Codes with an indicator of 4 signify services that include both the PC and TC. The 26 and TC modifiers are not applicable. However, there are associated codes that describe only the technical and professional components of the service.</p> <p>Intermediaries reject the service and notify the SNF to resubmit the service using the code that represents the TC only.</p>
5	<p>Incident to codes: These codes are not considered physician services in the SNF setting.</p> <p>These codes are paid by the intermediary.</p>
6	<p>Laboratory physician interpretation codes: These codes are for physician services to interpret lab tests.</p> <p>Intermediaries do not pay for these services. Intermediaries reject the service and notify the SNF that the services must be billed to the carrier.</p> <p>Considered a billable physician service and may be paid by the carrier.</p>
7	<p>Physician therapy services: These services are only billable by the SNF to the intermediary.</p> <p>Intermediaries pay.</p>
8	<p>Physician interpretation codes: An indicator of 8 signifies codes that represent the professional component of a clinical lab code for which separate payment may be made. It only applies to codes 88141, 85060, and P3001-26. A TC indicator is not applicable.</p> <p>Intermediaries do not pay for these services. Intermediaries reject the service and notify the SNF that the services must be billed to the carrier.</p> <p>Carriers reimburse the physician for these codes when submitted.</p>
9	<p>Concept of a professional/technical component does not apply: An indicator of 9 signifies a code that is not considered to be a physician service.</p> <p>Intermediaries pay for these services.</p>

Per section 4432(b)(4) of the BBA, when physicians provide services to a beneficiary residing in an SNF, the physician must include the Medicare facility provider number of the SNF on the claims form or electronic record. This provision is being implemented **effective April 1, 2001**. SNFs must provide physicians with the proper Medicare provider number so that they can file claims with the carrier for professional services.

B. Services

The following services are billed separately under Part B by the rendering provider (e.g., exempted under Part A PPS), and may be paid to the provider/supplier that furnished the service.

1. Certain Dialysis-Related Services Including Covered Ambulance Transportation to Obtain the Dialysis Services

Institutional dialysis services and supplies are not included in the SNF Part A PPS rate. They may be billed separately to the intermediary by the hospital or ESRD facility as appropriate. They are identified by type of bill 72x.

Some dialysis related services for Method 2 beneficiaries are billed by a hospital or ESRD facility. The following revenue codes must be accompanied by the dialysis related diagnosis code 585.

Revenue Codes for Method 2 beneficiaries:

- 825 – Hemodialysis Support Services
- 835 – Peritoneal Dialysis Support Services
- 845 – Continuous Ambulatory Peritoneal Dialysis (CAPD) Support Services
- 855 – Continuous Cycling Peritoneal Dialysis (CCPD) Support Services

Acute outpatient dialysis services are billed by a hospital type of bill 13X. Diagnosis code 585 must be on the bill. Revenue codes they may be billed are listed below:

Revenue Codes:

- 27X – Medical Surgical Supplies
- 30X – Laboratory
- 31X – Laboratory Pathological
- 32X – Radiology – Diagnostic
- 38X – Blood
- 39X – Blood Storage and Processing
- 636 – Drugs Requiring Detailed Coding
- 73X – EKG/ECG (Electrocardiogram)

2. Erythropoietin (EPO) for Certain Dialysis Patients

EPO is identified with the following revenue codes

- 634 – (EPO with less than 10,000 units)
- 635 – (EPO with 10,000 or greater units)

3. Hospice Care Related to a Terminal Condition

Hospice services are excluded from SNF PPS and billed by the hospice to the regional home health intermediary (RHHI) using type of bill 81x or 82x.

4. Certain Ambulance Trips

Ambulance trips that convey a beneficiary to the SNF for initial admission or from the SNF following final discharge are excluded. In addition, reasonable and necessary ambulance trips offsite during the SNF stay (including the return trip to the SNF) are excluded when used for the following purposes:

- Ambulance transportation related to dialysis services;
- Ambulance services that convey a beneficiary to a hospital or critical access hospital (CAH) to receive any of the following excluded services (See section C below):
 - Cardiac catheterization services
 - Computerized axial tomography (CT scans)
 - Magnetic resonance imaging (MRIs)
 - Radiation therapy
 - Ambulatory surgery involving the use of a hospital operating room
 - Emergency services
 - Angiography services
 - Lymphatic and venous procedures

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

1. Cardiac Catheterization Services

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

93501	93503	93505	93508	93510
93511	93514	93524	93526	93527
93528	93529	93530	93531	93532
93533	93536	93539	93540	93541
93542	93543	93544	93545	93555
93556	93561	93562	93571	93572

2. 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 CPT and HCPCS codes identify the excluded services.

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

3. Magnetic Resonance Imaging (MRIs)

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

70336	70540	70551	70552	70553
71550	71555	72141	72142	72146
72147	72148	72149	72156	72157
72158	72159	72196	72198	73220
73221	73225	73720	73721	73725
74181	74185	75552	75553	75554
75555	75556	76093	76094	76390
76400				

4. Radiation Therapy

Radiation therapy is not included in SNF PPS when furnished in a Medicare participating hospital or critical access hospital. The following CPT 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	77600	77605	77610
77615	77620	77750	77761	77762
77763	77776	77777	77778	77781
77782	77783	77784	77789	77790
77799				

5. 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 CPT 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 CPT codes that are included under SNF PPS are listed below.

10040	10060	10080	10120	11040
11041	11042	11043	11044	11055
11056	11057	11200	11300	11305
11400	11719	11720	11721	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	36406	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	95970-95975		

6. Emergency Services

Emergency services are not included in SNF PPS when furnished in a Medicare participating hospital or critical access hospital. They are identified by the hospital or CAH using revenue code 045x.

7. Angiography Services

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

75600	75605	75625	75630	75650
75658	75660	75662	75665	75671
75676	75680	75685	75705	75710
75716	75722	75724	75726	75731
75733	75736	75741	75743	75746
75756	75774	75790	75801	75803
75805	75807	75809	75810	75820
75822	75825	75827	75831	75833
75840	75842	75860	75870	75872
75880	75885	75887	75889	75891
75893	75894	75898	75900	75940
75960	75961	75962	75964	75966
75968	75970	75978	75980	75982
75992	75993	75994	75995	75996

8. Lymphatic and Venous Procedures

Lymphatic and venous procedures are not included in SNF PPS when furnished in a Medicare participating hospital or critical access hospital. The excluded CPT codes appear in the list of excluded angiography codes above, beginning with 75801 and continuing through 75893.

D. 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.

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

2. Chemotherapy Administration

Chemotherapy administration identified by the following CPT and HCPCS codes, when provided by any Medicare provider licensed to provide the service, is excluded from PPS.

36260	36261	36262	36489	36530
36531	36532	36533	36534	36535
36640	36823	96405	96406	96408
96410	96412	96414	96420	96422
96423	96425	96440	96445	96450
96520	96530	96542	Q0083	Q0084
Q0085				

3. Radioisotope Services

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

79030	79035	79100	79200	79300
79400	79420	79440		

4. 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. They must be billed by the supplier furnishing the service.

L5050-L5340	L6050-L6370
L5500-L5611	L6400-L6880
L5613-L5986	L6920-L7274
L5988	L7362-L7366

A. Transportation Costs of Electrocardiogram Equipment

For services furnished during 1998 only, the transportation costs of electrocardiogram equipment for electrocardiogram test services are excluded from Part A SNF PPS.

B. MCO Beneficiaries

All services provided to risk based MCO beneficiaries are excluded from Part A SNF PPS.

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES

Payment of Drugs, Biologicals and Supplies in a Comprehensive Outpatient Rehabilitation Facility

The implementation of outpatient prospective payment system provided for payment of all comprehensive outpatient rehabilitation facility (CORF) services under the Medicare physician fee schedule (MPFS). However, that implementation failed to address payment for drugs, biologicals and supplies provided in a CORF since these services are not part of the MPFS.

Effective for claims with dates of service **on or after April 1, 2001**, the following guidelines will be applied to implement a drug payment methodology and to address payment for supplies.

Drugs and Biologicals

Payment for drugs and biologicals in a CORF setting will no longer be reimbursed on cost. Payment will be made at the lower of the billed charge or 95 percent of the average wholesale price (AWP) as reflected in sources such as the *Red Book*, *Blue Book*, or *Medispan*. For single-source drug or biological the allowance is 95 percent of the AWP for the single product, or, for multi-source drug or biological, the AWP is the lesser of the median AWP of all generic forms of the drug or biological or the lowest brand name product AWP. The Part B deductible and coinsurances will be applied to these services.

Claims for drugs and biologicals in a CORF setting must be reported under revenue code 636 with the appropriate HCPCS code identifying the drug.

Supplies

CORFs are currently being reimbursed for supplies on the basis of cost. However, since supplies are part of the practice expense, separate payment under the MPFS will not be made, and CORFs should not bill for the supplies they furnish. The payment for supplies is included in the practice expense of services listed on the MPFS.

NOTE: Payment for influenza, pneumococcal pneumonia, and hepatitis B vaccines provided by a CORF are made under the outpatient prospective payment system.

FRAUD AND ABUSE

Justice Recovers Record \$1.5 Billion in Fraud Payments Highest Ever for One Year Period

The following is reprinted from a November 2, 2000, Department of Justice press release.

The United States [Justice Department] collected a record \$1.5 billion in civil fraud recoveries during the past fiscal year - an increase of almost 50 percent above the largest previous annual recovery in 1997, Attorney General Janet Reno announced today.

"This new record demonstrates the Department's continued commitment to ensure the proper use of taxpayer monies," said Attorney General Reno. "The Department will continue to pursue those who seek to defraud the United States, whether by providing defective products, billing for services that were not provided or otherwise misusing public funds for private gain."

Approximately \$1.2 billion of the Department's settlements and judgments occurred in connection with cases filed under the federal whistleblower statute, which allows individuals who disclose fraud to share in the government's recovery. To date, payments to whistleblowers for the past fiscal year (October 1, 1999 - September 30, 2000) have totaled approximately \$173 million.

Health care fraud cases once again topped the list of annual recoveries, totaling more than \$840 million. This amount included the largest civil fraud recovery ever - a \$385 million settlement with Fresenius Medical Care to resolve sweeping allegations of wrongdoing by its kidney dialysis subsidiary. The Department also recovered \$170 million from Beverly Enterprises, Inc., the largest nursing home operator in the United States, for alleged false billings to Medicare involving over 400 nursing homes around the country.

"Health care fraud imposes enormous costs on American taxpayers and decreases the quality of care provided to patients," said Assistant Attorney General David W. Ogden of the Department's Civil Division. "Although the vast majority of health care providers are honest and provide the highest standard of care, stopping those who prey on the health care system remains one of the Department's top law enforcement priorities."

After health care, the largest category of fraud recoveries involved the production of oil and other minerals from public lands. The Department recovered more than \$230 million from companies alleged to have underpaid

royalties on such production, including \$95 million from Chevron, \$56 million from Shell, \$32 million from BP Amoco, \$26 million from Conoco and \$11.9 million from Devon Energy.

The Department's recoveries also included over \$140 million in settlements with twenty-five brokerage firms. These companies allegedly sold open market securities with artificially low yields to municipalities refunding tax-exempt bonds, thereby reducing the municipalities' purchase of special low-interest Treasury bonds. Defense procurement fraud accounted for another \$100 million in recoveries, including up to \$54 million from the Boeing Corporation to resolve allegations that it placed defective transmission gears in army Chinook helicopters.

The Department's record level of recoveries for fiscal year 2000 also included the following:

- \$74 million from Anthem Blue Cross and Blue Shield, formerly the Medicare Part A intermediary for Connecticut, to resolve claims that it underreported the total amount of interim payments by hospitals to improve scores on Health Care Financing Administration evaluations;
- \$53 million from Gambro Healthcare Patient Services, Inc. to resolve allegations that it billed Medicare for unnecessary laboratory tests;
- \$35 million from Jacobs Engineering Group in connection with allegations that it improperly charged overhead costs to various government contracts;
- \$33.5 million from Toshiba Corporation to settle claims arising from its sale of defective computer laptops to various federal agencies;
- \$31 million from Community Health Systems for allegedly "upcoding" - the improper assignment of diagnostic codes to hospital inpatient discharges for the purpose of increasing reimbursement amounts to various hospital services; and
- \$16.6 million from two government contractors, CRSS, Inc. and Metcalf & Eddy, for alleged false billings in connection with the construction of an air defense system in Saudi Arabia.

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 **January 1, 2001**, and after, unless otherwise noted.

Medicare Part A Medical Policy Procedures

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

Final Medical Policies

33216: Implantation of Automatic Defibrillators	22
55873: Cryosurgical Ablation of the Prostate	24
62263: Percutaneous Lysis of Epidural Adhesions	26
70544: Magnetic Resonance Angiography (MRA)	28
70551: Magnetic Resonance Imaging of the Brain	31
72192: Computed Tomography of the Pelvis	34
80100: Qualitative Drug Screen	38
82105: Tumor Markers	40
82310: Total Calcium	43
82435: Chloride	46
84152: Complexed and Free Prostate Specific Antigen	48
93000: Electrocardiography	50
93312: Transesophageal Echocardiogram	53
93724: Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator	56
93990: Duplex Scan of Hemodialysis Access	59
95115: Allergen Immunotherapy	61
95900: Nerve Conduction Studies	63
A0426: Ground Ambulance Services	66
C1203: Ocular Photodynamic Therapy (OPT) with Verteporfin	70
DYSPHRT: Dysphagia/Swallowing Diagnosis and Therapy	72
J9999: Antineoplastic Drugs	75
PHPPROG: Psychiatric Partial Hospitalization Program	83

Additions and Revisions to Previously Published Medical Policy

44388: Colonoscopy	91
82108: Aluminum	91
93965: Non-Invasive Evaluation of Extremity Veins	92
G0108: Diabetes Outpatient Self-Management Training	92
J1950: Leuprolide Acetate	92
J7190: Hemophilia Clotting Factors	92
Percutaneous Transluminal Angioplasty and Carotid Stents	92

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).

33216: Implantation of Automatic Defibrillators

Policy Number

33216

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Implantation of Automatic Defibrillators

AMA CPT Copyright Statement

CPT codes, descriptions, and other data only are copyright 1998 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.

HCFA National Coverage Policy

Coverage Issues Manual, Section 35-85

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

11/15/1999

Revision Effective Date

11/30/2000

Revision Ending Effective Date

11/29/2000

Policy Ending Date

N/A

LMRP Description

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

Indications and Limitations of Coverage and/or Medical Necessity

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

the above-described conditions and stipulations are met in a particular case, **including the inducibility of tachyarrhythmia, etc.**, implantation of an automatic defibrillator may not be covered.

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

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

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

In addition to the above indications, removal and replacement of an automatic defibrillator is a covered service in such cases as mechanical complications and/or the end of the functional capacity of the device.

HCPCS Section & Benefit Category

Cardiovascular System/Surgery

Type of Bill Code

Hospital – 13x
Skilled Nursing Facility – 21x

Revenue Code

360 General Classification
361 Minor Surgery

CPT Codes

- 33216 Insertion or repositioning of a transvenous electrode (15 days or more after initial insertion); single chamber (one electrode) permanent pacemaker or single chamber pacing cardioverter-defibrillator
- 33217 dual chamber (two electrodes) permanent pacemaker or dual chamber pacing cardioverter-defibrillator
- 33218 Repair of single transvenous electrode for a single chamber, permanent pacemaker or single chamber pacing cardioverter-defibrillator
- 33220 Repair of two transvenous electrodes for a dual chamber permanent pacemaker or dual chamber pacing cardioverter-defibrillator
- 33223 Revision of skin pocket for single or dual chamber pacing cardioverter-defibrillator
- 33240 Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator
- 33241 Subcutaneous removal of single or dual chamber pacing cardioverter-defibrillator pulse generator

33216: Implantation of Automatic Defibrillators (continued)

- 33243 Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by thoracotomy
- 33244 by transvenous extraction
- 33245 Insertion of epicardial single or dual chamber pacing cardioverter-defibrillator electrodes by thoracotomy;
- 33246 with insertion of pulse generator
- 33249 Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

- 425.1 Hypertrophic obstructive cardiomyopathy
- 425.4 Other primary cardiomyopathies
- 427.1 Paroxysmal ventricular tachycardia
- 427.5 Cardiac arrest
- 794.31 Abnormal electrocardiogram [ECG][EKG] (long QT syndrome)
- 996.04 Mechanical complication due to automatic implantable cardiac defibrillator
- V53.32 Fitting and adjustment of other device, automatic implantable cardiac defibrillator

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

Procedure Codes 33243, 33245, and 33246 have been classified as Inpatient procedures. Effective for dates of service on or after August 1, 2000, these services cannot be reimbursed by Medicare when performed on hospital outpatients.

Documentation Requirements

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

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

N/A

Advisory Committee Notes

N/A

Start Date of Comment Period

N/A

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	4
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 <i>Bulletin</i>
Revised Effective Date:	11/30/2000
Explanation of Revision:	Revision was needed to add an indication and applicable diagnoses to address removal and replacement of AICDs due to functional ineffectiveness and mechanical complications.

55873: Cryosurgical Ablation of the Prostate

Policy Number

55873

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Cryosurgical Ablation of the Prostate

AMA CPT Copyright Statement

CPT codes, descriptions, and other data only are copyright 1998 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.

HCFA National Coverage Policy

Coverage Issues Manual, Section 35-96

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

07/22/1999

Revision Effective Date

01/01/2001

Revision Ending Effective Date

12/31/2000

Policy Ending Date

N/A

LMRP Description

Cryosurgery of the prostate gland, also known as cryosurgical ablation of the prostate (CSAP), destroys prostate tissue by applying extremely cold temperatures in order to reduce the size of the prostate gland.

CSAP can be carried out under general or spinal anesthesia and lasts approximately 2-3 hours. Five to six cryoprobe are placed transperineally under transrectal ultrasound (TRUS). Once the probes are in place, freezing is carried out while observing under TRUS the increasing echoes as the block of frozen prostate tissue approaches the rectal mucosa. Such monitoring minimizes the risk of rectal freezing. The possibility of injury to the urethra is decreased by the use of a warming device, which is inserted into the urethra.

Indications and Limitations of Coverage and/or Medical Necessity

Effective for services performed on or after July 1, 1999, Medicare will consider cryosurgery of the prostate medically reasonable and necessary under the following circumstance:

- For primary treatment of patients with clinically localized, stages T1-T3, prostate cancer.

The evidence is not yet sufficient to demonstrate the effectiveness of this procedure as salvage therapy for local failures after radical prostatectomy, external beam irradiation, and brachytherapy. Therefore, cryosurgery of the prostate as salvage therapy is not covered under Medicare.

HCPCS Section & Benefit Category

Male Genital System/Surgery

Type of Bill Code

Hospital – 13x

Revenue Code

361 Minor Surgery

CPT Codes

55873 Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

185 Malignant neoplasm of prostate

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.

Cryosurgery of the prostate as salvage therapy is not covered under Medicare.

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

55873: Cryosurgical Ablation of the Prostate (continued)

Documentation Requirements

Medical record documentation maintained in the patient's file must demonstrate that the service was performed as a primary treatment for clinically localized stage T1-T3 prostate cancer. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the office/progress notes, hospital notes, and/or operative report.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

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

Advisory Committee Notes

N/A

Start Date of Comment Period

N/A

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	1
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 <i>Bulletin</i>
Revised Effective Date:	01/01/2001
Explanation of Revision:	Annual 2001 HCPCS Update

62263: Percutaneous Lysis of Epidural Adhesions

Policy Number

62263

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Percutaneous Lysis of Epidural Adhesions

AMA CPT Copyright Statement

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HCFA National Coverage Policy

N/A

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

03/15/2001

Revision Effective Date

N/A

Revision Ending Effective Date

N/A

Policy Ending Date

N/A

LMRP Description

Percutaneous epidural lysis of adhesions (also referred to as epidural neuroplasty or epidural adhesiolysis) is an interventional pain management technique that is used to treat chronic low back pain with radiculopathy. The basis for performing this procedure is the premise that fibrous adhesions (scar tissue) develops after surgery, trauma, and/or inflammation that compounds pain associated with the nerve root by fixing it in one position and thus increasing the susceptibility of the nerve root to tension or compression. This scar tissue also prevents the direct application of medications to relieve pain (local anesthetics and corticosteroids) to the problem area. The goal of the procedure is to break down these fibrous adhesions to allow for delivery of high concentrations of injected drugs to the target area and free the nerve from mechanical tension/compression. The procedure usually involves either endoscopic or non-endoscopic (under fluoroscopy) placement of an epidural catheter and sequential adhesiolysis procedures performed over a 1-3 day period.

Adhesiolysis can be accomplished by solution injection (commonly hypertonic saline and/or hyaluronidase) and/or by mechanical means (by maneuvering a specially designed epidural catheter or epiduroscope).

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider the use of percutaneous lysis of epidural adhesions to be medically reasonable and necessary in the treatment of chronic refractory low back pain with radiculopathy that has failed to respond to more conservative treatment measures. This more conservative treatment may include local heat, traction, nonsteroidal anti-inflammatory medications, and anesthetic and/or steroid epidural injections. The chronic refractory low back pain may be secondary to post lumbar laminectomy syndrome, intervertebral lumbar disc disruption, lumbar epidural adhesions, and/or lumbar degenerative disc disorder.

HCPCS Section & Benefit Category

Nervous System/Surgery

Type of Bill Code

Hospital – 13x
Skilled Nursing Facility – 21x

Revenue Code

360 Operating Room Services, General Classification

CPT Codes

62263 Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, spring-wound catheter) including radiologic localization (includes contrast when administered)

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

722.10 Displacement of lumbar intervertebral disc without myelopathy
722.52 Degeneration of lumbar or lumbosacral intervertebral disc
722.73 Intervertebral disc disorder with myelopathy, lumbar region
722.83 Postlaminectomy syndrome, lumbar region
724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified (for lumbar adhesions only)

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

62263: Percutaneous Lysis of Epidural Adhesions (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

Percutaneous lysis of epidural adhesions involves the placement of an epidural catheter that may remain in place over several days for the purpose of lysis of adhesions. Procedure code 62263 is not reported for each adhesiolysis treatment, but should be reported once to describe the entire series of injections/infusions regardless of how many days or how many specific areas of scarring and inflammation in the epidural space are treated.

Procedure code 62263 includes the injection of contrast material for epidurography and subsequent fluoroscopic guidance and localization performed in association with sequential adhesiolysis treatment(s). Therefore, it would not be appropriate to report procedure codes 72275 (Epidurography, radiological supervision and interpretation) or 76005 [Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction] in addition to procedure code 62263. Procedure code 72275 can be reported in addition to procedure code 62263 only if all components of that procedure code (a formally interpreted contrast study involving multiplanar imaging generating “hard copy” images) are met.

Procedure code 62263 may be performed with an epiduroscope as a technical procedural option rather than using fluoroscopy to direct catheter placement for either mechanical or solution lysis of adhesions. If an epiduroscope is used as a technical procedural option, it would not be appropriate to bill the unlisted nervous system procedure code 64999 (there is no procedure code to represent epiduroscopy) in addition to reporting procedure code 62263. Furthermore, Florida Medicare has identified epiduroscopy/myelotomy performed as a separate procedure as a noncovered service.

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.

In addition, the medical record should clearly document the nature of the chronic refractory low back pain. This should include the location, intensity, type of pain present, and contributing factors (if any), duration of condition, and treatment regimes that have been utilized. Documentation should demonstrate failure of more conservative management in the treatment of the patient’s condition. This more conservative treatment may include local heat, traction, nonsteroidal anti-inflammatory medications, and anesthetic and/or steroid epidural injections.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from the Florida Society of Anesthesiologists, Florida Society of Physical Medicine and Rehabilitation, and the Florida Neurosurgical Society.

Start Date of Comment Period

11/15/2000

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	Original
Start Date of Comment Period:	11/15/2000
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 <i>Bulletin</i>
Original Effective Date:	03/15/2001

70544: Magnetic Resonance Angiography (MRA)

Policy Number

70544

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Magnetic Resonance Angiography (MRA)

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Coverage Issues Manual, Section 50-14

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

01/21/1999

Revision Effective Date

01/01/2001

Revision Ending Effective Date

12/31/2000

Policy Ending Date

N/A

LMRP Description

Magnetic Resonance Angiography (MRA) is an application of magnetic resonance (MR) imaging that provides visualization of blood flow, as well as images of normal and diseased blood vessels. MRA techniques are typically noninvasive because they do not require the use of contrast media. While contrast media may sometimes be used to enhance the images obtained in MRA, the use of these agents is not necessary. As a result, MRA is an imaging alternative for patients who cannot tolerate contrast media.

Indications and Limitations of Coverage and/or Medical Necessity

Although MRA appears to be a rapidly developing technology, the clinical safety and effectiveness of this procedure for all anatomical regions has not been proven. As a result Medicare will provide coverage on a limited basis. Below are the indications for which Medicare coverage is allowed for MRA. All other uses of MRA will not be covered.

Head and Neck (for services performed before 7/1/99) (Procedure codes 70544-70549)

Medicare will provide coverage for the evaluation of the carotid vessels in the head and neck when all of the following conditions are met:

- For a patient who has a positive ultrasonography; and

- When performed on patients with symptoms associated with carotid stenosis for which surgery may be found to be appropriate based on the results of these tests.

It should be noted that physicians may choose either contrast angiography (CA) or MRA as diagnostic tests **after** a positive ultrasound for their patients. MRA is not performed routinely as an adjunct to CA. CA furnished in addition to MRA might be appropriate **only** when the results from the MRA and the ultrasound are incongruent or inconclusive.

Head and Neck (for services performed on or after 7/1/99) (Procedure codes 70544-70549)

Medicare will provide coverage for the evaluation of the vessels in the head and neck when all of the following conditions are met:

- To evaluate the carotid arteries, the circle of Willis, the anterior, middle or posterior cerebral arteries, the vertebral or basilar arteries, or the venous sinuses; and
- Be performed on patients with conditions of the head and neck for which surgery is anticipated and may be found to be appropriate based on the MRA. These conditions include, but are not limited to, tumor, aneurysms, vascular malformations, vascular occlusion or thrombosis.

MRA and contrast angiography (CA) are not expected to be performed on the same patient for diagnostic purposes prior to the application of anticipated therapy. Only one of these tests will be covered routinely unless the physician can demonstrate the medical need to perform both tests.

Chest (Procedure code 71555)

Medicare will cover MRA of the chest for the following indications:

For the Diagnosis of Pulmonary Embolism

Medicare will consider MRA of the chest for diagnosing a suspected pulmonary embolism to be a covered service when the following criteria have been met:

- A patient is suspected of having a pulmonary embolism and it is contraindicated for the patient to receive intravascular iodinated contrast material.
- A patient is allergic to iodinated contrast material and would face a high risk of developing complications if they undergo pulmonary angiography or computed tomography angiography.

For Pre-operative or Post-operative Evaluation of Thoracic Aortic Dissection and Aneurysm

Medicare will consider MRA of the chest for the evaluation of thoracic aortic dissection and aneurysm to be a covered service when the following criteria are met:

- Depending on the clinical presentation, MRA may be used as an alternative to other non-invasive imaging technologies, such as transesophageal echocardiography and CT.
- Either MRA or CA may be used as a diagnostic test for thoracic aortic dissection and aneurysm, but not both tests on a routine basis.
- If both MRA and CA of the chest are used to diagnose thoracic aortic dissection and aneurysm, the physician must demonstrate the medical need for performing both tests.

70544: Magnetic Resonance Angiography (MRA) (continued)

Peripheral Arteries of Lower Extremities (Procedure code 73725)

Studies have proven that MRA of peripheral arteries is useful in determining the presence and extent of peripheral vascular disease in lower extremities.

Effective May 1, 1997, Medicare will consider MRA of the arteries of the lower extremities to be a covered service only when the following criteria have been met:

Either MRA or CA can be performed to evaluate peripheral arteries of the lower extremities. However, both MRA and CA may be useful in some cases, such as:

- A patient has had CA and this test was unable to identify a viable run-off for bypass. When exploratory surgery is not believed to be a reasonable medical course of action for this patient, MRA may be performed to identify the viable runoff vessel.
- A patient has had MRA, but the results are inconclusive.

Abdomen (Procedure code 74185)

Studies have proven that MRA is considered a reliable diagnostic tool for the preoperative evaluation of patients who will undergo elective abdominal aortic aneurysm (AAA) repair. In addition, scientific data has revealed that MRA is considered comparable to CA in determining the extent of AAA, as well as evaluation of aortoiliac occlusion disease and renal artery pathology that may be necessary in the surgical planning for AAA repair. These studies also reveal that MRA could provide a net benefit to the patient. If preoperative angiography is not necessary then patients are not exposed to the risks associated with invasive procedures, contrast media, end-organ damage or arterial injury. As with coverage of MRA for other anatomical sites, Medicare will provide coverage for either MRA or CA and not both tests on a routine basis.

The physician may choose between CA or MRA for preoperative imaging, after other tests such as computed tomography (CT) or ultrasound have been used to diagnose AAA and evaluate aneurysm size over time. However, both MRA and CA may be used when the physician can demonstrate the medical need for both tests to be performed, such as when a follow-up CA is necessary to clarify renal artery pathology, which might not be diagnosed definitively by an initial MRA.

HCPCS Section & Benefit Category

Radiology/Diagnostic Radiology

Type of Bill Code

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

Revenue Code

- 32x Radiology Diagnostic
- 615 Magnetic Resonance Angiography, Head and Neck
- 616 Magnetic Resonance Angiography, Lower Extremities
- 618 Magnetic Resonance Angiography, Other

CPT Codes

- 70544 Magnetic resonance angiography, head; without contrast material(s)

- 70545 with contrast material(s)
- 70546 without contrast material(s), followed by contrast material(s) and further sequences
- 70547 Magnetic resonance angiography, neck; without contrast material(s)
- 70548 with contrast material(s)
- 70549 without contrast material(s), followed by contrast material(s) and further sequences
- 71555 Magnetic resonance angiography, chest, (excluding myocardium), with or without contrast material(s)
- 73725 Magnetic resonance angiography, lower extremity, with or without contrast material(s)
- 74185 Magnetic resonance angiography, abdomen, with or without contrast material(s)

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

Head and Neck (procedure codes 70544-70549)

- 094.89 Other specified neurosyphilis
- 191.0-191.9 Malignant neoplasm of brain
- 192.1 Malignant neoplasm of cerebral meninges
- 194.5 Malignant neoplasm of carotid body
- 227.5 Benign neoplasm of carotid body
- 228.02 Hemangioma, any site, of intracranial structures
- 239.6 Neoplasms of unspecified nature of brain
- 325 Phlebitis and thrombophlebitis of intracranial venous sinuses
- 430 Subarachnoid hemorrhage
- 431 Intracerebral hemorrhage
- 432.1 Subdural hemorrhage
- 432.9 Unspecified intracranial hemorrhage
- 433.00-433.91 Occlusion and stenosis of precerebral arteries
- 434.00-434.91 Occlusion of cerebral arteries
- 435.0-435.9 Transient cerebral ischemia
- 436 Acute, but ill-defined, cerebrovascular disease
- 437.3 Cerebral aneurysm, nonruptured
- 437.4 Cerebral arteritis
- 437.6 Nonpyogenic thrombosis of intracranial venous sinus
- 442.81 Other aneurysm of artery of neck
- 446.5 Giant cell arteritis
- 747.81 Anomalies of cerebrovascular system
- 900.00-900.9 Injury to blood vessels of head and neck

Chest (procedure code 71555)

- 415.0 Acute cor pulmonale
- 415.11-415.19 Pulmonary embolism and infarction
- 416.0 Primary pulmonary hypertension
- 416.8 Other chronic pulmonary heart diseases
- 416.9 Chronic pulmonary heart disease, unspecified
- 441.01 Thoracic dissection of aorta
- 441.03 Thoracoabdominal dissection of aorta
- 441.2 Thoracic aneurysm without mention of rupture

70544: Magnetic Resonance Angiography (MRA) (continued)

- 441.7 Thoracoabdominal aneurysm, without mention of rupture
- 786.0 Respiratory abnormality, unspecified
- 786.05 Shortness of breath
- 786.06 Tachypnea
- 786.3 Hemoptysis

Peripheral Arteries of Lower Extremities (procedure code 73725)

- 250.70-250.73 Diabetes with peripheral circulatory disorders
- 440.20-440.29 Atherosclerosis of native arteries of the extremities
- 440.30-440.32 Atherosclerosis of bypass graft of extremities
- 442.3 Other aneurysm of artery of lower extremity
- 443.1 Thromboangiitis obliterans [Buerger's disease]
- 443.81 Peripheral angiopathy in diseases classified elsewhere
- 443.89 Other specified peripheral vascular diseases
- 443.9 Peripheral vascular disease, unspecified
- 444.22 Arterial embolism and thrombosis of the arteries of the lower extremity

Abdomen (procedure code 74185)

- 441.02 Abdominal dissection of aorta
- 441.03 Thoracoabdominal dissection of aorta
- 441.4 Abdominal aneurysm without mention of rupture
- 441.7 Thoracoabdominal aneurysm, without mention rupture
- 441.9 Aortic aneurysm of unspecified site without mention of rupture

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.

HCFA considers the following codes to be noncovered by Medicare:

- 72159 Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)
- 72198 Magnetic resonance angiography, pelvis, with or without contrast material(s)
- 73225 Magnetic resonance angiography, upper extremity, with or without contrast material(s)

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

Documentation maintained in the patient's file must indicate the medical necessity of this procedure. All coverage criteria listed in the "Indications and Limitations of Coverage and/ or Medical Necessity" section must be documented in the patient's medical record, as well as a hard copy of the procedure results and made available to Medicare upon request. This information can generally be found in the office/progress notes, history and physical, and/ or operative notes.

If the provider of the magnetic resonance angiography study 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. The physician must state the reason for the MRA in his order for the test.

MRA and contrast angiography (CA) are not expected to be performed on the same patient for diagnostic purposes prior to the application of anticipated therapy. Only one of these tests will be covered routinely unless the physician can demonstrate the medical need to perform both tests. The medical record must clearly document the medical necessity of performing both tests.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

Sources of information may be found online under LMRPs 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 the contractor's Advisory Committee, which includes representatives from the Florida Radiological Society, Inc.

Start Date of Comment Period

N/A

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	6
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 <i>Bulletin</i>
Revised Effective Date:	01/01/2001
Explanation of Revision:	Annual 2001 HCPCS Update

70551: Magnetic Resonance Imaging of the Brain

Policy Number

70551

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Magnetic Resonance Imaging of the Brain

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Coverage Issues Manual, Section 50-13

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

01/21/1999

Revision Effective Date

01/25/01

Revision Ending Effective Date

01/24/01

Policy Ending Date

NA

LMRP Description

Magnetic Resonance Imaging (MRI) is used to diagnose a variety of central nervous system disorders. Unlike computed tomography (CT) scanning, MRI does not make use of ionizing radiation or require iodinated contrast material to distinguish normal from pathologic tissue. Rather, the difference in the number of protons contained within hydrogen-rich molecules in the body (water, proteins, lipids, and other macromolecules) determines recorded image qualities and makes possible the distinction of white from gray matter, tumor from normal tissue, and flowing blood within vascular structures.

MRI provides superior tissue contrast when compared to CT, is able to image in multiple planes, is not affected by bone artifact, provides vascular imaging capability, and makes use of safer contrast media (gadolinium chelate agents). Its major disadvantage over CT is the longer scanning time required for study, making it less useful for emergency evaluations of acute bleeding or for unstable patients. Because a powerful magnetic field is required to obtain an MRI, patients with ferromagnetic materials in place may not be able to undergo MRI study. These include patients with cardiac pacemakers, implanted neurostimulators, cochlear implants, metal in the eye and older ferromagnetic intracranial aneurysm clips. All of these may be potentially displaced when exposed to the powerful magnetic fields used in MRI.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider Magnetic Resonance Imaging of the Brain medically reasonable and necessary when used to aid in the diagnosis of lesions of the brain and to assist in therapeutic decision making in the following conditions:

- For detecting or evaluating extra-axial tumors, A-V malformations, cavernous hemangiomas, small intracranial aneurysms, cranial nerve lesions, demyelination disorders including multiple sclerosis, lesions near dense bone, acoustic neuromas, pituitary lesions, and brain radiation injuries;
- For development abnormalities of the brain including neuroectodermal dysplasia;
- For subacute central nervous system hemorrhage or hematoma;
- For acute cerebrovascular accidents;
- For complex partial seizures, seizures refractory to therapy, temporal lobe epilepsy, or other atypical seizure disorders;
- MRI is usually not the procedure of choice in patients who have acute head trauma, acute intracranial bleeding, or investigation of skull fracture or other bone abnormality, or as follow-up for hydrocephalus. However, a MRI may be necessary in a patient whose presentation indicates a focal problem or who has a recent significant change in symptomatology;
- For brain infections;
- Where soft tissue contrast is necessary;
- When bone artifacts limit CT, or coronal, coronosagittal or parasagittal images are desired; and/or
- For procedures in which iodinated contrast material are contraindicated.

HCPCS Section & Benefit Category

Radiology/Diagnostic Radiology

Type of Bill Code

Hospital – 12x, 13x, 14x

Skilled Nursing Facility – 21x, 22x, 23x

Rural Health Clinic – 71x

Revenue Code

32x Radiology Diagnostic

611 MRI-Brain (including Brainstem)

CPT Codes

70551 Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material

70552 with contrast material(s)

70553 without contrast material, followed by contrast material(s) and further sequences

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

006.5 Amebic brain abscess

013.00-013.36 Tuberculosis of meninges and central nervous system

013.60-013.96 Tuberculosis encephalitis or myelitis and other specified and unspecified tuberculosis of central nervous system

70551: Magnetic Resonance Imaging of the Brain (continued)

036.0-036.2	Meningococcal infection	310.0-310.9	Specific nonpsychotic mental disorders due to organic brain damage
042	Human immunodeficiency virus (HIV) disease	320.0-326	Inflammatory diseases of the central nervous system
046.0-046.9	Slow virus infection of central nervous system	330.0-334.9	Hereditary and degenerative diseases of the central nervous system
047.0-047.9	Meningitis due to enterovirus	340	Multiple sclerosis
049.0-049.9	Other non-arthropod-borne viral diseases of central nervous system	341.0-341.9	Other demyelinating diseases of central nervous system
052.0	Postvaricella encephalitis	342.00-342.92	Hemiplegia and hemiparesis
053.0	Herpes zoster with meningitis	343.0-343.9	Infantile cerebral palsy
054.3	Herpetic meningoencephalitis	344.00-344.9	Other paralytic syndromes
054.72	Herpes simplex meningitis	345.00-345.91	Epilepsy
055.0	Postmeasles encephalitis	348.0-348.9	Other conditions of brain
056.01	Encephalomyelitis due to rubella	349.1-349.9	Other and unspecified disorders of the nervous system
062.0-062.9	Mosquito-borne viral encephalitis	350.1-350.9	Trigeminal nerve disorders
063.0-063.9	Tick-borne viral encephalitis	351.0-351.9	Facial nerve disorders
064	Viral encephalitis transmitted by other and unspecified arthropods	352.0-352.9	Disorders of other cranial nerves
072.1-072.2	Mumps meningitis or encephalitis	358.0-358.1	Myasthenia gravis and myasthenic syndromes in diseases classified elsewhere
090.40-090.49	Juvenile neurosyphilis		Sudden visual loss
094.0-094.9	Neurosyphilis	368.11	Transient visual loss
112.83	Candidal meningitis	368.12	Diplopia
114.2	Coccidioidal meningitis	368.2	Visual field defect, unspecified
115.01	Infection by <i>Histoplasma capsulatum</i> , meningitis	368.40	Other specified visual disturbances
115.11	Infection by <i>Histoplasma duboisii</i> , meningitis	368.8	Unspecified visual disturbance
115.91	Histoplasmosis, unspecified, meningitis	368.9	Paralytic ptosis
130.0	Meningoencephalitis due to toxoplasmosis	374.31	Papilledema
162.0-162.9	Malignant neoplasm of trachea, bronchus and lung	377.00-377.01	Disorders of optic chiasm associated with pituitary neoplasms and disorders and associated with other neoplasms
191.0-191.9	Malignant neoplasm of brain	377.51-377.52	Disorders of other visual pathways associated with neoplasms
192.0-192.1	Malignant neoplasm of cranial nerves or cerebral meninges	377.61	Disorders of visual cortex associated with neoplasms
194.3-194.4	Malignant neoplasm of pituitary gland and craniopharyngeal duct or pineal gland	377.71	Paralytic strabismus
196.0	Secondary and unspecified malignant neoplasm of lymph nodes of head, face, and neck	378.51-378.56	Vertigo of central origin
198.3-198.5	Secondary malignant neoplasm of brain and spinal cord, other parts of nervous system or bone and bone marrow	386.2	Sudden hearing loss, unspecified
225.0-225.2	Benign neoplasm of brain and other part of nervous system	388.2	Disorders of acoustic nerve
225.8	Benign neoplasm of other specified sites of nervous system	388.5	Cerebrovascular disease
227.3-227.4	Benign neoplasm of pituitary gland and craniopharyngeal duct (pouch) or pineal gland	430-438.9	Hepatic coma
228.02	Hemangioma of intracranial structures	572.2	Nonalopathic lesions, not elsewhere classified, head region
237.0-237.1	Neoplasm of uncertain behavior of pituitary gland and craniopharyngeal duct or pineal gland	739.0	Other congenital anomalies of nervous system
237.5-237.9	Neoplasm of uncertain behavior of endocrine glands and nervous system	742.0-742.4	Other specified anomalies of nervous system
239.6-239.7	Neoplasm of unspecified nature of brain or endocrine glands and other parts of nervous system	742.8	Unspecified anomaly of brain, spinal cord, and nervous system
253.0-253.9	Disorders of the pituitary gland and its hypothalamic control	742.9	Anomalies of cerebrovascular system
298.9	Unspecified psychosis	747.81	Other and unspecified congenital anomalies
		759.2-759.9	Birth trauma, subdural and cerebral hemorrhage
		767.0	Severe birth asphyxia
		768.5	Mild or moderate birth asphyxia
		768.6	Unspecified birth asphyxia in liveborn infant
		768.9	Intraventricular or subarachnoid hemorrhage
		772.1-772.2	Alteration of consciousness
		780.01-780.09	Hallucinations
		780.1	Syncope and collapse
		780.2	Convulsions
		780.31-780.39	

70551: Magnetic Resonance Imaging of the Brain (continued)

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
784.2	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
800.00-801.99	Fracture of skull
850.0-854.19	Intracranial injury, excluding those with skull fracture
950.0-950.9	Injury to optic nerve and pathways
951.0-951.9	Injury to other cranial nerve(s)
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.

Magnetic Resonance Imaging is considered investigational when medical records document the service was performed only for one of the following:

- measurement of blood flow and spectroscopy,
- imaging of cortical bone and calcifications, and
- procedures involving spatial resolution of bone or calcifications.

In general, it is not medically necessary to perform myelography, CT examinations, and MRI examinations for evaluation of the same condition on the same day. The medical record should document the necessity for evaluations in addition to a MRI.

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

If the procedure is performed using contrast only, procedure code **70552** should be billed. If the procedure is performed initially without contrast, followed by contrast, then procedure code **70553** should be billed. Procedure codes **70551**, **70552**, and/or **70553** should not be billed on the same day for the same patient.

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.

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.

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

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from the Florida Radiological Society.

Start Date of Comment Period

N/A

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	3
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 <i>Bulletin</i>

Revised Effective Date: 01/25/01

Explanation of Revision: A revision was made to add ICD-9-CM code range 162.0-162.9 to the policy.

72192: Computed Tomography of the Pelvis

Policy Number

72192

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Computed Tomography of the Pelvis

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Coverage Issues Manual, Section 50-12
 Medicare Hospital Manual, Section 443
 Medicare Intermediary Manual, Sections 3604, 3631
 Medicare Skilled Nursing Facility Manual, Addendum C

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

07/22/1999

Revision Effective Date

01/25/01

Revision Ending Effective Date

01/24/01

Policy Ending Date

N/A

LMRP Description

Computed Tomography of the Pelvis (CT Scan of the Pelvis) is a noninvasive yet accurate X-ray procedure which results in images from passing X-rays through an organ at many angles. The variation and density of each tissue allows for variable penetration of the X-rays. Each density is computed by utilizing a coefficient (or numeric value) which is digitally computed into shades of gray. These shades of gray are then displayed on a monitor as thousands of dots in various shades.

The pelvis is a basin-like structure that supports the spinal column and rests on the lower limbs. The "true pelvis" is defined as that portion of the pelvis situated below and behind the pelvic brim.

The CT scan of the pelvic area includes the bladder, prostate, ovaries, uterus, lower retroperitoneum and iliac lymph node chains. CT scans are generally performed to study the pelvic viscera. In males, this includes the bladder and prostate and in females, the bladder, uterus and adnexa. The CT scan of the pelvis is useful in evaluating cysts, tumors, masses, metastasis to one or more of these organs, and iliac lymph nodes. Intravenous contrast material may be administered when enhanced views are needed.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider a CT scan of the pelvis medically necessary and reasonable under the following conditions:

- To evaluate cysts, tumors, or masses of the pelvic structure (i.e., that which lies at or below the pelvic brim, or true pelvis);
- To evaluate metastasis of primary cancers to this region;
- To evaluate inflammatory processes of this region;
- To evaluate abnormalities of pelvic vascular structures;
- To evaluate lymphadenopathies of this region;
- To evaluate lower abdominal, generalized abdominal or pelvic pain;
- To evaluate other genitourinary disorders in which the physician cannot make a diagnosis on physical examination and/or by ultrasound;
- To evaluate trauma to the pelvic structure/organs; and/or
- To evaluate the effectiveness of a radiation treatment plan.

HCPCS Section & Benefit Category

Radiology/Diagnostic Radiology

Type of Bill Code

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

Revenue Code

32x Radiology Diagnostic
 350 Computed Tomography Scan, General
 Classification

CPT Codes

- 72192 Computerized axial tomography, pelvis; without contrast material
- 72193 with contrast material(s)
- 72194 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

- 015.00-015.06 Tuberculosis of vertebral column
- 016.10-016.96 Tuberculosis of genitourinary system
- 153.0-153.9 Malignant neoplasm of colon
- 154.0-154.8 Malignant neoplasm of rectum, rectosigmoid junction, and anus
- 171.6 Malignant neoplasm of pelvis
- 179 Malignant neoplasm of uterus, part unspecified
- 180.0-180.9 Malignant neoplasm of cervix uteri
- 182.0-182.8 Malignant neoplasm of body of uterus
- 183.0-183.9 Malignant neoplasm of ovary and other uterine adnexa
- 184.0 Malignant neoplasm of vagina
- 184.8 Malignant neoplasm of other specified sites of female genital organs
- 184.9 Malignant neoplasm of female genital organ, site unspecified
- 185 Malignant neoplasm of prostate
- 186.0-186.9 Malignant neoplasm of testis

72192: *Computed Tomography of the Pelvis (continued)*

187.8	Malignant neoplasm of other specified sites of male genital organs	218.0-218.9 219.0-219.9	Uterine leiomyoma Other benign neoplasm of uterus
187.9	Malignant neoplasm of male genital organ, site unspecified	220 221.0	Benign neoplasm of ovary Benign neoplasm of fallopian tube and uterine ligaments
188.0-188.9	Malignant neoplasm of bladder		
189.2	Malignant neoplasm of uretra	228.04	Hemangioma, of intra-abdominal structures (peritoneum and retroperitoneum)
189.3	Malignant neoplasm of other specified sites of urinary organs	228.1	Lymphangioma, any site
189.9	Malignant neoplasm of urinary organ, site unspecified	230.4 233.1-233.9	Carcinoma in situ of rectum Carcinoma in situ of genitourinary system
195.3	Malignant neoplasm of pelvis	235.2	Neoplasm of uncertain behavior of stomach, intestines, and rectum
196.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes	235.4	Neoplasm of uncertain behavior of retroperitoneum and peritoneum
196.5	Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb	236.0-236.2	Neoplasm of uncertain behavior of uterus, placenta, or ovary
196.6	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes	236.5 236.7	Neoplasm of uncertain behavior of prostate Neoplasm of uncertain behavior of bladder
197.6	Secondary malignant neoplasm of retroperitoneum and peritoneum	236.90	Neoplasm of uncertain behavior of urinary organ, unspecified
198.1	Secondary malignant neoplasm of other urinary organs	239.4-239.5	Neoplasms of unspecified nature of bladder or other genitourinary organs
198.5	Secondary malignant neoplasm of bone and bone marrow	256.4 441.3	Polycystic ovaries Abdominal aneurysm, ruptured
198.6	Secondary malignant neoplasm of ovary	441.4	Abdominal aneurysm without mention of rupture
200.00	Reticulosarcoma, unspecified site, extranodal and solid organ sites	442.2	Other aneurysm of iliac artery
200.05	Reticulosarcoma of lymph nodes of inguinal region and lower limb	444.0	Arterial embolism and thrombosis of abdominal aorta (includes aortailiac obstruction)
200.06	Reticulosarcoma of intrapelvic lymph nodes		
200.08	Reticulosarcoma of lymph nodes of multiple sites	457.1 540.0	Other lymphedema Acute appendicitis with generalized peritonitis
200.10	Lymphosarcoma, unspecified site, extranodal and solid organ sites	540.1	Acute appendicitis with peritoneal abscess
200.15	Lymphosarcoma of lymph nodes of inguinal region and lower limb	543.9 552.21	Other and unspecified diseases of appendix Incisional hernia with obstruction
200.16	Lymphosarcoma of intrapelvic lymph nodes	553.8	Hernia of other specified sites
200.18	Lymphosarcoma of lymph nodes of multiple sites	553.9 555.0	Hernia of unspecified site Regional enteritis of small intestine
200.20	Burkitt's tumor or lymphoma, unspecified site, extranodal and solid organ sites	555.1	Regional enteritis of large intestine (Crohn's disease involving sigmoid colon and rectum)
200.25	Burkitt's tumor or lymphoma, lymph nodes of inguinal region and lower limb	555.2	Regional enteritis of small intestine with large intestine
200.26	Burkitt's tumor or lymphoma of intrapelvic lymph nodes	555.9	Regional enteritis, unspecified site
200.28	Burkitt's tumor or lymphoma of lymph nodes of multiple sites	557.0-557.9 560.0	Vascular insufficiency of intestine Intussusception
201.00-201.98	Hodgkin's disease	560.81	Intestinal or peritoneal adhesions with obstruction (postoperative) (postinfection)
202.80	Other lymphomas of unspecified site, extranodal and solid organ sites	560.9	Unspecified intestinal obstruction
202.85	Other lymphomas of lymph nodes of inguinal region and lower limb	562.10	Diverticulosis of colon (without mention of hemorrhage)
202.86	Other lymphomas of intrapelvic lymph nodes	562.11	Diverticulitis of colon (without mention of hemorrhage)
202.88	Other lymphomas of lymph nodes of multiple sites	566 567.2	Abscess of anal and rectal regions Other suppurative peritonitis
211.3	Benign neoplasm of colon	567.9	Unspecified peritonitis
211.4	Benign neoplasm of rectum and anal canal	568.0	Peritoneal adhesions (postoperative)(postinfection)
211.8	Benign neoplasm of retroperitoneum and peritoneum	568.81	Hemoperitoneum (nontraumatic)
215.6	Other benign neoplasm of pelvis	568.82	Peritoneal effusion (chronic)

72192: *Computed Tomography of the Pelvis (continued)*

568.89	Other specified disorders of peritoneum	752.51-752.52	Undescended and retractile testicle
569.41-569.5	Other specified disorders of rectum and anus and abscess of intestine	752.8	Other specified anomalies of genital organs
569.60-569.69	Colostomy and enterostomy complications	753.0-753.9	Congenital anomalies of urinary system
569.83	Perforation of intestine	780.6	Fever
569.89	Other specified disorders of intestine	785.6	Enlargement of lymph nodes
578.1	Blood in stool	789.03	Abdominal pain, right lower quadrant
591	Hydronephrosis	789.04	Abdominal pain, left lower quadrant
593.3	Stricture or kinking of ureter	789.05	Abdominal pain, periumbilic
593.4	Other ureteric obstruction	789.07	Abdominal pain, generalized
593.5	Hydroureter	789.09	Abdominal pain, other specified site
593.82	Ureteral fistula	789.33-789.35	Abdominal or pelvic swelling, mass or lump (right lower quadrant, left lower quadrant or periumbilic)
593.89	Other specified disorders of kidney and ureter	789.5	Ascites
596.0	Bladder neck obstruction	789.63-789.65	Abdominal tenderness (right lower quadrant, left lower quadrant, periumbilic)
596.6	Rupture of bladder, nontraumatic	789.67	Abdominal tenderness, generalized
596.8	Other specified disorders of bladder	789.9	Other symptoms involving the abdomen and pelvis
599.1	Urethral fistula		
599.7	Hematuria	793.5	Nonspecific abnormal findings on radiological and other examination of genitourinary organs
614.0-614.9	Inflammatory disease of ovary, fallopian tube, pelvic cellular tissue, and peritoneum	793.6	Nonspecific abnormal findings on radiological and other examination of abdominal area, including retroperitoneum
615.0-615.9	Inflammatory diseases of uterus, except cervix	793.9	Nonspecific abnormal findings on radiological and other examination of other body structure
617.0-617.9	Endometriosis	820.00-820.99	Fracture of neck of femur
619.0-619.9	Fistula involving female genital tract	863.89	Injury to other gastrointestinal sites without mention of open wound into cavity
620.0-620.9	Noninflammatory disorders of ovary, fallopian tube, and broad ligament	867.0-867.9	Injury to pelvic organs
621.4	Hematometra	876.0-876.1	Open wound of back
621.8	Other specified disorders of uterus, not elsewhere classified	877.0-877.1	Open wound of buttock
625.8	Other specified symptoms associated with female genital organs	879.2	Open wound of abdominal wall, anterior, without mention of complication
626.6	Metrorrhagia	879.3	Open wound of abdominal wall, anterior, complicated
639.0	Genital tract and pelvic infection following abortion and ectopic and molar pregnancies	879.4	Open wound of abdominal wall, lateral, without mention of complication
639.1	Delayed or excessive hemorrhage following abortion and ectopic and molar pregnancies	879.5	Open wound of abdominal wall, lateral, complicated
665.10	Rupture of uterus during labor, unspecified as to episode of care or not applicable	879.6	Open wound to other and unspecified parts of trunk, without mention of complication
665.40	High vaginal laceration, unspecified as to episode of care or not applicable	879.7	Open wound to other and unspecified parts of trunk, complicated
665.50	Other injury to pelvic organs, unspecified as to episode of care or not applicable	902.81-902.9	Injury to other specified and unspecified blood vessels of abdomen and pelvis
670.00-670.04	Major puerperal infection	958.4	Traumatic shock
682.2	Other cellulitis and abscess of trunk	958.5	Traumatic anuria
682.5	Other cellulitis and abscess of buttock	959.1	Trunk injury
682.9	Other cellulitis and abscess of unspecified site	995.54	Child physical abuse
719.45	Pain in joint, pelvic region	995.81	Adult physical abuse
751.0	Meckel's diverticulum	996.1	Mechanical complication of other vascular device, implant and graft
751.2	Atresia and stenosis of large intestine, rectum, and anal canal	996.30-996.39	Mechanical complication of genitourinary device, implant, and graft
752.0	Anomalies of ovaries	996.81	Complication of transplanted organ, kidney
752.10-752.19	Anomalies of fallopian tubes and broad ligaments	996.87	Complications of transplanted organ, intestines
752.3	Other anomalies of uterus		
752.40	Unspecified anomaly of cervix, vagina, and external female genitalia		

72192: Computed Tomography of the Pelvis (continued)

- 997.5 Urinary complications
- 998.2 Accidental puncture or laceration during a procedure
- 998.4 Foreign body accidentally left during a procedure
- 998.51-998.59 Postoperative infection
- V42.0 Kidney replaced by transplant
- V42.84 Organ or tissue replaced by transplant, intestines
- V44.3 Colostomy status
- V44.50-V44.59 Cystostomy status

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

If the procedure is performed using contrast only, procedure code **72193** should be billed. If the procedure is performed initially without contrast, followed by contrast then procedure code **72194** should be billed. Procedure codes **72192**, **72193** and/or **72194** should not be billed on the same day for the same patient.

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.

If the provider of 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.

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

According to Golish (1994), a CT scan of the pelvic area includes the bladder, prostate, ovaries, uterus, lower

retroperitoneum, and iliac lymph nodes. Melloni (1985) describes the pelvis as a basin-like structure that supports the spinal canal and rests on the lower limbs.

In addition, the “true pelvis” is described as that lying below the pelvic brim. Therefore, according to Gray’s Anatomy (1975), the male pelvic region includes the bladder and prostate and the female pelvic region includes the bladder, uterus and adnexa. Also, the rectum, anal canal, and anus are seen retroperitoneally. In addition, a portion of the sigmoid flexure may be viewed with the CT scan of the pelvis. Moreover, a portion of the ileum may be viewed, particularly in females (Gray’s Anatomy, 1975).

According to MacKay (1996), in some cases, ultrasound, or echography, can identify a lesion or mass and the CT scan of the pelvis is used for staging these tumors and/or when ultrasound results are suboptimal.

According to ACR (1995), CT scans of the pelvis are generally indicated to evaluate pain, masses, cysts, malignancies, inflammatory processes, trauma, treatment planning for radiation therapy, clarification of findings from other imaging studies and/or abnormal laboratory values.

According to the *Coverage Issues Manual (CIM)*, Computerized Tomography is covered if medical and scientific literature and opinion support the effective use of a scan for the condition, the scan is reasonable and necessary and performed with equipment which is known to the Food and Drug Administration (FDA) and is in the full market release phase of development. According to CIM, there is no general rule that requires other diagnostic tests be performed before CT scanning is done. However, CIM further states that in individual cases the contractor’s medical staff may determine that the use of a CT scan as the initial diagnostic test was not medically necessary and reasonable because it was not supported by the patient’s symptoms or complaints.

Sources of Information

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from the Florida Radiological Society.

Start Date of Comment Period

N/A

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	3
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 <i>Bulletin</i>
Revised Effective Date:	01/25/01
Explanation of Revision:	A revision was made to add ICD-9-CM codes 820.00-820.99, 867.0-867.9 and 902.81-902.9.

80100: Qualitative Drug Screen

Policy Number

80100

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Qualitative Drug Screen

AMA CPT Copyright Statement

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HCFA National Coverage Policy

N/A

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

07/22/1999

Revision Effective Date

01/01/2001

Revision Ending Effective Date

12/31/2000

Policy Ending Date

N/A

LMRP Description

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

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

Examples of drugs or classes of drugs that are commonly assayed by qualitative screen, followed by confirmation with a second method, are: Alcohols, Amphetamines, Barbiturates, Benzodiazepines, Cocaine and

Metabolites, Methadones, Methaqualones, Opiates, Phencyclidines, Phenothiazines, Propoxyphenes, Tetrahydrocannabinoids, and Tricyclic Antidepressants.

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

Indications and Limitations of Coverage and/or Medical Necessity

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

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

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

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

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

HCPCS Section & Benefit Category

Pathology and Laboratory/Drug Testing

Type of Bill Code

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

Revenue Code

301 Chemistry

80100: Qualitative Drug Screen (continued)

CPT Codes

80100	Drug, screen, qualitative; multiple drug classes chromatographic method, each procedure
80101	single drug class method (e.g., immunoassay, enzyme assay), each drug class
80102	Drug, confirmation, each procedure

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

276.2	Acidosis
304.90	Unspecified drug dependence
345.90-345.91	Epilepsy, unspecified
780.01	Coma
780.09	Alteration of consciousness, other
977.9	Poisoning by unspecified drug or medicinal substance

Diagnosis that Support Medical Necessity

N/A

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

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

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

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

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

Immunoassays, which are used to identify single drug classes, should be coded using 80101 (when used in drug screening), whether the test is performed using a random access analyzer, a single analyte test kit, or a multiple

analyte test kit. For procedure code 80101, each single drug class method tested and reported is to be counted as one drug class. For example, if a sample is aliquoted to five wells and separate class-specific immunoassays are run on each of the five wells and reported separately, report 80101 five times. Similarly, if a sample is run on a rapid assay kit comprising five class-specific immunoassays in a single kit, and the five classes are reported separately, code 80101 should be reported five times.

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

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

Documentation Requirements

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

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

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from numerous societies.

Start Date of Comment Period

N/A

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	2
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 <i>Bulletin</i>
Revised Effective Date:	01/01/2001
Explanation of Revision:	Annual 2001 HCPCS Update

82105: Tumor Markers

Policy Number

82105

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Tumor Markers

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Program Memorandum 536 A/B

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

03/23/1998

Revision Effective Date

01/01/2001

Revision Ending Effective Date

12/31/2000

Policy Ending Date

N/A

LMRP Description

Tumor markers are hormones, enzymes, or antigens produced by tumor cells and measurable in the blood or in some cases in the urine (e.g., bladder tumor associated antigens) of persons with malignancies. Tumor markers are measured by monoclonal antibodies designed to identify specific antigens. These tumor markers may reflect tumor size and grade and may be helpful in monitoring response to treatment. However, tumor markers are not useful for making a differential diagnosis of cancer since the sensitivity and specificity of these tests make it unreliable.

Indications and Limitations of Coverage and/or Medical Necessity

Alpha - fetoprotein; serum (procedure code 82105)

Florida Medicare will consider Alpha-fetoprotein; serum to be medically reasonable and necessary for:

- Evaluating the extent of involvement of hepatocellular carcinoma and germ cell tumors of the testis, ovary and extragonadal sites;

- Choosing therapy and predicting tumor behavior (prognosis); and/or
- Predicting effects of therapy and detecting recurrent cancer of hepatocellular carcinoma and germ cell tumors of the testis, ovary, and extragonadal sites.

Gonadotropin, Chorionic (hCG) (procedure codes 84702-84703)

Gonadotropin is a glycoprotein hormone which is normally produced by the developing placenta and aberrantly produced by gestational trophoblastic tumors, seminomatous and nonseminomatous testis cancer and ovarian tumors.

hCG is considered medically reasonable and necessary for:

- Evaluating the extent of involvement of specific types of cancer (see covered ICD-9-CM list); and/or
- Monitoring therapy response and evaluating the patient's prognosis.

CA125 (procedure code 86304)

The cancer antigen CA125 is recognized by a monoclonal antibody OC-125. It is increased in most patients with advanced, nonmucinous (serous) ovarian cancer.

CA125 is a covered service for patients with ovarian cancer (see covered ICD-9-CM list). CA125 is considered investigational for diagnoses other than ovarian cancer.

CA125 is not covered for making a differential diagnosis of pelvic masses since the sensitivity and specificity of the test makes it unreliable.

CA125 is advocated for prognostic information. When measured serially, it may also be useful in the detection of relapse and as a monitor of patient response to chemotherapeutic agents.

CA27.29 (procedure code 86300)

The cancer antigen CA27.29 is a mucinous glycoprotein that can be detected by monoclonal antibodies. The CA27.29 marker is a tumor-associated marker available for monitoring the treatment and recurrence of carcinoma of the breast.

Florida Medicare will consider CA27.29 to be medically reasonable and necessary for the following conditions:

- CA27.29 is used as an aid to predict recurrent breast cancer in patients with previously treated Stage II or Stage III disease; or
- CA27.29 is used as an aid in monitoring response to therapy in patients with Stage IV breast cancer. A partial or complete response to treatment will be confirmed by declining levels. Likewise, a persistent rise of CA27.29 levels despite therapy strongly suggests progressive disease.

Additionally, only those tests that are FDA approved, are covered by Medicare.

CA27.29 is **not** indicated as a screening test.

CA15-3 (procedure code 86300)

The mucin glycoprotein-detecting assay CA15-3 is a valuable tool for monitoring the course of disease in breast

82105: Tumor Markers (continued)

cancer patients. Assays of CA15-3 are based on the use of two monoclonal antibodies to polymorphic epithelial mucin (PEM).

Florida Medicare will consider CA15-3 to be medically reasonable and necessary for the following condition:

- To aid in the management of Stage II and Stage III breast cancer patients. Serial testing for patient CA15-3 assay values should be used in conjunction with other clinical methods for monitoring breast cancer.

Additionally, only those tests that are FDA approved, are covered by Medicare.

CA15-3 is **not** indicated as a screening test.

Bladder Tumor Antigen (procedure code 86294)

There are immunoassay devices that use monoclonal antibodies to detect the presence of bladder tumor associated antigens in the urine of persons diagnosed with bladder cancer.

Florida Medicare will consider testing for bladder tumor antigens to be medically reasonable and necessary for the following condition:

- To be used with standard cystoscopic examination as an aid in the management of bladder cancer.

Testing for bladder tumor antigens is not indicated as a screening test for bladder cancer. Coverage may only be extended for its use in patients with a prior or known diagnosis of bladder cancer. Therefore, it will be allowed for follow-up of treatment for bladder cancer, to monitor for eradication of the cancer, or recurrences after eradication.

Evaluation of bladder tumor antigen has been proposed as an alternative to urine cytology; therefore, there is no medical necessity for the simultaneous performance of both tests.

HCPCS Section & Benefit Category

Pathology and Laboratory/Immunology
Pathology and Laboratory/Chemistry

Type of Bill Code

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

Revenue Code

301 Chemistry
302 Laboratory Immunology
312 Histology

CPT Codes

82105 Alpha-fetoprotein; serum
84702 Gonadotropin, chorionic (hCG); quantitative
84703 qualitative
86294 Immunoassay for tumor antigen, qualitative or semiquantitative (e.g., bladder tumor antigen)
86300 Immunoassay for tumor antigen, quantitative; CA15-3 (27.29)
86304 CA125

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

Alpha-fetoprotein (procedure code 82105)

155.0-155.2	Malignant neoplasm of the liver and intrahepatic bile ducts
183.0	Malignant neoplasm, ovary
186.0	Malignant neoplasm of undescended testis
186.9	Malignant neoplasm, other and unspecified testis
197.7	Secondary malignant neoplasm of liver, specified as secondary
198.6	Secondary malignant neoplasm of ovary
198.82	Secondary malignant neoplasm of genital organs
V10.43	Personal history of malignant neoplasm, ovary
V10.47	Personal history of malignant neoplasm, testis

Gonadotropin, Chorionic (hCG) (procedure codes 84702-84703)

181	Malignant neoplasm of placenta
183.0	Malignant neoplasm, ovary
186.0	Malignant neoplasm of undescended testis
186.9	Malignant neoplasm, other and unspecified testis
198.6	Secondary malignant neoplasm of ovary
198.82	Secondary malignant neoplasm of genital organs
V10.43	Personal history of malignant neoplasm, ovary
V10.47	Personal history of malignant neoplasm, testis

CA125 (procedure code 86304)

183.0	Malignant neoplasm, ovary
198.6	Secondary malignant neoplasm of ovary
V10.43	Personal history of malignant neoplasm, ovary

CA27.29 and CA15-3 (procedure code 86300)

174.0-174.9	Malignant neoplasm of the female breast
175.0-175.9	Malignant neoplasm of the male breast
V10.3	Personal history of malignant neoplasm, breast

Bladder Tumor Antigen (procedure code 86294)

188.0-188.9	Malignant neoplasm of bladder
V10.51	Personal history of malignant neoplasm, bladder

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

82105: Tumor Markers (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.

Testing performed for tumor markers by investigational methods that are not approved by the FDA are not covered by Medicare.

Routine screening services are not covered by Florida Medicare.

All other tumor markers (e.g., procedure code 86316) including those listed below are considered investigational and therefore, ineligible for payment.

A2-PAG	pregnancy-associated alpha2 glycoprotein
BCM	breast cancer mucin
CA19-9	Cancer antigen 19-9 (procedure code 86301)
CA50	Cancer antigen 50
CA72-4	Cancer antigen 72-4
CA195	Cancer antigen 195
CA242	Cancer antigen 242
CA549	Cancer antigen 549
CA-SCC	Squamous cell carcinoma
CAM17-1	Monoclonal antimucin antibody 17-1
CAM26	Monoclonal antimucin antibody 26
CAM29	Monoclonal antimucin antibody 29
CAR3	Antigenic determinant recognized by monoclonal antibody AR3
DU-PAN-2	Sialylated carbohydrate antigen DU-PAN-2
MCA	Mucin-like carcinoma associated antigen
NSE	Neuron-specific enolase
P-LAP	Placental alkaline phosphatase
PNA-ELLA	Peanut lectin bonding assay
SLEX	Sialylated Lewis X-antigen
SLX	Sialylated SSEA-1 antigen
SPAN-1	Sialylated carbonated antigen SPAN-1
ST-439	Sialylated carbonated antigen ST-439
TAG12	Tumor-associated glycoprotein 12
TAG72	Tumor-associated glycoprotein 72
TAG72.3	Tumor-associated glycoprotein 72.3
TATI	Tumor-associated trypsin inhibitor
TNF-a	Tumor necrosis factor alpha
TPA	tissue polypeptide antigen

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

Claims for tumor antigen tests will be denied unless medical necessity is established by use of one or more of the above procedure and diagnosis codes.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing this test, including the appropriate ICD-9-CM codes. This information is usually found in the history and physical, office/progress notes, and/or laboratory results.

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

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from numerous societies.

Start Date of Comment Period

N/A

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	4
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 <i>Bulletin</i>
Revised Effective Date:	01/01/2001
Explanation of Revision:	Annual 2001 HCPCS Update

82310: Total Calcium

Policy Number

82310

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Total Calcium

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Medicare Intermediary Manual, Section 3167
Coverage Issues Manual, Section 50-17A

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

03/15/2001

Revision Effective Date

N/A

Revision Ending Effective Date

N/A

Policy Ending Date

N/A

LMRP Description

Calcium is a predominantly extracellular cation. It is of great importance in blood coagulation; it gives firmness and rigidity to bones and teeth; it is important in acid-base balance; it is essential for lactation; it is important in activating enzymes; it is essential for the function of nerves and muscles, including the myocardium; and for maintaining the permeability of membranes. Over 98% of body's calcium is found in the bones and teeth. The serum calcium test is used to evaluate parathyroid function and calcium metabolism by directly measuring the total amount of calcium in the blood. About 50% of blood calcium is ionized; the rest is protein bound (with albumin). The serum calcium level is a measurement of both. The normal adult serum calcium level is between 8.5-10.5mg/dl.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider a calcium test medically reasonable and necessary for the following conditions:

- Evaluation of patients with clinical signs and symptoms of hypercalcemia. Signs and symptoms of hypercalcemia include, but are not limited to, the following:

nausea and vomiting	prominent skeletal muscle weakness
anorexia	polyuria, nocturia, polydipsia
constipation	stupor
abdominal pain	coma
dehydration	ECG changes/prolongation of QT interval
lethargy	death
confusion	
flank pain due to renal calculi	

Conditions in which a serum calcium test may be medically necessary for hypercalcemia include, but are not limited to the following: hyperparathyroidism; malignancies; adrenal insufficiency; acromegaly; hypervitaminosis D; immobilization; and drugs (e.g., thiazide diuretics, calcium salts, etc.).

- Evaluation of patients with clinical signs and symptoms of hypocalcemia. Signs and symptoms of hypocalcemia include, but are not limited to, the following:

muscle twitching	arrhythmias
Chvostek's sign	bronchospasm
Trousseau's sign (carpopedal spasm)	dysphagia
tetany	diplopia and photophobia
muscle cramping	anxiety
malaise	unexplained dementia,
circumforal and peripheral numbness and tingling	depression, and, psychosis
ECG changes/shortened QT interval	

Conditions in which a serum calcium test may be medically reasonable and necessary for hypocalcemia include, but are not limited to, the following: hypoparathyroidism; hypoalbuminemia; renal failure; pancreatitis; vitamin D deficiency; severe malnutrition and malabsorption; septic shock; and drugs (e.g., anticonvulsants, heparin, laxatives, loop diuretics, magnesium salts, and etc.).

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

Disorders of calcium metabolism are initially evaluated with measurements of serum phosphorus, albumin, chloride, magnesium, potassium, total protein, parathyroid hormone levels, and often a 24-hour urine calcium level.

82310: Total Calcium (continued)

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

HCPCS Section & Benefit Category

Pathology and Laboratory/Chemistry

Type of Bill Code

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

Revenue Code

301 Chemistry

CPT Codes

82310 Calcium; total

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

135	Sarcoidosis
140.0-208.91	Malignant neoplasms
252.0	Hyperparathyroidism
252.1	Hypoparathyroidism
255.4	Corticoadrenal insufficiency
260-269.9	Nutritional deficiencies
275.41	Hypocalcemia
275.42	Hypercalcemia
275.49	Other disorders of calcium metabolism
276.0-276.9	Disorders of fluid, electrolyte, and acid-base balance
278.4	Hypervitaminosis D
293.0-293.1	Acute and subacute delirium (confusion)
298.9	Unspecified psychosis
368.13	Visual discomfort
368.2	Diplopia
427.0-427.9	Cardiac dysrhythmias
519.1	Other diseases of trachea and bronchus, not elsewhere classified (bronchospasms)
564.0	Constipation
577.0-577.1	Pancreatitis
579.0-579.9	Intestinal malabsorption
585	Chronic renal failure
728.89	Other disorders of muscle, ligament, and fascia (rhabdomyolysis)
728.9	Unspecified disorder of muscle, ligament, and fascia (muscle weakness and soreness)
733.90	Disorder of bone and cartilage, unspecified (bone pain)
780.01	Coma
780.39	Other convulsions
780.79	Other malaise and fatigue
781.0	Abnormal involuntary movements
781.7	Tetany

782.0	Disturbance of skin sensation (parasthesias)
783.0	Anorexia
783.5	Polydipsia
785.59	Other shock without mention of trauma
787.01-787.03	Nausea and vomiting
787.2	Dysphagia
788.42	Polyuria
E934.2	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, anticoagulants
E936.3	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, other and unspecified anticonvulsants
E943.3	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, other cathartics, including intestinal atonia drugs
E944.4	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, other diuretics
E944.5	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, electrolytic, caloric, and water-balance agents

Diagnosis that Support Medical Necessity

N/A

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

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

Routine serum calcium laboratory tests, those performed at a frequency of once per month for hemodialysis, intermittent peritoneal dialysis, continuous cycling peritoneal dialysis, and hemofiltration beneficiaries, are included in the *renal facility’s* composite rate and may not be billed separately to the Medicare program. Services performed at a greater frequency than specified are separately billable if medically necessary. A diagnosis of ESRD alone (ICD-9-CM code 585) is not sufficient medical evidence to warrant coverage of additional tests.

82310: Total Calcium (continued)

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 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

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

Other Comments

N/A

Sources of Information

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from multiple societies.

Start Date of Comment Period

06/12/2000

Start Date of Notice Period

02/01/2001

Revision History

Revision:	Original
Start Date of Comment Period:	06/12/2000
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 <i>Bulletin</i>
Original Effective Date:	03/15/2001

82435: Chloride

Policy Number

82435

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Chloride

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Coverage Issues Manual, Section 50-17
Hospital Manual, Section E204.3
Intermediary Manual, Section 3167.3
Renal Dialysis Facility Manual, Section 207.3

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

03/15/2001

Revision Effective Date

N/A

Revision Ending Effective Date

N/A

Policy Ending Date

N/A

LMRP Description

Chloride is an anion that exists primarily in the extracellular spaces as part of sodium chloride or hydrochloric acid. Chloride maintains cellular integrity through its influence on osmotic pressure and acid-base and water balance. Chloride concentration increases or decreases in response to concentrations of other anions.

Measurement of chloride is usually done for inferential value and is helpful in diagnosing disorders of acid-base and water balance. The normal adult serum chloride level is 96-106 mEq/L.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider a serum chloride test medically reasonable and necessary when performed for the following indications:

1. Evaluation of patients with signs and symptoms of hypochloremia. Signs and symptoms of hypochloremia include, but are not limited to, the following:
 - Hyperexcitability of the nervous system and muscles
 - Shallow breathing
 - Hypotension
 - Tetany

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

- Severe vomiting
 - Severe diarrhea
 - Excessive sweating
 - Gastric suction
 - Chronic respiratory acidosis
 - Burns
 - Metabolic alkalosis
 - Congestive heart failure
 - Addison's disease
 - Primary aldosteronism
 - Syndrome of inappropriate antidiuretic hormone (SIADH)
 - Overhydration or water intoxication
 - Acute intermittent porphyria
2. Evaluation of patients with signs and symptoms of hyperchloremia. Signs and symptoms of hyperchloremia can include, but are not limited to, the following:
 - Lethargy
 - Weakness
 - Deep breathing

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

- Dehydration
- Cushing's syndrome
- Hyperventilation which causes respiratory alkalosis
- Metabolic acidosis with prolonged diarrhea
- Hyperparathyroidism
- Renal tubular acidosis
- Diabetes insipidus
- Salicylate intoxication
- Head injury with hypothalamic damage
- Multiple myeloma
- Acute or chronic renal failure
- Excessive infusion of sodium chloride
- Hyperchloremic acidosis resulting from gastrointestinal bicarbonate loss caused by drugs (e.g., calcium chloride, magnesium sulfate, and cholestyramine)
- Hyperchloremic acidosis resulting from drug induced hyperkalemia with renal insufficiency (e.g., potassium sparing diuretics, trimethoprim, pentamidine, angiotensin-converting enzyme inhibitors, nonsteroidal anti-inflammatory drugs, and cyclosporine)

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

Interpretation of chloride usually requires clinical information and other electrolytes such as sodium, potassium, and carbon dioxide to assess electrolyte, acid-base, and water balance.

In accordance with national Medicare coverage policy, serum chloride laboratory tests are routinely covered at a frequency of once per month for hemodialysis, intermittent peritoneal dialysis, continuous cycling peritoneal dialysis, and hemofiltration beneficiaries. Services performed at a

82435: Chloride (continued)

greater frequency are covered if medically necessary and used in timely medical decision making.

HCPCS Section & Benefit Category

Pathology and Laboratory/Chemistry

Type of Bill Code

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

Revenue Code

301 Laboratory, Chemistry

CPT Codes

82435 Chloride; blood

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

203.00-203.01 Multiple myeloma
 252.0 Hyperparathyroidism
 253.5 Diabetes insipidus
 253.6 Other disorders of neurohypophysis
 255.1 Cushing’s syndrome
 255.1 Hyperaldosteronism
 255.4 Corticoadrenal insufficiency
 276.0-276.6 Disorders of fluid, electrolyte, and acid-base balance
 277.1 Disorders of porphyrin metabolism
 428.0 Congestive heart failure
 518.81 Acute respiratory failure
 518.83 Chronic respiratory failure
 518.84 Acute and chronic respiratory failure
 536.2 Persistent vomiting
 585 Chronic renal failure
 588.8 Other specified disorders resulting from impaired renal function
 780.79 Other malaise and fatigue
 780.8 Hyperhidrosis
 781.7 Tetany
 786.01 Hyperventilation
 965.1 Poisoning by salicylates

Diagnosis that Support Medical Necessity

N/A

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

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

Routine serum chloride laboratory tests, those performed at a frequency of once per month for hemodialysis, intermittent peritoneal dialysis, continuous cycling peritoneal dialysis, and hemofiltration beneficiaries, are included in the renal facility’s composite rate and may not be billed separately to the Medicare program. Serum chloride tests performed more frequently than once per month are separately billable if medically justified. A diagnosis of ESRD (ICD-9-CM code 585) alone is not sufficient medical evidence for coverage of additional tests.

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 procedure report.

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

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

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

Other Comments

N/A

Sources of Information

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from numerous societies.

Start Date of Comment Period

11/15/2000

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	Original
Start Date of Comment Period:	11/15/2000
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 <i>Bulletin</i>
Original Effective Date:	03/15/2001

84152: Complexed and Free Prostate Specific Antigen

Policy Number

84152

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Complexed and Free Prostate Specific Antigen

AMA CPT Copyright Statement

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HCFA National Coverage Policy

N/A

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

07/22/1999

Revision Effective Date

01/01/2001

Revision Ending Effective Date

12/31/2000

Policy Ending Date

N/A

LMRP Description

Prostate-specific antigen (PSA) is a serum glycoprotein tumor marker used in the early detection of prostate cancer. The PSA exists in multiple forms in serum and is predominantly complexed to protease inhibitors; however, one form of PSA, free PSA, is not bound to these proteins. The measurement of PSA forms in serum helps discriminate between prostate cancer and benign prostatic disease. For unknown reasons, the percentage of free PSA (fPSA) is lower in serum samples from patients with prostate cancer than in serum samples from patients with a normal prostate or benign disease.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider a complexed or free PSA medically reasonable and necessary in the following circumstances:

- To evaluate the patient whose total PSA level is between 4.0-10.0 ng/mL and has a palpable benign prostate gland; and
- To eliminate the need for unnecessary biopsies.

A complexed and free PSA are not indicated for patients that demonstrate a palpable abnormal gland that is suspicious for carcinoma. In addition, since this test is used to eliminate unnecessary biopsies, usually when the complexed or free PSA to total PSA ratio is at least 25 percent, it is not expected that a biopsy would be performed on patients with documentation suggestive of benign prostatic disease.

NOTE: Complexed and free PSA are not medically necessary to monitor for the recurrence of disease or to monitor the response of therapy.

HCPCS Section & Benefit Category

Pathology and Laboratory/Chemistry

Type of Bill Code

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

Revenue Code

301 Chemistry

CPT Codes

84152 Prostate specific antigen (PSA); complexed (direct measurement)
 84154 free

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

790.93 Elevated prostate specific antigen, (PSA)

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.

84152: Complexed and Free Prostate Specific Antigen (continued)

Noncovered Diagnosis

N/A

Coding Guidelines

Since complexed and free PSA measure identical information, however, in a converse relationship, it is not expected that both a complexed PSA and a free PSA be performed when evaluating the patient for the conditions identified in the “Indications and Limitations of Coverage and/or Medical Necessity” section of this policy.

Documentation Requirements

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

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

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from the Florida Urology Society.

Start Date of Comment Period

N/A

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	1
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 <i>Bulletin</i>
Revised Effective Date:	01/01/2001
Explanation of Revision:	Annual 2001 HCPCS Update

93000: Electrocardiography

Policy Number

93000

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Electrocardiography

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Intermediary Manual, Sections 3112.3, 3642E, 3627.9
 Coverage Issues Manual, Section 50-15
 Hospital Manual, Sections 462, E204.3, E211.2, 442.7, 442.8, 443
 Renal Dialysis Facility Manual, Sections 207.3, 240.3D

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

11/18/1996

Revision Effective Date

11/21/2000

Revision Ending Effective Date

11/20/2000

Policy Ending Date

N/A

LMRP Description

Electrocardiography (ECG, EKG) is the graphic tracing of the variations in electrical potential caused by the excitation of the heart muscle as detected at the body surface by electrodes placed on the patient's limbs and chest. The monitoring electrodes detect the electrical activity of the heart from a variety of spatial perspectives. The EKG lead system is composed of several electrodes that are placed on each of the four extremities and at varying sites on the chest. It provides information regarding rate, rhythm, myocardial injury, and conduction system.

The normal EKG pattern is composed of waves arbitrarily designated by the letters P, Q, R, S, and T. Through the analysis of these wave forms and time intervals, valuable information about the heart may be

obtained. The EKG is used primarily to identify abnormal heart rhythms (arrhythmias or dysrhythmias) and to diagnose acute myocardial defects, ventricular hypertrophy, and/or strain.

Indications and Limitations of Coverage and/or Medical Necessity

Electrocardiograms are indicated for diagnosis and patient management purposes involving symptoms of the heart, pericardium, thoracic cavity, and systemic diseases, which produce cardiac abnormalities.

Florida Medicare will consider an EKG medically necessary in any of the following circumstances:

1. Initial diagnostic workup for a patient that presents with complaints of symptoms such as chest pain, palpitations, dyspnea, dizziness, syncope, etc. which may suggest a cardiac origin.
2. Evaluation of a patient on a cardiac medication for a cardiac arrhythmia or other cardiac condition which affects the electrical conduction system of the heart (e.g., inotropics such as digoxin; antiarrhythmics such as Tambocor, Procainamide, or Quinidine; and antianginals such as Cardizem, Isordil, Corgard, Procardia, Inderal and Verapamil). The EKG is necessary to evaluate the effect of the cardiac medication on the patient's cardiac rhythm and/or conduction system.
3. Evaluation of a patient with a pacemaker with or without clinical findings (history or physical examination) that suggest possible pacemaker malfunction.
4. Evaluation of a patient who has a significant cardiac arrhythmia or conduction disorder in which an EKG is necessary as part of the evaluation and management of the patient. These disorders may include, but are not limited to, the following: Complete Heart Block, Second Degree AV Block, Left Bundle Branch Block, Right Bundle Branch Block, Paroxysmal VT, Atrial Fib/Flutter, Ventricular Fib/Flutter, Cardiac Arrest, Frequent PVCs, Frequent PACs, Wandering Atrial Pacemaker, and any other unspecified cardiac arrhythmia.
5. Evaluation of a patient with known Coronary Artery Disease (CAD) and/or heart muscle disease that presents with symptoms such as increasing shortness of breath (SOB), palpitations, angina, etc.
6. Evaluation of a patient's response to a newly established therapy for angina, palpitations, arrhythmias, SOB or other cardiopulmonary disease process.
7. Evaluation of patients after coronary artery revascularization by Coronary Artery Bypass Grafting (CABGs), Percutaneous Transluminal Coronary Angiography (PTCA), thrombolytic therapy (e.g., TPA, Streptokinase, Urokinase), and/or stent placement.
8. Evaluation of patients presenting with symptoms of a Myocardial Infarction (MI).

93000: *Electrocardiography (continued)*

9. Evaluation of other symptomatology which may indicate a cardiac origin especially in those patients who have a history of an MI, CABG surgery or PTCA or patients who are being treated medically after a positive stress test or cardiac catheterization.	276.0-276.9	Disorders of fluid, electrolyte, and acid-base balance
	277.00-277.01	Cystic fibrosis
	277.3	Amyloidosis
	337.0	Idiopathic peripheral autonomic neuropathy
10. Pre-operative Evaluation of the patient when:	337.9	Unspecified disorder of autonomic nervous system
- undergoing cardiac surgery such as CABGs, automatic implantable cardiac defibrillator, or pacemaker, or	390-429.9	Diseases of the circulatory system
	435.9	Unspecified transient cerebral ischemia (Transient ischemic attack [TIA])
- the patient has a medical condition associated with a significant risk of serious cardiac arrhythmia and/or myocardial ischemia such as Dressler's Syndrome, history of MI, angina pectoris, aneurysm of heart wall, chronic ischemic heart disease, pericarditis, valvular disease or cardiomyopathy to name a few.	436	Acute, but ill-defined, cerebrovascular disease
	440.0-448.9	Diseases of arteries, arterioles, and capillaries
	668.10-668.14	Cardiac complications
	710.0-710.9	Diffuse diseases of connective tissue
	714.0-714.9	Rheumatoid arthritis and other inflammatory polyarthropathies
11 Evaluation of a patient's response to the administration of an agent known to result in cardiac or EKG abnormalities (for patients with suspected, or at increased risk of developing, cardiovascular disease or dysfunction). Examples of these agents are antineoplastic drugs, lithium, tranquilizers, anticonvulsants, and antidepressant agents.	745.0-745.9	Bulbus cordis anomalies and anomalies of cardiac septal closure
	746.00-747.9	Other congenital anomalies of heart and circulatory system
	780.02	Transient alteration of awareness
	780.2	Syncope and collapse
	780.31-780.39	Convulsions
	780.4	Dizziness and giddiness
	780.79	Other malaise and fatigue
	782.0	Disturbance of skin sensation
	782.61-782.62	Pallor and flushing
	785.0	Tachycardia, unspecified
	785.1	Palpitations
	785.2	Undiagnosed cardiac murmurs
	785.3	Other abnormal heart sounds
	785.50-785.59	Shock without mention of trauma
	786.00	Respiratory abnormality, unspecified
	786.01	Hyperventilation
	786.02	Orthopnea
	786.03-786.09	Dyspnea and respiratory abnormalities
	786.50-786.59	Chest pain
	786.6	Swelling, mass, or lump in chest
	789.01	Abdominal pain, right upper quadrant
	789.02	Abdominal pain, left upper quadrant
	789.06	Abdominal pain, epigastric
	794.30-794.39	Nonspecific abnormal results of cardiovascular function study
	799.0	Asphyxia
	799.1	Respiratory arrest
	860.0-860.5	Traumatic pneumothorax and hemothorax
	861.00-861.32	Injury to heart and lung
	959.1	Injury of trunk
	972.0-972.9	Poisoning by agents primarily affecting the cardiovascular system
	980.0-989.9	Toxic effects of substances chiefly nonmedicinal as to source
	995.0-995.89	Certain adverse effects not elsewhere classified
	996.00-996.09	Mechanical complication of cardiac device, implant and graft
	996.80-996.89	Complications of transplanted organ
	997.1	Cardiac complications

NOTE: An EKG performed as a baseline evaluation prior to the initiation of an agent known to result in cardiac or EKG abnormalities is considered screening and is noncovered by Medicare.

HCPCS Section & Benefit Category

Cardiovascular/Medicine

Type of Bill Code

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

Revenue Code

730 Electrocardiogram, General Classification

CPT Codes

- 93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
- 93005 tracing only, without interpretation and report
- 93010 interpretation and report only

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

- 079.0-079.99 Viral and chlamydial infection in conditions classified elsewhere and of unspecified site
- 240.0-246.9 Disorders of thyroid gland
- 250.10-250.13 Diabetes with ketoacidosis
- 250.20-250.23 Diabetes with hyperosmolarity
- 250.30-250.33 Diabetes with other coma
- 250.70-250.73 Diabetes with peripheral circulatory disorders

93000: Electrocardiography (continued)

997.2	Peripheral vascular complications
997.3	Respiratory complications
E933.1	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antineoplastic drugs
E936.0-E936.3	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, anticonvulsant drugs
E939.0-E939.9	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, psychotropic agents
V45.01-V45.09	Other postsurgical states, cardiac pacemaker, automatic implantable cardiac defibrillator, and other specified cardiac device
V45.81-V45.82	Other postsurgical status, aortocoronary bypass status and percutaneous transluminal coronary angioplasty status
V58.69	Long-term (current) use of other medications
V58.83	Encounter for therapeutic drug monitoring
V72.81	Pre-operative cardiovascular examination

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

Outpatient hospitals, hospital-based rural health clinics and CORFS may use **only** code 93005 when billing for this service.

The claim must indicate the signs and symptoms or other clinical reason necessitating the service.

When using diagnosis code V72.81, it is expected that the medical record would contain information supporting either of the two pre-operative evaluation indications listed under the “Indications and Limitations of Coverage and/or Medical Necessity” section of this policy.

If an EKG is being performed to evaluate a patient’s response to the administration of an agent known to result in

cardiac or EKG abnormalities for patients with suspected, or at increased risk of developing cardiovascular disease or dysfunction, then diagnosis code V58.69 or V58.83 should be used. The “E” diagnoses should be used when the patient is experiencing adverse effects to high risk medications.

Documentation Requirements

Medical record documentation (e.g., office/progress notes) maintained by the ordering/referring physician must indicate the medical necessity for performing the test. Additionally, the EKG strip and a copy of the test results should be maintained in the medical record.

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

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from the Florida Chapter of the American College of Cardiology.

Start Date of Comment Period

N/A

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	6
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/01/2001 ^{2nd} Quarter 2001 <i>Bulletin</i>
Revised Effective Date:	11/21/2000
Explanation of Revision:	Based on an inquiry, additional diagnoses were added to use when an EKG is performed to monitor patients taking high risk medication that cause cardiac or EKG abnormalities.

93312: Transesophageal Echocardiogram

Policy Number

93312

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Transesophageal Echocardiogram

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Coverage Issues Manual, Section 50-7
Hospital Manual, Section 443
Intermediary Manual, Sections 3627, 3631

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

05/27/1999

Revision Effective Date

01/01/2001

Revision Ending Effective Date

12/31/2000

Policy Ending Date

N/A

LMRP Description

Transesophageal Echocardiography (TEE) is a cardiac diagnostic procedure in which a modified endoscope, with an ultrasound transducer, is passed into the esophagus and/or stomach in order to obtain 2-D echo images and spectral and color doppler information about the heart and its great vessels.

Transesophageal Echocardiography (TEE) imaging is a viable alternative when transthoracic imaging is problematic or difficult. In many instances, abnormalities can be displayed that are missed with standard diagnostic techniques. The images displayed are often of superior quality because of the high-resolution probes that can be used.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider transesophageal echocardiogram to be medically necessary in any of the following circumstances:

- Examination of prosthetic heart valves, primarily mitral
- Detection of:
 - aortic dissection
 - atrial septal defect
 - congenital heart disease
 - embolism or thrombosis, primarily involving left atrium
 - intracardiac foreign bodies, tumors or masses
 - mitral valve regurgitation
 - vegetative endocarditis
- Intra-operative guide to left ventricular function
- Inadequacy of transthoracic echo due to:
 - chest wall deformity, Chronic Obstructive Pulmonary Disease (COPD)
 - open heart or chest surgery
 - chest trauma
 - obesity

HCPCS Section & Benefit Category

Medicine/Cardiovascular

Type of Bill Code

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

Revenue Code

480 Cardiology, General Classification

CPT Codes

- 93312 Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
- 93313 placement of transesophageal probe only
- 93314 image acquisition, interpretation and report only
- 93315 Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
- 93316 placement of transesophageal probe only
- 93317 image acquisition, interpretation and report
- 93318 Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis

Not Otherwise Classified Codes (NOC)

N/A

93312: Transesophageal Echocardiogram (continued)

ICD-9-CM Codes that Support Medical Necessity			
164.1	Malignant neoplasm of heart	429.71	Acquired cardiac septal defect
212.7	Benign neoplasm of heart	434.10-434.11	Cerebral embolism
278.00-278.01	Obesity	441.00-441.03	Dissection of aorta
391.0-391.9	Rheumatic fever with heart involvement	444.0	Arterial embolism and thrombosis of abdominal aorta
394.0-394.9	Diseases of mitral valve	444.1	Arterial embolism and thrombosis of thoracic aorta
395.0-395.9	Diseases of aortic valve	444.21	Arterial embolism and thrombosis of arteries of upper extremity
396.0-396.9	Diseases of mitral and aortic valves	444.22	Arterial embolism and thrombosis of arteries of lower extremity
397.0-397.9	Diseases of other endocardial structures	444.81	Arterial embolism and thrombosis of iliac artery
410.00-410.02	Acute myocardial infarction of anterolateral wall	444.89	Arterial embolism and thrombosis of other specified artery
410.10-410.12	Acute myocardial infarction of other anterior wall	444.9	Arterial embolism and thrombosis of unspecified artery
410.20-410.22	Acute myocardial infarction of inferolateral wall	453.2	Other venous embolism and thrombosis of vena cava
410.30-410.32	Acute myocardial infarction of inferoposterior wall	458.9	Hypotension, unspecified
410.40-410.42	Acute myocardial infarction of other inferior wall	496	Chronic airway obstruction, not elsewhere classified (COPD)
410.50-410.52	Acute myocardial infarction of other lateral wall	738.3	Acquired deformity of chest and rib
410.60-410.62	True posterior wall infarction	745.0	Common truncus
410.70-410.72	Subendocardial infarction	745.10-745.19	Transposition of great vessels
410.80-410.82	Acute myocardial infarction of other specified sites	745.2	Tetralogy of Fallot
410.90-410.92	Acute myocardial infarction of unspecified site	745.3	Common ventricle
411.0	Postmyocardial infarction syndrome	745.4	Ventricular septal defect
411.1	Intermediate coronary syndrome	745.5	Ostium secundum type atrial septic defect
411.81	Coronary occlusion without myocardial infarction	745.60-745.69	Endocardial cushion defects
411.89	Other acute and subacute forms of ischemic heart disease	745.7	Cor biloculare
414.00	Coronary atherosclerosis of unspecified type of vessel, native or graft	745.8	Other bulbus cordis anomalies and anomalies of cardiac septal closure
414.01	Coronary atherosclerosis of native coronary artery	745.9	Unspecified defect of septal closure
414.02	Coronary atherosclerosis of autologous vein bypass graft	746.00-746.09	Anomalies of pulmonary valve
414.03	Coronary atherosclerosis of nonautologous biological bypass graft	746.1	Tricuspid atresia and stenosis, congenital
414.04	Coronary atherosclerosis of artery bypass graft	746.2	Ebstein's anomaly
414.05	Coronary atherosclerosis of unspecified type of bypass graft	746.3	Congenital stenosis of aortic valve
414.10-414.19	Aneurysm of heart	746.4	Congenital insufficiency of aortic valve
415.11-415.19	Pulmonary embolism and infarction	746.5	Congenital mitral stenosis
421.0-421.9	Acute and subacute endocarditis	746.6	Congenital mitral insufficiency
423.0-423.9	Other diseases of pericardium	746.7	Hypoplastic left heart syndrome
424.0-424.3	Other diseases of endocardium	746.81-746.89	Other specified anomalies of heart
424.90	Endocarditis, valve unspecified, unspecified cause	746.9	Unspecified anomaly of heart
424.91	Endocarditis in diseases classified elsewhere	747.0	Patent ductus arteriosus
424.99	Other endocarditis, valve unspecified	747.10-747.11	Coarctation of aorta
425.0-425.9	Cardiomyopathy	747.3	Anomalies of pulmonary artery
429.4	Functional disturbances following cardiac surgery	754.81-754.89	Other specified nonteratogenic anomalies
429.5	Rupture of chordae tendineae	785.50	Shock, unspecified
429.6	Rupture of papillary muscle	785.51	Cardiogenic shock
		785.59	Other shock without mention of trauma
		861.00-861.03	Injury to heart, without mention of open wound into thorax
		861.10-861.13	Injury to heart, with open wound into thorax
		996.02	Mechanical complication due to heart valve prosthesis
		996.03	Mechanical complication due to coronary bypass graft
		996.61	Infection and inflammatory reaction due to cardiac device, implant, and graft

93312: Transesophageal Echocardiogram (continued)

- 996.71 Other complications due to heart valve prosthesis
- 996.72 Other complications due to other cardiac device, implant, and graft
- V42.1 Heart transplant
- V42.2 Heart valve transplant
- V43.3 Heart valve replaced by other means

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

It is not expected the indication of intraoperative guide to left ventricular function be utilized in the SNF or RHC setting.

CPT codes 93314 and 93317 are packaged according to outpatient prospective payment system implementation and are not separately reimbursed for dates of service on or after August 1, 2000.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of transesophageal echocardiography

studies covered by the Medicare program. Also, the results of transesophageal echocardiography studies covered by the Medicare program must be included in the patient’s medical record. This information is normally found in the office/progress notes, hospital notes, and/or test results.

If the provider of transesophageal echocardiography studies 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.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from the Florida Cardiology Society.

Start Date of Comment Period

N/A

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	2
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 <i>Bulletin</i>
Revised Effective Date:	01/01/2001
Explanation of Revision:	Annual 2001 HCPCS Update

93724: Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator

Policy Number

93724

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Coverage Issues Manual, Section 50-1
Change Request 1229 (A-00-36, June 2000)

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

03/15/2001

Revision Effective Date

N/A

Revision Ending Effective Date

N/A

Policy Ending Date

N/A

LMRP Description

Electronic analysis of single and dual chamber pacemakers and pacing cardioverter-defibrillators involves the interrogation and testing of the programmable parameters of the device using electrocardiographic recordings with analysis of event markers and device response. Follow-up with electronic analysis after insertion of these devices is dictated by multiple factors, including other cardiovascular or medical problems, the device used, and evolving technology. The goals of routine monitoring of the pacemakers and cardioverter-defibrillators is to determine overall system function; optimize performance for maximal clinical effectiveness and system longevity; minimize complications; anticipate replacement of system components; and ensure timely intervention for clinical problems.

Indications and Limitations of Coverage and/or Medical Necessity

Electronic analysis to monitor the patient's pacemaker and/or cardioverter-defibrillator is medically necessary on a

regular basis to evaluate the device. The frequency of follow-up is determined by the patient's attending physician who takes into account the condition and circumstances of the individual patient. If the monitoring is done by some entity other than the patient's physician, such as a commercial monitoring service or hospital outpatient department, the physician's prescription for monitoring is required and must be renewed at least annually to assure that the frequency of monitoring is proper for the patient. When services are performed by entities other than the attending physician, such as monitoring services and pacemaker clinics, it is expected that the information obtained from these monitoring activities be communicated to the attending physician for use in the management of the patient's condition. This information must be documented in the patient's medical record.

Transtelephonic Monitoring of Cardiac Pacemakers (procedure codes 93733 and 93736)

Telephone monitoring of pacemakers is medically efficacious in identifying early signs of possible pacemaker failure, thus reducing the number of sudden pacemaker failures requiring emergency replacement. All systems which monitor the pacemaker rate (bpm) in both the free-running and/or magnetic mode are effective in detecting subclinical pacemaker failure due to battery depletion. More sophisticated systems are also capable of detecting internal electronic problems within the pulse generator itself and other potential problems. In the case of dual chamber pacemakers, such monitoring may detect failure of synchronization of atria and ventricles, and the need for adjustment and reprogramming of the device.

In order for transtelephonic monitoring services to be covered, the services must consist of the following elements:

- A minimum 30-second readable strip of the pacemaker in the free-running mode;
- Unless contraindicated, a minimum 30-second readable strip of the pacemaker in the magnetic mode; and
- A minimum 30 seconds of readable ECG strip.

National Medicare Frequency Guidelines

Frequency guidelines for transtelephonic monitoring (procedure codes 93733 and 93736) are divided into two categories: Guideline I which applies to the majority of pacemakers now in use and Guideline II which applies to pacemaker systems for which sufficient long-term clinical information exists to assure that they meet the standards of the Intersociety Commission for Heart Disease Resources (ICHD) for longevity and end-of-life decay. The two groups of guidelines are further divided into single and dual-chamber pacemakers. The frequency guidelines identified below represent the maximum frequency of transtelephonic monitoring that is expected to occur under routine follow-up. The frequency with which a patient is monitored may be changed for a number of reasons, such as a change in the patient's overall condition, a reprogramming of the patient's pacemaker, and the development of better information on the pacemaker's longevity or failure mode.

93724: Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator (continued)

<p>Guideline I <i>Single-chamber pacemaker</i> 1st month – every 2 weeks 2nd through 36th month – every 8 weeks 37th month to failure – every 4 weeks</p> <p><i>Dual-chamber pacemaker</i> 1st month – every 2 weeks 2nd through 6th month – 4 weeks 7th through 36th month – every 8 weeks 37th month to failure – every 4 weeks</p>	<p>Guideline II <i>Single-chamber pacemaker</i> 1st month – every 2 weeks 2nd through 48th month – every 12 weeks 49th through 72nd month – every 8 weeks After 72nd month – every 4 weeks</p> <p><i>Dual-chamber pacemaker</i> 1st month – every 2 weeks 2nd through 30th month – every 12 weeks 31st through 48th month – every 8 weeks</p>
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Pacemaker Clinic Services

Pacemaker monitoring (procedure codes 93724, 93731-93732, 93734-93735) is covered by pacemaker clinics and may be done in conjunction with transtelephonic monitoring or as a separate service. The services rendered by a pacemaker clinic are more extensive than those currently possible by telephone. They include, for example, physical examination of patients and reprogramming of pacemakers.

The frequency of pacemaker clinic services is the decision of the patient’s physician, taking into account the medical condition of the patient. The following monitoring guidelines apply to lithium-battery pacemakers (all pacemakers currently have lithium batteries):

- Single-chamber pacemakers – twice in the first 6 months following implant, then once every 12 months.
- Dual-chamber pacemakers – twice in the first 6 months, then once every 6 months.

Local Medicare Frequency Guidelines

Electronic analysis of a pacing cardioverter-defibrillator (procedure codes 93737-93744) is performed in an office or outpatient hospital setting. Procedure codes 93737-93738 include only interrogation and evaluation of the pulse generator status without any attempt made to induce an arrhythmia or to evaluate defibrillation thresholds. Procedure codes 93741-93744 involve the interrogation and evaluation of the pulse generator status in addition to evaluation of the programmable parameters, analysis of event markers and device response during periods of rest and activity. The monitoring of these complex devices requires more frequent monitoring than a single or dual chamber pacemaker. Therefore, Florida Medicare will allow routine electronic analysis of a pacing cardioverter-defibrillator (single and dual chamber) at one month following implantation and then every three months thereafter. Transtelephonic monitoring of a pacer cardioverter-defibrillator is noncovered and should be billed as a noncovered service.

HCPCS Section & Benefit Category

Medicine/Cardiovascular

Type of Bill Code

Hospital – 13x

Revenue Code

480 Cardiology, General Classification

CPT Codes

<p>93724</p> <p>93731</p> <p>93732</p> <p>93733</p> <p>93734</p> <p>93735</p> <p>93736</p> <p>93737</p> <p>93738</p> <p>93741</p> <p>93742</p> <p>93743</p> <p>93744</p>	<p>Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)</p> <p>Electronic analysis of dual-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming</p> <p>with reprogramming</p> <p>Electronic analysis of dual chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker), telephonic analysis</p> <p>Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming</p> <p>with reprogramming</p> <p>Electronic analysis of single chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker), telephonic analysis</p> <p>Electronic analysis of single or dual chamber pacing cardioverter-defibrillator only (interrogation, evaluation of pulse generator status); without reprogramming</p> <p>with reprogramming</p> <p>Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber, without reprogramming</p> <p>single chamber, with reprogramming</p> <p>dual chamber, without reprogramming</p> <p>dual chamber, with reprogramming</p>
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Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

<p>426.-426.9</p> <p>427.0-427.9</p> <p>429.4</p> <p>780.2</p> <p>785.1</p>	<p>Conduction disorders</p> <p>Cardiac dysrhythmias</p> <p>Functional disturbances following cardiac surgery (pacemaker, automatic implantable cardiac defibrillator)</p> <p>Syncope and collapse</p> <p>Palpitations</p>
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93724: Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator (continued)

996.01	Mechanical complication due to cardiac pacemaker (electrode)
996.04	Mechanical complication due to automatic implantable cardiac defibrillator
996.09	Mechanical complication of other cardiac device, implant, and graft
V45.01	Other postsurgical states, cardiac pacemaker
V45.02	Other postsurgical states, automatic implantable cardiac defibrillator
V53.31	Fitting and adjustment of other device, cardiac pacemaker (reprogramming)
V53.32	Fitting and adjustment of other device, automatic implantable cardiac defibrillator (reprogramming)
V53.39	Fitting and adjustment of other device, other cardiac device (reprogramming)
V67.9	Unspecified follow-up examination

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.

Transtelephonic monitoring of a pacer cardioverter-defibrillator is noncovered.

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

Procedure codes 93741-93744 are intended to be reported for postimplantation electronic analysis performed in an office or outpatient setting, and do not involve induction of an arrhythmia. It is not appropriate to bill for procedure codes 93741-93744 at the time of pacer cardioverter-defibrillator insertion (procedure codes 33216, 33217, 33240, 33245, 33246, and 33249).

The pacemaker analysis codes 93731-93736 are intended to be reported for subsequent encounters separate from the insertion procedure. Therefore, it would be inappropriate to bill for the pacemaker analysis codes 93731, 93732, 93734, 93735 or 93736 at the time of single-chamber or dual-chamber pacemaker insertion (procedure codes 33212-33213).

If the electronic analysis of the pacemaker, automatic implantable cardiac defibrillator or pacing cardioverter-defibrillator is being performed for routine follow-up of that device, then the appropriate “V” diagnosis should be billed.

Transtelephonic monitoring of pacer cardioverter-defibrillators are noncovered and should be billed as a noncovered service.

Documentation Requirements

Medical record documentation maintained by the performing provider must clearly indicate the medical necessity of the service being billed and must demonstrate the medical necessity of the services performed in excess of the established frequency guidelines. In addition, the documentation must support that the service was performed. This information is normally found in the office/progress notes, hospital records, testing results.

Also, a physician’s prescription for monitoring is required and must be renewed annually when the monitoring is performed by a commercial monitoring service or an outpatient hospital department. In addition, the documentation must indicate the date and type of device implanted.

For services performed by entities other than the attending physician, such as monitoring services and pacemaker clinics, it is expected that the medical record documentation will demonstrate how the information obtained is used in the management of the patient.

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

The frequency of transtelephonic monitoring of cardiac pacemakers and the frequency of monitoring of lithium-battery pacemakers in a pacemaker clinic are identified in the Coverage Issues Manual, Section 50-1. These guidelines are identified in the “Indications and Limitations of Coverage and/or Medical Necessity” section of this policy.

Other Comments

N/A

Sources of Information

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from the Florida Chapter of the American College of Cardiology.

Start Date of Comment Period

11/15/2000

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	Original
Start Date of Comment Period:	11/15/2000
Start Date of Notice Period:	02/01/2001 ^{2nd}
	Quarter 2001 <i>Bulletin</i>
Original Effective Date:	03/15/2001

93990: Duplex Scan of Hemodialysis Access

Policy Number

93990

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Duplex Scan of Hemodialysis Access

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Intermediary Manual 3, Addendum K
 Provider Reimbursement Manual, Section 2710
 Transmittals AB-00-44 and AB-00-55

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

03/15/2001

Revision Effective Date

N/A

Revision Ending Effective Date

N/A

Policy Ending Date

N/A

LMRP Description

Duplex scanning is an ultrasonic scanning procedure with display of both two-dimensional structure and motion with time and Doppler ultrasonic signal documentation with spectrum analysis and/or color flow velocity mapping or imaging. This technique allows sampling of a particular imaged blood vessel with analysis of the blood flow velocity.

Evaluation of endogenous arteriovenous fistulae and synthetic polytetrafluoroethylene (PTFE) grafts, which are the two principal means of creating permanent vascular access for hemodialysis, can be achieved by duplex scanning.

Indications and Limitations of Coverage and/or Medical Necessity

Limited coverage has been established for diagnostic duplex scanning of hemodialysis access sites in patients

with end stage renal disease (ESRD). These procedures are medically necessary only in the presence of signs and symptoms of possible failure of the access site, and when the results of the procedures will permit medical intervention to address the problem. However, other diagnostic vascular services, such as venography, would be considered duplicative services and would not be covered by Medicare.

Appropriate indications for duplex scan of hemodialysis access site would include clear documentation in the dialysis record of signs of chronic (i.e., 3 successive dialysis sessions) abnormal function, including:

I Clinical Indicators

- difficult cannulation by multiple personnel;
- thrombus aspiration by multiple personnel;
- prolonged bleeding after needle withdrawal;
- pain in graft arm;
- persistent swelling in graft arm;
- elevated venous pressure greater than 200 mm Hg on a 200 cc/min. pump;
- elevated recirculation time of 12% or greater;
- low urea reduction rate of less than 60%; or
- shunt collapse, suggesting poor arterial flow.

II Physical Findings by Examination of Graft

- bruit is discontinuous, systolic only, harsh, high pitched;
- thrill is at stenotic sites, possibly multiple, discontinuous, systolic only; and/or
- pulse is water-hammer.

HCPCS Section & Benefit Category

Medicine/Non-invasive Vascular Diagnostic Studies

Type of Bill Code

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

Revenue Code

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

CPT Codes

- 93990 Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

- 996.73 Other complications due to renal dialysis device, implant, and graft

Diagnosis that Support Medical Necessity

N/A

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

N/A

93990: Duplex Scan of Hemodialysis Access (continued)

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

The use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be a part of the physical examination of the vascular system and is not separately reported.

Doppler flow studies being used to monitor the hemodialysis access site are not covered as separately billable services. The professional component of these monitoring studies is included in the monthly capitation payment or other evaluation and management visits delivered to the patient. The technical component of monitoring procedures is included in the ESRD facility’s composite payment rate.

Billing for monitoring of hemodialysis access using CPT codes for non-invasive vascular studies other than 93990 (e.g., 93922, 93923, 93924, 93925, 93926, 93930, 93931, 93965, 93970, 93971) is considered a misrepresentation of the service actually provided and will be considered for fraud investigation.

Documentation Requirements

Medical record documentation maintained by the facility and/or physician must clearly indicate the medical necessity of the services being billed. The results of the study must be included in the medical record.

Utilization Guidelines

N/A

Other Comments

ESRD facilities are responsible as part of the dialysis treatment to monitor access. A number of ESRD facilities are monitoring hemodialysis access through flow studies. All such procedures are covered under the composite rate.

Sources of Information

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from various societies.

Start Date of Comment Period

08/15/2000

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	Original
Start Date of Comment Period:	08/15/2000
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 <i>Bulletin</i>
Original Effective Date:	03/15/2001

95115: Allergen Immunotherapy

Policy Number

95115

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Allergen Immunotherapy

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Medicare Hospital Manual, Section 442

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

11/15/2000

Revision Effective Date

01/01/2001

Revision Ending Effective Date

12/31/2000

Policy Ending Date

N/A

LMRP Description

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

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

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will provide coverage for allergen immunotherapy for patients with allergic rhinitis, allergic conjunctivitis, or asthma when **all four** of the following criteria are met:

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

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

HCPCS Section & Benefit Category

Medicine/Allergy and Clinical Immunology

Type of Bill Code

Hospital – 13x

Revenue Code

924 Allergy Test

CPT Codes

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

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

- 372.05 Acute atopic conjunctivitis
- 372.14 Other chronic allergic conjunctivitis
- 477.0 Allergic rhinitis due to pollen
- 477.8 Allergic rhinitis due to other allergen
- 493.00-493.02 Extrinsic asthma (allergic asthma)
- 493.90-493.92 Asthma, unspecified (allergic bronchial asthma)
- 989.5 Toxic effect of other substances, venom (not applicable to procedure code 95165)

Diagnosis that Support Medical Necessity

N/A

95115: Allergen Immunotherapy (continued)

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

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

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

A dose of code 95165 is defined as one cc aliquot from a single multidose vial.

Documentation Requirements

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

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

Utilization Guidelines

N/A

Other Comments

Terms Defined:

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

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

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

Immunotherapy—the production or enhancement of immunity.

Rhinitis—inflammation of the nasal mucosa.

Sources of Information

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from numerous societies.

Start Date of Comment Period

N/A

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	1
Start Date of Comment Period:	N/A
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Explanation of Revision:	Annual 2001 HCPCS Update
Revision Number:	Original
Start Date of Comment Period:	06/01/2000
Start Date of Notice Period:	10/01/2000
	Oct/Nov 2000 <i>Bulletin</i>
Original Effective Date:	11/15/2000

95900: Nerve Conduction Studies

Policy Number

95900

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Nerve Conduction Studies

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Coverage Issues Manual, Section 50-17

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

07/13/1998

Revision Effective Date

08/01/2000

Revision Ending Effective Date

07/31/2000

Policy Ending Date

N/A

LMRP Description

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

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

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

- hereditary and idiopathic peripheral neuropathy*

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

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

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

Indications and Limitations of Coverage and/or Medical Necessity

Nerve Conduction Studies:

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

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

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

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

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

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

95900: Nerve Conduction Studies (continued)

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

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

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

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

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

HCPCS Section & Benefit Category

Medicine/Neurology and Neuromuscular Procedures

Type of Bill

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

Revenue Codes

92x Other Diagnostic Services

CPT Codes

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

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

- 250.61-250.63 Diabetes with neurological manifestations
- 335.0-335.9 Anterior horn cell disease
- 337.20-337.29 Reflex sympathetic dystrophy
- 354.0-354.9 Mononeuritis of upper limb and mononeuritis multiplex
- 355.0-355.6 Mononeuritis of lower limb
- 355.71-355.79 Other mononeuritis of lower limb
- 355.8-355.9 Mononeuritis of lower limb, unspecified and of unspecified site
- 356.0-356.9 Hereditary and idiopathic peripheral neuropathy

- 357.0-357.9 Inflammatory and toxic neuropathy
- 359.0-359.9 Muscular dystrophies and other myopathies
- 722.80-722.83 Postlaminectomy syndrome
- 723.1 Cervicalgia
- 723.4 Brachial neuritis or radiculitis NOS
- 724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified
- 729.5 Pain in limb
- 780.79 Other malaise and fatigue (weakness, generalized)
- 782.0 Disturbance of skin sensation

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.

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

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

Quantitative Sensory Testing (QST) performed with portable hand-held devices (e.g., current, vibration, thermal perception, or tactile) does not represent nerve conduction and/or latency studies and should not be billed using the nerve conduction codes (95900, 95903, 95904). QST testing is considered part of the evaluation and management service, and therefore, should not be billed separately.

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

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

95900: Nerve Conduction Studies (continued)

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 should include a hard copy computer generated recording of the test results along with the physician’s interpretation. This information is normally found in the office/progress notes, hospital records, and/or procedure notes.

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

Utilization Guidelines

N/A

Other Comments

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

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

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

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

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

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

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

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

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

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

Radiculopathy - any diseased condition of roots of spinal nerves.

Sources of Information

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from the Neurology Society.

Start Date of Comment Period

N/A

Start Date of Notice Period

02/25/2000

Revision History

Revision Number:	4
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/25/2000 February 25, 2000 <i>Bulletin/2nd Quarter</i> 2001 <i>Bulletin</i>
Revised Effective Date:	08/01/2000
Explanation of Revision:	Outpatient PPS implementation. Added statement regarding QST testing.

A0426: Ground Ambulance Services

Policy Number

A0426

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Ground Ambulance Services

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Medicare Hospital Manual, Sections 236, 279, 433
Intermediary Manual, Sections 3114, 3322, 3660.1
Skilled Nursing Facility Manual, Section 539
Program Memorandum B-00-09 (Change request 1065)
Program Memorandum, AB-00-118 (change request 1461), dated 11/30/2000
Program Memorandum, AB-00-88 (change request 1281), dated 09/18/2000

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

07/17/2000

Revision Effective Date

01/01/2001

Revision Ending Effective Date

12/31/2000

Policy Ending Date

N/A

LMRP Description

The Medicare program includes an ambulance benefit. Covered services may be provided either by a freestanding ambulance supplier or a participating Part A provider such as a hospital or skilled nursing facility. Three basic requirements must be met for ambulance services to be covered:

The ambulance and crew must meet specific requirements outlined in the Medicare Intermediary Manual.

The transportation must be medically reasonable and necessary as outlined in the Medicare Intermediary Manual.

This requires that other means of transportation be medically contraindicated, in other words, that the patient cannot be safely transported by any other means.

The origin and destination requirements outlined in the Medicare Intermediary Manual must be met.

Indications and Limitations of Coverage and/or Medical Necessity

Situations in which a patient is considered to be in a life threatening/acute condition or not able to be safely transported by other than an ambulance cannot be exhaustively defined. Nor can these "conditions" be represented accurately by the current ICD-9-CM diagnosis coding structure. Therefore, the conditions and ICD-9-CM diagnosis codes listed below are used as examples to assume that the patient meets the above coverage requirements during routine claims processing.

The intermediary reserves the right to validate coverage based on the narrative description of the patient's condition and pertinent physical objective findings of the crew's patient assessment on a pre or post payment basis, whenever it deems necessary, to ensure appropriate payments.

Some of the most common situations which suggest transportation by ambulance would be medically indicated are listed below. Additionally, a listing of ICD-9-CM codes is given upon which the Intermediary will presume medical necessity is met on a **prepayment** basis. In no case will transportation be reimbursed if the patient could have been transported by any other means.

- The patient's condition necessitated emergency care and resulted from an acute injury or illness in which the patient was left in an unstable condition. Examples include a patient that has had a major bone compound fracture where bleeding and signs of shock are present, a patient who has suffered a serious cardiac event where blood pressure and pulse are unstable, and a patient who has suffered multiple trauma, and a spinal cord injury is suspected.
- The patient needed to be restrained to prevent injury to himself or others (e.g., combative, abusive, convulsive).
- The patient was unconscious, unable to respond to stimuli.
- The patient was in shock as evidenced by some of the following signs and symptoms secondary to the patient's condition: blood pressure of less than 90/60, pulse >100 or <45, respirations greater than 24, significant changes in mental status, cold and/or cyanotic skin, excessive perspiration.
- Emergency measures or treatment were required (e.g., administration of emergency drugs, cardiopulmonary resuscitation, continuous cardiac monitoring).
- The patient required IV fluids to maintain adequate blood pressure (e.g., dehydration, bleeding, cardiac arrhythmias, etc.) or an access line was established to administer emergency medication(s).
- The patient's acute condition required oxygen as part of the emergency treatment procedures enroute to destination (this does not include patients who already

A0426: Ground Ambulance Services (continued)

require oxygen therapy on an ongoing basis to manage an existing condition).

- The patient required immobilization to prevent further injury of a fracture or possible fracture or was in a condition that movement by any other means of transportation would potentially make the condition worse.
- The patient has sustained an acute stroke or myocardial infarction (this does not include patients who have a history of stroke or myocardial infarction and are able to be transported by other means because no acute medical condition exists).
- The patient was experiencing symptoms indicative of a possible myocardial infarction or stroke.
- The patient has or was experiencing a severe hemorrhage.
- The patient is bed confined (definition of bed confined must be met).

Bed Confined

The patient’s condition must be documented to include the reason why the patient was bed confined. Bed confined is defined as unable to get up from the bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair. Bed confined is not synonymous with nonambulatory since the paraplegic or quadriplegic is nonambulatory but spends significant time in a wheelchair. Bed confined is also not equivalent to bedrest, which is a recommended state of affair that does not exclude an occasional ambulation to the commode or chair.

The patient’s condition was such that the patient could be moved **only by stretcher** and any other method of transport would result in injury or would be detrimental to the patient’s health.

Certification

Certification for ambulance services for a provider is based on the information contained in Section 279 of the Hospital Manual and Section 3322 of the Intermediary Manual. Certification by a physician in connection with ambulance services furnished by a participating hospital is required. In cases in which the hospital provides ambulance service to transport the patient from the scene of an accident and no physician is involved until the patient reaches the hospital, then any physician in the hospital who examines the patient or has knowledge of the case may certify as to the medical need for the ambulance service.

HCPCS Section & Benefit Category

Ambulance

Type of Bill Code

Hospital – 13x
Skilled Nursing Facility – 22x, 23x

Revenue Code

540 Ambulance, General Classification

HCPCS Codes

- A0380 BLS mileage (per mile)
- A0390 ALS mileage (per mile)
- A0426 Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
- A0427 Ambulance service, advanced life support, emergency transport, level 1 (ALS1-emergency)

- A0428 Ambulance service, basic life support, non-emergency transport (BLS)
- A0429 Ambulance service, basic life support, emergency transport (BLS-emergency)
- A0433 Advanced life support, level 2 (ALS2)
- A0434 Specialty care transport (SCT)

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

- 250.20-250.23 Diabetes with hyperosmolarity (severe diabetic complication)
- 250.30-250.33 Diabetes with other coma
- 251.0 Hypoglycemic coma
- 255.4 Corticoadrenal insufficiency
- 293.0 Acute delirium
- 298.8 Other and unspecified reactive psychosis (psychosis requiring restraints)
- 345.3 Grand mal status
- 410.00-410.92 Acute myocardial infarction
- 411.0-411.89 Other acute and subacute forms of ischemic heart disease
- 413.0-413.9 Angina pectoris
- 414.10-414.19 Aneurysm of heart
- 415.11-415.19 Pulmonary embolism and infarction
- 426.0-426.9 Conduction disorders
- 427.0-427.9 Cardiac dysrhythmias
- 428.0-428.9 Heart failure (severe)
- 430-434.91, 436 Cerebrovascular disease (severe cerebral vascular problems)
- 441.00-441.9 Aortic aneurysm and dissection
- 442.0-442.9 Other aneurysm
- 493.01, 493.11, 493.21, 493.91 Asthma with status asthmaticus
- 518.0 Pulmonary collapse
- 518.4 Acute edema of lung, unspecified
- 518.5 Pulmonary insufficiency following trauma and surgery
- 518.81 Acute respiratory failure
- 518.82 Other pulmonary insufficiency, not elsewhere classified
- 519.00-519.09 Tracheostomy complications
- 531.00-531.21, 531.40-531.61, 532.00-532.21, 532.40-532.61, 533.00-533.21, 533.40-533.61, 534.00-534.21, 534.40-534.61, 535.01, 535.11, 535.21, 535.31, 535.41, 535.51, 535.61 Diseases of esophagus, stomach, and duodenum (severe gastrointestinal complication)
- 578.9 Hemorrhage of gastrointestinal tract, unspecified
- 669.10-669.14 Shock during or following labor and delivery

A0426: Ground Ambulance Services (continued)

669.90-669.94	Unspecified complication of labor and delivery
719.49	Pain in joint, multiple sites (severe joint pain causing immobility)
780.01	Coma
780.2	Syncope and collapse
780.31-780.39	Convulsions
785.50-785.59	Shock without mention of trauma
786.09	Other symptoms involving respiratory system and other chest symptoms (severe respiratory distress)
786.50-786.59	Chest pain
789.00-789.09	Abdominal pain (severe)
799.0	Asphyxia
799.1	Respiratory arrest
800.00-804.99	Fracture of skull
805.00-809.1	Fracture of neck and trunk
820.00-823.92	Fracture of femur, patella, tibia, and fibula
835.00-835.13	Dislocation of hip
850.1-854.19	Intracranial injury, excluding those with skull fracture
860.0-869.1	Internal injury of thorax, abdomen, and pelvis
871.0-871.9	Open wound of eyeball
925.1-929.9	Crushing injury
948.00-948.99	Burns classified according to extent of body surface involved
952.00-952.9	Spinal cord injury without evidence of spinal bone injury
958.4	Traumatic shock
959.01-959.3,	Injury, other and unspecified (severe injuries to
959.6-959.8	include those with open fractures, unstable fractures where movement could result in further injury, moderate to heavy bleeding, traumatic amputations, incapacitating pain)
960.0-979.9	Poisoning by drugs, medicinal, and biological substances
980.0-989.9	Toxic effects of substances chiefly nonmedicinal as to source
991.6	Hypothermia (severe with decreased level of consciousness)
993.3	Caisson disease
994.0	Effects of lightening
994.1	Drowning and nonfatal submersion
994.7	Asphyxiation and strangulation
994.8	Electrocution and nonfatal effects of electric current
995.0	Other anaphylactic shock
995.60-995.69	Anaphylactic shock due to adverse food reaction
999.4	Anaphylactic shock due to serum

*** **Please note that the descriptor listed is the condition which will be presumed to meet medical necessity criteria. It is not always the descriptor as it appears in the ICD-9-CM code book. An example is 789.0 which reads as “abdominal pain” in the book. This code is listed on the previous page with the descriptor of “severe abdominal pain” as only pain of a severe, incapacitating nature would meet the medical necessity criteria.**

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

Ambulance services will be denied when the patient’s condition does not warrant its use either because the patient could have been safely transported by another means of transportation, independent of whether or not it was available, or if the patient’s condition did not require the skills of specially trained staff or equipment due to an acute condition or injury. A denial will also occur if all the requirements identified in the Medicare Intermediary Manual are not met (e.g., ambulance and crew requirements, physician certification, bed confined).

Noncovered ICD-9-CM Code(s)

N/A

Noncovered Diagnosis

N/A

Coding Guidelines

Origin and destination modifiers are to be used with codes A0380-A0434. The first position alpha code equals origin and the second position alpha code equals destination. The origin and destination codes are:

- D Diagnostic or therapeutic site other than “P” or “H” when these are used as origin codes
- E Residential, domiciliary, custodial facility
- G Hospital-based dialysis facility (hospital or hospital-related)
- H Hospital
- I Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
- J Non-hospital based dialysis facility
- N Skilled Nursing Facility (SNF)
- P Physician’s office (includes HMO non-hospital facility, clinic, etc.)
- R Residence
- S Scene of accident or acute event
- X* Intermediate stop at physician’s office en route to the hospital (includes HMO non-hospital facility, clinic, etc.)

* Destination code only

In addition to the origin and destination codes, one of the following modifiers must be billed with every HCPCS code to describe whether the service was provided under arrangement or directly:

- QM Ambulance service provided under arrangement by a provider of services
- QN Ambulance service furnished directly by a provider of services

The charges for mileage must be coded on a “loaded” basis (i.e. from the pick up of the patient to his/her

A0426: Ground Ambulance Services (continued)

destination). Separate charges for “unloaded” mileage should not be coded. Charges for unloaded mileage will be denied.

Effective on or after January 1, 2001, a new HCPCS code, A0425, was established for ambulance mileage and the two current codes, A0380 and A0390 will be deleted. However, based on implementation instructions, the new code will not be implemented at this time. Providers should continue to bill A0380 or A0390 until further notice.

Effective for services performed on or after January 01, 2001, HCPCS code A0434 (Specialty Care Transport) will be reviewed on a prepayment basis. All claims submitted with HCPCS code A0434 must include documentation as outlined in the “Documentation Requirements” to support medical necessity and the need for specialty care transport.

Documentation Requirements

Appropriate documentation for review includes an ambulance transport sheet, an itemized breakdown of charges, and a certification for all transports.

If Medicare coverage criteria is not met, a copy of the notice of non-coverage signed and dated by the patient must be available for review. This notice must be given to the patient prior to transport.

Documentation is required to be submitted on a prepayment basis when billing HCPCS code A0434.

Utilization Guidelines

N/A

Other Comments

Terms defined:

Basic Life Support (BLS) – when medically necessary, the provision of BLS services as defined in the National EMS Education and Practice Blueprint for the EMT –Basic, including the establishment of a peripheral intravenous (IV) line.

Basic Life Support (BLS) – emergency – when medically necessary, the provision of BLS services, as specified above, in the context of an emergency response. An emergency response is one that, at the time the ambulance supplier is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the beneficiary’s health in serious jeopardy; in impairment to bodily functions; or in serious dysfunction to any bodily organ or part.

Advanced Life Support, level 1 (ALS1) – when medically necessary, the provision of an assessment by an advanced life support (ALS) provider or supplier or the provision of one or more ALS interventions. An ALS provider/supplier is defined as a provider trained to the level of the EMT-Intermediate or Paramedic as defined in the National EMS Education and Practice Blueprint. An ALS intervention is defined as a procedure beyond the scope of an AMT-Basic as defined in the National EMS Education and Practice Blueprint.

Advanced Life Support, level 1 (ALS1) – emergency – when medically necessary, the provision of ALS1 services, as specified above, in the context of an emergency response. An emergency response is one that, at the time the ambulance supplier is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the beneficiary’s health in serious jeopardy; in impairment to bodily functions; or in serious dysfunction to any bodily organ or part.

Advanced Life Support, level 2 (ALS2) – when medically necessary, the administration of three or more different medications and the provision of at least one of the following ALS procedures:

- Manual defibrillation/cardioversion
- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompression
- Surgical airway
- Intraosseous line

Specialty Care Transport (SCT) – when medically necessary, for a critically injured or ill beneficiary, a level of inter-facility service provided beyond the scope of the paramedic defined in the National EMS Education and Practice Blueprint. This is necessary when a beneficiary’s condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area, e.g., nursing, medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

Sources of Information

N/A

Advisory Committee Notes

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

Start Date of Comment Period

N/A

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	2
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 <i>Bulletin</i>
Revised Effective Date:	01/01/2001

Explanation of Revision: The information under “Documentation Requirements” regarding the submission of trip sheets or a narrative statement on an EMC claim does not apply to ambulance providers billing to the intermediary. Therefore, the entire paragraph was deleted.

C1203: Ocular Photodynamic Therapy (OPT) with Verteporfin

Policy Number

C1203

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Ocular Photodynamic Therapy (OPT) with Verteporfin

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HCFA National Coverage Policy

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

Policy Effective Date

03/15/2001

Revision Effective Date

N/A

Revision Ending Effective Date

N/A

Policy Ending Date

N/A

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 indications:

- For the treatment of age-related wet form macular degeneration in patients with predominantly classic or >50% classic subfoveal CNV.

Prior to initial verteporfin OPT treatment, documentation of the patient’s condition must include all of the following:

- Fluorescein angiographic evidence of predominantly classic or >50% classic subfoveal CNV secondary to age-related wet macular degeneration;
- CNV extending below the geometric center of the foveal avascular zone;
- Area of predominantly classic or >50% classic subfoveal CNV is at least fifty percent (50%) of the area of the total neovascular lesion;
- Snellen chart visual acuity of 20/40 through 20/800; and
- Age equal to or greater than 50 years.

Follow-up for recurrent leakage is generally expected to occur approximately every three months, to include fluorescein angiography and further treatment. It is expected that retreatment OPT with verteporfin will occur less frequently in subsequent years.

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;
- History of previous thermal laser in the geometric center of the fovea in the eye(s) to be treated;
- Active hepatitis or clinically significant liver disease;
- Porphyria or other porphyrin sensitivity; and
- There is no evidence of CNV leakage (as determined by fluorescein angiography).

C1203: Ocular Photodynamic Therapy (OPT) with Verteporfin (continued)

HCPCS Section & Benefit Category

Surgery/ Eye and Ocular Adnexa

Type of Bill Code

Hospital – 13x

Revenue Code

636 Drugs Requiring Detailed Coding

HCPCS Codes

C1203 Injection, Visudyne (verteporfin)

C1360 Ocular photodynamic therapy

Not Otherwise Classified Codes (NOC)

N/A

ICD-9 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

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 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.

Noncovered ICD-9 Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

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 both C1203 (verteporfin) and C1360 (OPT).

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 most recent visual acuity; the name and total calculated drug dose (mg) of the photodynamic therapy drug administered; the patient’s body surface area on which the dose of the drug is based; and the laser spot size and greatest linear dimension of CNV lesion.
- Fluorescein angiogram or the digital angiogram. There should be an available copy used by the clinician to determine the size and location of the CNV lesion, unless there is a documented history of fluorescein allergy.
- 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

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from the Florida Society of Ophthalmology.

Start Date of Comment Period

08/15/2000

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	Original
Start Date of Comment Period:	08/15/2000
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 <i>Bulletin</i>
Original Effective Date:	03/15/2001

DYSPHRT: Dysphagia/Swallowing Diagnosis and Therapy

Policy Number

DYSPHRT

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Dysphagia/Swallowing Diagnosis and Therapy

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HCFA National Coverage Policy

Coverage Issues Manual, Section 35-89
 Outpatient Physical Therapy and CORF Manual, Section 205
 Intermediary Manual 3, Section 3910
 Skilled Nursing Facility Manual, Section 260
 HCFA Letter, June 13, 1996, Modified Barium Swallow Studies and Mobile Video Fluoroscopy X-rays
 Rural Health Clinic Manual, Section 402

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

02/24/1997

Revision Effective Date

01/01/2001

Revision Ending Effective Date

12/31/2000

Policy Ending Date

N/A

LMRP Description

Dysphagia/swallowing therapy is a medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury. Phases of swallowing addressed include oral, pharyngeal, and/or esophageal (upper one third) phases of swallowing.

The diagnosis of dysphagia, or difficulties in swallowing, requires an extensive evaluation by the physician. Many difficulties can be identified and treated based on the findings of this examination alone. In some cases, more extensive evaluations are required using a

variety of studies such as echography and modified barium swallow studies and an evaluation by a swallowing therapist.

The treatment of dysphagia/swallowing difficulties may include simple recommendations for such things as intake consistency or positioning, or may require a therapeutic regime targeted at the attainment of functional improvement.

Indications and Limitations of Coverage and/or Medical Necessity

Dysphagia/Swallowing Therapy:

Each of the following conditions for coverage of service must be met:

1. The patient is under the care of a physician.
2. The attending physician may be the patient's private physician or a physician associated with an institution. There must be evidence in the clinical record maintained by the therapist that the patient has been seen by the physician at least every 60 days and the therapist must indicate the name of the physician and date the patient was last seen by the physician.
3. The physician must establish a preliminary diagnosis addressing the symptoms associated with the dysphagia. This preliminary diagnosis should address the treatability of the patient. Collaboration between the physician and the speech language pathologist or other dysphagia therapist is necessary to establish the medical necessity for the dysphagia evaluation and/or treatment.
4. There must be supporting documentation in the medical record to demonstrate the need for a dysphagia evaluation such as a recent significant change in swallowing function.

One or more of the following conditions must be present:

- History of aspiration problems or definite risk of aspiration.
- Presence of oral motor disorder.
- Impaired salivary gland performance and/or presence of local structural lesions in the pharynx in marked oropharyngeal swallowing difficulties.
- Dyscoordination, sensation loss, postural difficulties, or other neuromotor disturbances affecting oropharyngeal abilities necessary to close the buccal cavity and/or bite, chew, suck, shape, and squeeze the food bolus into the upper esophagus, while protecting the airway.
- Post surgical reaction.
- Significant weight loss with loss directly related to reduced oral intake as a consequence of dysphagia.
- Existence of other conditions such as: presence of tracheotomy tube, nasogastric feeding tube, endotracheal tube, or ventilator reduced or inadequate

DYSPHRT: Dysphagia/Swallowing Diagnosis and Therapy (continued)

laryngeal elevation, labial closure, velopharyngeal closure, laryngeal closure, or pharyngeal peristalsis and cricopharyngeal disjunction.

5. Assessment:

Professional assessments including bedside evaluation administered by a qualified dysphagia therapist must document history, current status, and clinical observations such as:

- presence of feeding tube
- presence of tracheotomy tube
- paralysis
- coughing and/or choking
- oral motor structure and function
- muscle tone
- oral sensitivity
- positioning
- oropharyngeal reflexes
- swallowing function
- oral infections and lesions
- medications to include psychopharmacological drugs

6. Treatability

The attending physician and/or the dysphagia therapist must address the treatability of the patient in terms of the patient's:

- level of alertness
- ability to cooperate
- ability to retain new learning
- cognitive status
- medical stability
- psychological stability

7. Videofluoroscopy or other visual instrumental assessments should be conducted when oral or pharyngeal disorders are suspected. Documentation must establish that an exact diagnosis cannot be substantiated through oral exam and that there is a question as to whether aspiration is occurring. The videofluoroscopic assessment is usually conducted and interpreted by a radiologist with the assistance and input from the physician and/or individual disciplines. The assessment and final analysis and interpretation should include a definitive diagnosis, identification of the swallowing phase(s) affected, and a recommended treatment plan.

8. The therapy must be furnished under the written plan of treatment, with measurable goals and time frames established by the physician or therapist caring for the patient.

9. The services must be of such a level of complexity and sophistication that they can only be performed by a qualified dysphagia therapist. A qualified speech/language pathologist for treatment coverage purposes is an individual who is licensed as a speech/language pathologist by the state in which they are practicing, has a minimum of a masters degree, holds a certificate of clinical competence and is prepared to produce evidence of special preparation in the field of dysphagia.

10. Reasons for denial of diagnostic procedures:

- Documentation does not support their need in making a diagnosis or in defining the etiology of the patient's condition.
- Modified Barium Swallow studies (**70370, 70371, and 74230**) are not covered when performed on a mobile basis.

11. Reasons for denial of therapy:

- Services are not reasonable and/or medically necessary. (Patient is unable to meet treatability criteria.)
- Routine feeding, which can be completed by support staff and/or family members.
- Exercises that can be carried out by the patient, support staff, and/or family members.
- The level of treatment does not require the skills of a trained dysphagia specialist.
- Treatment provided is maintaining the patient's functioning at the level to which it has been restored.
- Daily visits do not decrease as patient improves.
- Treatment addresses the esophageal (lower two-thirds) phase of swallowing. Esophageal dysphagia is difficulty in passing food from the esophagus to the stomach. If peristalsis is ineffective, patients may complain of food "sticking", have more difficulty with solids than liquids, and/or experience reflux or regurgitation if they lie down too soon after meals. This is a common problem in geriatric patients and does not generally respond to behavioral swallowing therapy techniques and would not be approved.
- Treatment is provided by an individual therapist who is unable to present documentation of training qualifications.

HCPCS Section & Benefit Category

Radiology/Diagnostic Radiology
 Medicine/Special Otorhinolaryngologic Services
 Radiology/Diagnostic Ultrasound

Type of Bill Code

Hospital – 12x, 13x, 14x
 Skilled Nursing Facility – 21x, 22x, 23x
 Rural Health Clinic – 71x
 Outpatient Rehabilitation Facility – 74x
 Comprehensive Outpatient Rehabilitation Facility – 75x

Revenue Code

32x Radiology-Diagnostic
 440 Speech-Language Pathology, General
 Classification

CPT/HCPCS Codes

70370 Radiologic examination; pharynx or larynx, including fluoroscopy and/or magnification technique
 70371 Complex dynamic pharyngeal and speech evaluation by cine or video recording
 74230 Swallowing function, pharynx and/or esophagus, with cineradiography and/or video

DYSPHRT: Dysphagia/Swallowing Diagnosis and Therapy (continued)

76536	Echography, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), B-scan and/or real time with image documentation
92511	Nasopharyngoscopy with endoscope (separate procedure)
92526	Treatment of swallowing dysfunction and/or oral function for feeding
G0195	Clinical evaluation of swallowing function (not involving interpretation of dynamic radiological studies or endoscopic study of swallowing)
G0196	Evaluation of swallowing involving swallowing of radio-opaque materials

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

N/A

Diagnosis that Support Medical Necessity

N/A

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

N/A

Diagnosis that DO NOT Support Medical Necessity

N/A

Reasons for Denial

CPT codes 70370, 70371, and 74230 are covered only in the places of services listed below, and **never** when performed on a mobile basis or in the **absence** of physician supervision:

- Inpatient Hospital (11, 12, 18)
- Outpatient Hospital (13, 14, 83)
- Skilled Nursing Facility (21, 22, 23)
- Rural Health Clinic (71)

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

Noncovered ICD-9-CM Code(s)

N/A

Noncovered Diagnosis

N/A

Coding Guidelines

CPT codes 70370, 70371, and 74230 describe complete procedures and should not be billed more than one time on the same patient on the same day. Only one of the stated procedure codes should be billed per patient per day.

Other fluoroscopy codes, including the following, are not allowed in addition to the swallow studies as each of the swallow study codes already contain the fluoroscopy component:

76000 Fluoroscopy (separate procedure), up to one hour physician time, other than **71023** or **71034** (e.g., cardiac fluoroscopy)

76001 Fluroroscopy, physician time more than one hour, assisting a non-radiologic physician (e.g., nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy).

- Diagnostic radiology tests performed by Rural Health Clinics are billed to the carrier.

When coding units on the UB-92, each unit reported is based on the number of times the procedure, as described in the CPT/HCPCS definition, is performed.

Effective for services performed on or after January 1, 2001, procedure code 92525 is not valid for Medicare purposes. HCPCS codes G0195 or G0196 should be billed.

Documentation Requirements

Medical record documentation such as office/progress notes, etc. must indicate that the physician’s evaluation demonstrated a need for any further diagnostic testing related to dysphagia/swallowing difficulties, as well as a need for any treatment.

Specific plans of treatment should be developed in conjunction with a qualified therapist, and include a statement of functional improvement expected, specific goals for therapy, and the specific interventions to be used in achieving the goals. The frequency, type and duration of these interventions must also be specified.

Finally, each intervention must be documented as having been performed, along with the patient’s progress and reaction to the intervention.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

N/A

Advisory Committee Notes

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

Start Date of Comment Period

N/A

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	5
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 Bulletin
Revised Effective Date:	01/01/2001
Explanation of Revision:	A revision is necessary to reflect the status changes based on Change Request 1470 (Transmittal B-00-75). Procedure Code 92525 was changed from noncovered to not valid for Medicare purposes.

J9999: Antineoplastic Drugs**Policy Number**

J9999

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Antineoplastic Drugs

AMA CPT Copyright Statement

CPT codes, descriptions, and other data only are copyright 2000 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply.

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

Policy Effective Date

11/02/1998

Revision Effective Date

01/08/2001

Revision Ending Effective Date

01/07/2001

Policy Ending Date

N/A

LMRP Description

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

The purpose of this policy is to establish the FDA approved indications of antineoplastic drugs and to indicate the circumstances under which Medicare will consider off-label uses for chemotherapy drugs to be medically reasonable and necessary, and to specify those drugs and

their FDA approved and off-label uses as they become available. This policy does not restrict what providers can provide nor what beneficiaries receive. It simply defines what can be covered by Medicare in order to avoid or reduce denials for unapproved treatment.

Indications and Limitations of Coverage and/or Medical Necessity

For off-label use:

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

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

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

Use peer-reviewed medical literature appearing in the following publications:

J9999: Antineoplastic Drugs (continued)

- American Journal of Medicine;
- Annals of Internal Medicine;
- The Journal of the American Medical Association;
- Journal of Clinical Oncology;
- Blood;
- Journal of the National Cancer Institute;
- The New England Journal of Medicine;
- British Journal of Cancer;
- British Journal of Hematology;
- British Medical Journal;
- Cancer;
- Drugs;
- European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology);
- Lancet; or
- Leukemia.

The intermediary is not required to maintain copies of these publications. Physicians seeking to establish Medicare coverage for specific off-label uses of chemotherapeutic drugs must submit documentation from any of the above publications supporting the efficacy of each of the off-label uses to the Medicare Medical Policy and Procedures Department.

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

Doxorubicin HCL 10mg (Adriamycin PFS; Adriamycin RDF; Rubex)-J9000

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

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

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

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

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

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

- AIDS related Kaposi's sarcoma
- Retinoblastoma
- Esophageal carcinoma
- Adrenocortical carcinoma

Doxorubicin, Liposomal (Doxil)-J9001

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

Liposomal Doxorubicin is FDA approved for the following medical conditions:

- AIDS-related Kaposi's sarcoma disease that has progressed in spite of prior combination chemotherapy or patients who are intolerant of such therapy.
- Metastatic carcinoma of the ovary that is refractory to treatment.

Florida Medicare will cover Liposomal Doxorubicin for its FDA approved uses, as well as for the treatment of the off-labeled indication, breast carcinoma.

Aldesleukin (Proleukin®, interleukin-2, recombinant, and rIL-2)-J9015

Aldesleukin is classified as a biological response modifier. It increases cellular immunity and inhibits tumor growth. Because of its potential life-threatening toxicities, it is recommended that this medication be given only after careful consideration of the risks and benefits.

Aldesleukin is FDA approved for treatment of renal carcinoma and metastatic melanoma.

Florida Medicare will cover Aldesleukin for its FDA approved uses, as well as for the off-labeled indication, chronic myelogenous leukemia.

Carboplatin (Paraplatin®, Paraplatin-AQ®)-J9045

Carboplatin resembles an alkylating agent. Although the exact mechanism of action is unknown, it is thought to be similar to that of the bifunctional alkylating agents, that is, possible cross-linking and interference with the function of DNA.

Carboplatin is FDA approved for the treatment of ovarian carcinoma, when refractive to standard chemotherapy that did or did not include Cisplatin and for the initial treatment of advanced ovarian carcinoma in combination with other approved chemotherapeutic agents.

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

- Bladder carcinoma
- Primary brain tumors
- Breast carcinoma
- Endometrial carcinoma
- Head & neck carcinoma
- Small cell and non-small cell lung carcinoma
- Malignant melanoma
- Neuroblastoma
- Retinoblastoma

J9999: Antineoplastic Drugs (continued)

- Testicular carcinoma
- Wilms' Tumor
- Esophageal carcinoma
- Cervical carcinoma
- Cancer of Unknown Primary site (CUPs)

Docetaxel (Taxotere®)-J9170

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

Taxotere is FDA approved in the treatment of breast cancer, as a second-line treatment of AIDS-related Kaposi's sarcoma, and for the treatment of cisplatin-resistant, non-small cell lung cancer.

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

- Small cell carcinoma of the lung
- Head and neck carcinoma
- Bladder carcinoma
- Ovarian carcinoma
- Gastric carcinoma
- Melanoma
- Prostatic carcinoma

Etoposide (Etopophos®, Toposar®, VePesid®, VP-16)-J9181 & J9182

Etoposide is a podophyllotoxin which inhibits DNA synthesis prior to mitosis by blocking topoisomerase II.

Etoposide is FDA approved for the treatment of testicular carcinoma and small cell lung carcinoma.

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

- Gastric carcinoma
- Hepatoblastoma
- Neuroblastoma
- Non-small cell lung carcinoma
- Thymoma
- Osteosarcoma
- Ewing's sarcoma
- Soft tissue sarcomas
- Cutaneous T cell lymphomas
- Breast carcinoma
- Kaposi's sarcoma
- Endometrial carcinoma
- Ovarian carcinoma
- Bladder carcinoma
- Wilms' Tumor
- Retinoblastoma
- Adrenocortical carcinoma
- Acute lymphocytic leukemia
- Acute nonlymphocytic leukemia
- Chronic myelocytic leukemia
- Hodgkin's lymphoma
- Non-Hodgkin's lymphoma
- Multiple myeloma
- Primary brain tumor

- Gestational trophoblastic tumor
- Cancer of Unknown Primary site (CUPs)

Fludarabine (Fludara®)-J9185

Fludarabine phosphate is a nucleotide analog which is incorporated into DNA and inhibits further DNA synthesis.

Fludarabine is FDA approved for treatment of chronic lymphocytic leukemia.

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

- Acute Non-Lymphocytic Leukemia
- Non-Hodgkin's Lymphoma

Gemcitabine (Gemzar®)-J9201

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

Gemzar is FDA approved for treatment of patients with advanced or metastatic adenocarcinoma of the pancreas and non-small cell lung cancer.

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

- Breast carcinoma
- Ovarian carcinoma
- Bladder carcinoma
- Transitional cell carcinoma of kidney and ureter

Irinotecan (Camptosar®)-J9206

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

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

- Small-cell lung carcinoma
- Cervical carcinoma

Paclitaxel (Taxol®)-J9265

Paclitaxel is an antimicrotubule agent. It interferes with the normal cellular microtubule function that is required for interphase and mitosis.

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

Breast carcinoma after failure of combination chemotherapy or at relapse within 6 months of adjuvant chemotherapy; advanced carcinoma of ovary; as a second-line treatment for AIDS-associated Kaposi's sarcoma; and non-small cell lung carcinoma in combination with Cisplatin as a first-line treatment for patients who are not candidates for radiation therapy or potentially curative surgery.

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

J9999: Antineoplastic Drugs (continued)

- Bladder carcinoma
- Cervical carcinoma
- Endometrial carcinoma
- Esophageal carcinoma
- Head & neck carcinoma
- Small cell lung carcinoma
- Prostatic carcinoma
- Gastric carcinoma
- Malignant pleural effusion
- Cancer of Unknown Primary site (CUPs)

Mitomycin (Mutamycin®, mitomycin-C)-J9280, J9290 & J9291

Mitomycin is classified as an antitumor antibiotic. It inhibits DNA synthesis by causing cross-linking. It also inhibits RNA and protein synthesis.

Mitomycin concentrate may be used intravenously or as a topical bladder instillation.

Mitomycin is FDA approved for treatment of gastric and pancreatic carcinoma.

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

- Bladder carcinoma
- Cervical carcinoma
- Breast carcinoma
- Esophageal carcinoma
- Head & neck carcinoma
- Non-small cell lung carcinoma
- Prostatic carcinoma
- Gallbladder & biliary carcinoma
- Colorectal & anal carcinoma
- Chronic myelocytic & myelomonocytic leukemias

Mitoxantrone Hydrochloride (Novantrone®)-J9293

Mitoxantrone hydrochloride is an anthracenedione which inhibits DNA and RNA synthesis.

Mitoxantrone hydrochloride is FDA approved for treatment of advanced symptomatic prostate carcinoma and acute non-lymphocytic leukemia.

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

Topotecan Hydrochloride (Hycamtin®)-J9350

Topotecan Hydrochloride is a semi-synthetic derivative of camptothecin and is an anti-tumor drug with topoisomerase I-inhibitory activity. The cytotoxicity of topotecan is thought to be due to double strand DNA damage.

Hycamtin is FDA approved for treatment of metastatic carcinoma of the ovary and small cell carcinoma of the lung. Florida Medicare will cover Hycamtin for its FDA approved use, as well as for the treatment of the following off-labeled indications:

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

Trastuzumab (Herceptin®)-J9355

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

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

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

Porfimer (Photofrin®)-J9600

Porfimer is a photosensitizing agent that in combination with light, can cause cellular damage and tumor death. Tumor selectivity occurs as a result of selective distribution and retention of Porfimer on tumor tissue, and by selective delivery of light. Illumination of target tissue with 630 nanometer wavelength laser light induces a photochemical reaction that activates Porfimer. Porfimer photodynamic therapy causes the release of thromboxane A2, which results in vasoconstriction, activation and aggregation of platelets, and increased clotting. These factors contribute to ischemic necrosis which leads to tissue and tumor death.

Porfimer is for intravenous use. It is supplied as a 75 mg single dose vial. After reconstitution, 2 mg per kg of body weight should be administered slowly over three to five minutes followed by illumination with laser light and debridement of the tumor at appropriate and specific intervals. Photodynamic treatment with Porfimer may be given for a total of three courses of therapy, each separated by at least 30 days.

Porfimer is FDA approved for the palliative treatment of partial or complete obstruction of the esophagus due to esophageal cancer in patients who cannot be satisfactorily treated with Nd:YAG laser therapy alone.

Porfimer is also FDA approved for patients with non-small cell lung cancer (NSCLC) for whom surgery and radiotherapy are not indicated.

Denileukin diftitox (Ontak®)-J9999, C1084

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

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

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

HCPCS Section & Benefit Category

Chemotherapy Drugs

Type of Bill Code

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

J9999: Antineoplastic Drugs (continued)

Revenue Code		186.0-186.9	Malignant neoplasm of testis
636 Drugs Requiring Detailed Coding		188.0-188.9	Malignant neoplasm of bladder
HCPCS Codes		189.0	Malignant neoplasm of kidney, except pelvis
C1084 Denileukin diftitox, 300 mcg, Ontak IV		190.5	Malignant neoplasm of retina (retinoblastoma)
J9000 Doxorubicin HCl, 10 mg.		193	Malignant neoplasm of thyroid gland
J9001 Doxorubicin hydrochloride, all lipid formulations, 10 mg		194.0-194.9	Malignant neoplasm of other endocrine glands and related structures (adrenal cortex)
J9015 Aldesleukin, per single use vial		195.0	Malignant neoplasm of head, face, and neck
J9045 Carboplatin, 50mg		200.00-200.88	Lymphosarcoma and reticulosarcoma
J9170 Docetaxel, 20 mg.		201.00-201.98	Hodgkin's disease
J9181 Etoposide, 10 mg		202.00-202.98	Other malignant neoplasms of lymphoid and histiocytic tissue (non-Hodgkin's lymphoma)
J9182 Etoposide, 100 mg		203.00-203.01	Multiple myeloma
J9185 Fludarabine phosphate, 50 mg		204.00-204.01	Acute lymphoid leukemia
J9201 Gemcitabine HCl, 200 mg.		204.10-204.11	Chronic lymphoid leukemia
J9206 Irinotecan, 20 mg		205.00-205.91	Myeloid leukemia
J9265 Paclitaxel, 30mg		206.00-206.01	Acute monocytic leukemia
J9280 Mitomycin, 5mg		207.00-207.01	Acute erythremia and erythroleukemia
J9290 Mitomycin, 20mg		236.1	Neoplasm of uncertain behavior of placenta (Gestational trophoblastic tumor)
J9291 Mitomycin, 40mg			
J9293 Injection, mitoxantrone HCL, per 5 mg			
J9350 Topotecan, 4 mg.			
J9355 Trastuzumab, 10 mg			
J9600 Porfimer sodium, 75 mg			
J9999 Not otherwise classified, antineoplastic drug, (Denileukin diftitox, 300 mcg)			
Not Otherwise Classified Codes (NOC)			
N/A			
ICD-9-CM Codes that Support Medical Necessity			
J9000-Doxorubicin HCl, 10 mg.		J9001-Doxorubicin, Liposomal (Doxil)	
140.0-149.9 Malignant neoplasm of lip, oral cavity, and pharynx (carcinoid tumors)		174.0-174.9 Malignant neoplasm of female breast	
150.0-150.9 Malignant neoplasm of esophagus		175.0-175.9 Malignant neoplasm of male breast	
151.0-151.9 Malignant neoplasm of stomach		176.0-176.9 Kaposi's sarcoma	
155.0 Malignant neoplasm of liver, primary		183.0-183.9 Malignant neoplasm of ovary and other uterine adnexa	
155.2 Malignant neoplasm of liver, not specified as primary or secondary			
157.0-157.9 Malignant neoplasm of pancreas		J9015-Aldesleukin (Proleukin®, interleukin-2, recombinant, and rIL-2)	
160.0-160.9 Malignant neoplasm of nasal cavities, middle ear, and accessory sinuses		172.0-172.9 Malignant melanoma of skin	
161.0-161.9 Malignant neoplasm of larynx		189.0 Malignant neoplasm of kidney, except pelvis	
162.2-162.9 Malignant neoplasm of lung (non-small/small cell lung carcinoma)		189.1 Malignant neoplasm of renal pelvis	
164.0 Malignant neoplasm of thymus		205.10-205.11 Chronic myeloid leukemia	
170.0-170.9 Malignant neoplasm of bone and articular cartilage		J9045-Carboplatin (Paraplatin®, Paraplatin-AQ®)	
171.0-171.9 Malignant neoplasm of connective and other soft tissue		140.0-149.9 Malignant neoplasm of lip, oral cavity, and pharynx	
174.0-174.9 Malignant neoplasm of female breast		150.0-150.9 Malignant neoplasm of esophagus	
175.0-175.9 Malignant neoplasm of male breast		160.0-160.9 Malignant neoplasm of nasal cavities, middle ear, and accessory sinuses (neuroblastoma)	
176.0-176.9 Kaposi's sarcoma		161.0-161.9 Malignant neoplasm of larynx	
180.0-180.9 Malignant neoplasm of cervix uteri		162.2-162.9 Malignant neoplasm of bronchus and lung (small cell & non-small cell)	
182.0 Malignant neoplasm of corpus uteri, except isthmus		172.0-172.9 Malignant melanoma of skin	
183.0 Malignant neoplasm of ovary		174.0-174.9 Malignant neoplasm of female breast	
183.9 Malignant neoplasm of uterine adnexa, unspecified		175.0-175.9 Malignant neoplasm of male breast	
184.0 Malignant neoplasm of vagina		180.0-180.9 Malignant neoplasm of cervix uteri	
185 Malignant neoplasm of prostate		182.0 Malignant neoplasm of corpus uteri, except isthmus	
		183.0-183.9 Malignant neoplasm of ovary and other uterine adnexa	
		186.0-186.9 Malignant neoplasm of testis	
		188.0-188.9 Malignant neoplasm of bladder	
		189.0 Malignant neoplasm of kidney, except pelvis (Wilms' Tumor)	

J9999: Antineoplastic Drugs (continued)

190.5	Malignant neoplasm of retina (retinoblastoma)	194.0-194.9	Malignant neoplasm of other endocrine glands and related structures (neuroblastoma)
191.0-191.9	Malignant neoplasm of brain	199.0-199.1	Malignant neoplasm without specification of site
194.0-194.9	Malignant neoplasm of other endocrine glands and related structures (neuroblastoma)	200.00-200.88	Lymphosarcoma and reticulosarcoma
195.0	Malignant neoplasm of head, face, and neck	201.00-201.98	Hodgkin's disease
199.0-199.1	Malignant neoplasm without specification of site	202.00-202.98	Other malignant neoplasms of lymphoid and histiocytic tissue (non-Hodgkin's and cutaneous T cell lymphoma)
		203.00-203.01	Multiple myeloma
J9170-Docetaxel (Taxotere®)		204.00-204.01	Acute lymphoid leukemia
140.0-149.9	Malignant neoplasm of lip, oral cavity, and pharynx	205.00-205.01	Acute myeloid leukemia
151.0-151.9	Malignant neoplasm of stomach	205.10-205.11	Chronic myeloid leukemia
161.0-161.9	Malignant neoplasm of larynx	206.00-206.01	Acute monocytic leukemia
162.2-162.9	Malignant neoplasm of lung (non-small/small cell lung carcinoma)	207.00-207.01	Acute erythremia and erythroleukemia
172.0-172.9	Malignant melanoma of skin	236.1	Neoplasm of uncertain behavior of placenta (Gestational trophoblastic tumor)
174.0-174.9	Malignant neoplasm of female breast		
175.0-175.9	Malignant neoplasm of male breast	J9185-Fludarabine (Fludara®)	
176.0-176.9	Kaposi's sarcoma	200.00-200.88	Lymphosarcoma and reticulosarcoma
183.0-183.9	Malignant neoplasm of ovary and other uterine adnexa	202.00-202.98	Other malignant neoplasms of lymphoid and histiocytic tissue (non-Hodgkin's lymphoma)
185	Malignant neoplasm of prostate	204.10-204.11	Chronic lymphoid leukemia
188.0-188.9	Malignant neoplasm of bladder	205.00-205.01	Acute myeloid leukemia
195.0	Malignant neoplasm of head and neck	206.00-206.01	Acute monocytic leukemia
		207.00-207.01	Acute erythremia and erythroleukemia
J9181 & J9182-Etoposide (Etopophos®, Toposar®, VePesid®, VP-16)		J9201-Gemcitabine (Gemzar®)	
151.0-151.9	Malignant neoplasm of stomach	157.0-157.9	Malignant neoplasm of pancreas
155.0	Malignant neoplasm of liver, primary (hep [a] toblastoma)	162.2-162.9	Malignant neoplasm of lung (non-small cell lung carcinoma)
155.2	Malignant neoplasm of liver, not specified as primary or secondary	174.0-174.9	Malignant neoplasm of female breast
160.0-160.9	Malignant neoplasm of nasal cavities, middle ear, and accessory sinuses (neuroblastoma)	175.0-175.9	Malignant neoplasm of male breast
162.2-162.9	Malignant neoplasm of bronchus and lung (small cell/non-small cell)	183.0-183.9	Malignant neoplasm of ovary and other uterine adnexa
164.0	Malignant neoplasm of thymus	188.0-188.9	Malignant neoplasm of bladder
170.0-170.9	Malignant neoplasm of bone and articular cartilage (osteosarcomas and Ewing's sarcoma)	189.0-189.2	Malignant neoplasm of kidney, renal pelvis, and ureter
171.0-171.9	Malignant neoplasm of connective and other soft tissue		
173.0-173.9	Other malignant neoplasm of skin (Cutaneous T-cell lymphoma)	J9206-Irinotecan (Camptosar®)	
174.0-174.9	Malignant neoplasm of female breast	153.0-154.8	Malignant neoplasm of colon, rectum, rectosigmoid junction, and anus
175.0-175.9	Malignant neoplasm of male breast	162.2-162.9	Malignant neoplasm of lung (small-cell lung carcinoma)
176.0-176.9	Kaposi's sarcoma	180.-180.9	Malignant neoplasm of cervix uteri
182.0-182.8	Malignant neoplasm of body of uterus		
183.0	Malignant neoplasm of ovary (germ and nongerml cell)	J9265-Paclitaxel (Taxol®)	
183.9	Malignant neoplasm of uterine adnexa, unspecified	140.0-149.9	Malignant neoplasm of lip, oral cavity, and pharynx
186.0-186.	Malignant neoplasm of testis	150.0-150.9	Malignant neoplasm of esophagus
188.0-188.9	Malignant neoplasm of bladder	151.0-151.9	Malignant neoplasm of stomach
189.0	Malignant neoplasm of kidney, except pelvis (Wilms' Tumor)	161.0-161.9	Malignant neoplasm of larynx
190.5	Malignant neoplasm of retina (retinoblastoma)	162.2-162.9	Malignant neoplasm of bronchus and lung (small cell/non-small cell)
191.0-191.9	Malignant neoplasm of brain	174.0-174.9	Malignant neoplasm of female breast
		175.0-175.9	Malignant neoplasm of male breast
		176.0-176.9	Kaposi's sarcoma
		180.0-180.9	Malignant neoplasm of cervix uteri
		182.0-182.8	Malignant neoplasm of body of uterus
		183.0-183.9	Malignant neoplasm of ovary and other uterine adnexa

J9999: Antineoplastic Drugs (continued)

185 Malignant neoplasm of prostate
 188.0-188.9 Malignant neoplasm of bladder
 195.0 Malignant neoplasm of head, face, and neck
 197.2 Secondary malignant neoplasm of pleura (malignant pleural effusion)
 199.0-199.1 Malignant neoplasm without specification of site

J9280, J9290, & J9291-Mitomycin (Mutamycin®, mitomycin-C)

140.0-149.9 Malignant neoplasm of lip, oral cavity, and pharynx
 150.0-150.9 Malignant neoplasm of esophagus
 151.0-151.9 Malignant neoplasm of stomach
 153.0-154.8 Malignant neoplasm of colon, rectum, rectosigmoid junction, and anus
 156.0-156.9 Malignant neoplasm of gallbladder and extrahepatic bile ducts
 157.0-157.9 Malignant neoplasm of pancreas
 161.0-161.9 Malignant neoplasm of larynx
 162.2-162.9 Malignant neoplasm of bronchus and lung (non-small cell)
 174.0-174.9 Malignant neoplasm of female breast
 175.0-175.9 Malignant neoplasm of male breast
 180.0-180.9 Malignant neoplasm of cervix uteri
 185 Malignant neoplasm of prostate
 188.0-188.9 Malignant neoplasm of bladder
 195.0 Malignant neoplasm of head, face and neck
 205.10-205.11 Chronic myeloid leukemia

J9293-Mitoxantrone Hydrochloride (Novantrone®)

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

J9350-Topotecan Hydrochloride (Hycamtin®)

162.2-162.9 Malignant neoplasm of lung (non-small/small cell lung carcinoma)
 183.0-183.9 Malignant neoplasm of ovary and other uterine adnexa
 205.10 Chronic myeloid leukemia without mention of remission (CML)
 205.11 Chronic myeloid leukemia in remission (CML)
 238.7 Neoplasm of uncertain behavior of other lymphatic and hematopoietic tissues (MDS)

J9355-Trastuzumab (Herceptin®)

174.0-174.9 Malignant neoplasm of female breast
 175.0-175.9 Malignant neoplasm of male breast
 196.0-196.9 Secondary and unspecified malignant neoplasm of lymph nodes

197.0-197.8 Secondary malignant neoplasm of respiratory and digestive systems
 198.0 Secondary malignant neoplasm of kidney
 198.1 Secondary malignant neoplasm of other urinary organs
 198.2 Secondary malignant neoplasm of skin
 198.4 Secondary malignant neoplasm of other parts of nervous system
 198.5 Secondary malignant neoplasm of bone and bone marrow
 198.6 Secondary malignant neoplasm of ovary
 198.7 Secondary malignant neoplasm of adrenal gland
 198.82 Secondary malignant neoplasm of other specified sites, genital organs

NOTE: The billing of Herceptin® requires dual diagnoses. To ensure reimbursement for this service, dual diagnoses must be submitted. The primary and secondary site of the malignancy must both be billed to indicate the breast malignancy is metastatic (e.g., ICD-9-CM code 174.0 and 198.5).

J9600-Porfimer (Photofrin®)

150.0 to 150.9 Malignant neoplasm of esophagus
 162.2 to 162.9 Malignant neoplasm of bronchus and lung (non-small cell)

J9999, C1084-Denileukin diftitox (Ontak®)

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

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 a chemotherapy drug that has a specific HCPCS code, use the appropriate ICD-9-CM diagnosis code which indicates the medical condition being treated.

When billing for Trastuzumab 10mg, use HCPCS code J9355 and include the name of the drug and the appropriate ICD-9-CM diagnosis code which indicates the medical condition being treated. The primary and secondary site of

J9999: Antineoplastic Drugs (continued)

the malignancy must **both** be billed to indicate the breast malignancy is metastatic (e.g., ICD-9-CM code 174.0 **and** 198.5). Documentation which demonstrates that the patient’s tumor overexpresses the HER2 protein or gene must be maintained in the patient’s medical record.

When billing for Denileukin diftitox, use HCPCS code J9999 and include the name of the drug and the appropriate ICD-9-CM diagnosis code which indicates the medical condition being treated. Hospital outpatient providers must report HCPCS code C1084 for services provided on or after August 1, 2000 in accordance with Hospital Outpatient Prospective Payment System (OP PPS) implementation. Documentation which demonstrates that the patient’s malignant cells express CD25 must be maintained in the patient’s medical record.

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

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

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

OP PPS implementation has identified J9182, J9290, J9291, and J9999 as non-covered items and services. For services provided on or after August 1, 2000, bill Etoposide under HCPCS code J9181 and adjust the units billed field. Mitomycin should be billed utilizing HCPCS code J9280 and adjust the units billed field.

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

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from numerous societies.

Start Date of Comment Period

N/A

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	8
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 Bulletin
Revised Effective Date:	01/08/2001
Explanation of Revision:	Additional indications and ICD-9-CM codes were added to eight drugs.

PHPPROG: Psychiatric Partial Hospitalization Program

Policy Number

PHPPROG

Contractor Name

First Coast Service Options, Inc.

Contractor Number

090

Contractor Type

Intermediary

LMRP Title

Psychiatric Partial Hospitalization Program

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Title XVIII of the Social Security Act, Section 1862 (a) (1)

(A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

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

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

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

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

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

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

Medicare Hospital Manual, Sections 230.5 and 452

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

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

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

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

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

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

HCFA Ruling 97-1, 2/97

Program Transmittal 15 (change request 1346), dated 12/12/2000

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

05/15/2000

Revision Effective Date

01/01/2001

Revision Ending Effective Date

12/31/2000

Policy Ending Date

N/A

LMRP Description

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

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

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

A program comprised primarily of diversionary activity, social, or recreational therapy does not constitute a PHP. Psychosocial programs which provide only a structured environment, socialization, and/or vocational rehabilitation are not covered by Medicare. A program that only monitors the management of medication for patients whose psychiatric condition is otherwise stable, is not the combination, structure, and intensity of services which make up active treatment in a PHP.

Indications and Limitations of Coverage and/or Medical Necessity

Eligibility Requirements

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

- **Outpatient hospital** – Partial hospitalization services rendered within a hospital outpatient department are

PHPPROG: Psychiatric Partial Hospitalization Program (continued)

considered “incident to” a physician’s (MD/DO) services and require physician supervision. The physician supervision requirement is presumed to be met when services are performed on hospital premises (i.e., certified as part of the hospital). If a hospital outpatient department operates a PHP offsite, the services must be rendered under the direct personal supervision of a physician (MD/DO). Direct supervision means that the physician must be physically present in the same office suite and immediately available to provide assistance and direction throughout the time the employee is performing the service.

- **Community mental health center (CMHC)** – The CMHC must meet applicable certification or licensure requirements of the state in which they operate, and additionally be certified by Medicare. A CMHC is a Medicare provider of services only with respect to the furnishing of partial hospitalization services under Section 1866(e)(2) of the Social Security Act. Health Care Finance Administration definition of a CMHC is based on Section 1916 (c)(4) of the Public Health Service (PHS) Act. The PHS definition of a CMHC is cross-referenced in Section 1861 (ff) of the Act.

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

Patients eligible for Medicare reimbursement for PHP services are:

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

The following eligibility requirements must also be met:

- The services must be reasonable and necessary for the diagnosis or active treatment of the individual’s condition.
- The patient must be under the care of a physician (M.D./D.O.) trained in the diagnosis and treatment of psychiatric illness, who is knowledgeable about the patient and certifies the need for partial hospitalization.
- The patient or legal guardian must provide written informed consent for partial hospitalization treatment.
- The patient must require comprehensive, multimodal treatment requiring medical supervision and coordination because of a mental disorder, which **severely** interferes with multiple areas of daily life including social, vocational, and/or educational

functioning. *Such dysfunction must be an acute illness or exacerbation of a chronic illness (acute in nature).*

- The patient must have the capacity for active participation in all phases of the multidisciplinary and multimodal program (i.e., the patient is medically stable and not limited by another serious medical condition, the patient demonstrates an appropriate level of cognition).
- There must be reasonable expectation of improvement in the patient’s disorder and level of functioning as a result of the active treatment provided by the PHP.
- The active treatment must directly address the presenting problems necessitating admission to the PHP and be vigorous and proactive as opposed to passive and custodial. Active treatment consists of clinically recognized therapeutic interventions including individual, group, and family psychotherapies, occupational, activity, and psychoeducational groups pertinent to the patient’s current illness. Medical and psychiatric diagnostic evaluation and medical management are also integral to active treatment. Evidence of active monitoring of the patient’s physical status, which could impact the patient’s psychiatric condition, is required.
- The individualized treatment plan is developed by a physician and the multidisciplinary team, with the patient’s involvement.
- A physician must provide supervision and evaluation of the patient’s treatment and the extent to which the therapeutic goals are being met.
- The program must be prepared to appropriately treat the co-morbid substance abuse disorder when it exists (dual diagnosis patients). Dual diagnosed individuals suffer from concomitant mental illness and chemical dependency. Sobriety, as an initial clinical goal, is essential for further differential diagnosis and clinical decisions about appropriate treatment. *It is not generally expected that a patient who is actively using a chemical substance be admitted to or engaged in a partial hospitalization program, as a patient under the influence of a chemical substance would not be capable of actively participating in his/her psychiatric treatment program.*

Admission Criteria (Intensity of Service)

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

Patients admitted to a PHP must:

- **Not require a 24-hour a day level of care as provided in an inpatient setting.** *Therefore, it is not expected for the patient to be an inpatient.*
- **Have an adequate support system to sustain/maintain themselves outside the partial program.** *The patient is expected to have an identifiable significant support system while he/she is not actively engaged in the program (i.e., in the evening, on the weekend, or anytime the PHP services are not available).*

PHPPROG: Psychiatric Partial Hospitalization Program (continued)

- **Require PHP services at a level of intensity and frequency comparable to patients in an inpatient setting for similar psychiatric illnesses.**

Admission Criteria (Severity of Illness)

Patients admitted to a PHP must:

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

Discharge Criteria (Intensity of Service):

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

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

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

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

Discharge Criteria (Severity of Illness):

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

- The patient's clinical condition declines and the individual requires inpatient psychiatric care (24-hour supervision).

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

Covered Services:

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

PHPPROG: Psychiatric Partial Hospitalization Program (continued)

- Patient training and education, when the training and educational sessions are closely and clearly related to the individual’s care and treatment of their diagnosed psychiatric condition. *Providers must not bill training and education as individual or group psychotherapy services. Providers must also not bill for general education (e.g., providing information in a group setting regarding a medication the patient is not receiving, information regarding the PHP’s schedule, policies, changes in personnel, etc.).*
- | | | |
|---|--|--|
| <p>HCPCS Section & Benefit Category
 Medicine, Psychiatry, Central Nervous System
 Assessments/Tests, Physical Medicine and Rehabilitation</p> <p>Type of Bill Code
 Hospital – 13x
 Community Mental Health Center – 76x</p> <p>Revenue Code
 250 General classification for drugs and biologicals
 43x Occupational therapy
 904 Activity therapy
 910 General classification for psychiatric/psychological services
 914 Individual therapy
 915 Group therapy
 916 Family therapy
 918 Testing
 942 Education training</p> <p>CPT/HCPCS Codes
 There are no specific CPT or HCPCS codes for partial hospitalization “programs”. However, outpatient hospitals are required to report the following appropriate CPT/HCPCS codes for the individual or specific partial hospitalization services provided. Effective for dates of services on or after June 5, 2000 Community Mental Health Centers will also be required to utilize the same CPT/HCPCS codes for reporting partial hospitalization services.</p> | <p>90826</p> <p>90828</p> <p>90846</p> <p>90847</p> <p>90849</p> <p>90853</p> <p>90857</p> <p>90875</p> <p>90876</p> <p>90899</p> <p>96100</p> <p>96115</p> <p>96117</p> <p>97532</p> <p>97533</p> | <p>communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20-30 minutes face-to-face with the patient;</p> <p>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45-50 minutes face-to-face with the patient;</p> <p>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75-80 minutes face-to-face with the patient;</p> <p>Family psychotherapy (without the patient present)</p> <p>Family psychotherapy (conjoint psychotherapy) (with patient present)</p> <p>Multiple-family group psychotherapy</p> <p>Group psychotherapy (other than of a multiple-family group)</p> <p>Interactive group psychotherapy</p> <p>Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes</p> <p>Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 45-50 minutes</p> <p>Unlisted psychiatric service or procedure</p> <p>Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, eg, WAIS-R, Rorschach, MMPI) with interpretation and report, per hour</p> <p>Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour</p> <p>Neuropsychological testing battery (eg, Halstead-Reitan, Luria, WAIS-R) with interpretation and report, per hour</p> <p>Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes</p> <p>Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes</p> |
|---|--|--|

PHPPROG: Psychiatric Partial Hospitalization Program (continued)

- G0129 Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day
- G0176 Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)
- G0177 Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)

There are CPT/HCPCS codes on this list that may not be reimbursable through Medicare due to existing national or local medical review policies. Please refer to the applicable Medicare manuals and local medical review policies for coverage criteria information regarding each service.

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

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

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 furnished by a facility other than an outpatient hospital or a community mental health center (CMHC);
- The treatment of chronic conditions without acute exacerbation;
- Individual or group psychotherapy rendered by someone who is not licensed or authorized by Florida State Law;
- Professional services of physicians, physician assistants, nurse practitioners, and clinical psychologists billed to the Intermediary;
- Occupational therapy services related primarily to specific employment opportunities, work skills, or work settings;
- Activity therapy that is primarily recreational or diversionary;
- Any service that does not have a specific treatment goal;
- Daycare programs, which provide primarily social, recreational, or diversional activities, custodial or respite care;
- Psychosocial programs attempting to maintain

psychiatric wellness (e.g., daycare programs for the chronically mentally ill which provide only a structured environment, socialization, and/or vocational rehabilitation);

- Patients who are otherwise psychiatrically stable or require medication management only;
- Services to a skilled nursing facility or nursing home resident that should be expected to be provided by the nursing facility staff (e.g., adjustment difficulties related to their placement in the skilled nursing facility or nursing home);
- Services to hospital inpatients;
- Meals;
- Transportation;
- Self-administered medications;
- Vocational training;
- General education (e.g., information provided about the partial hospitalization program's schedule, policies, changes in staffing, etc.);
- Biofeedback therapy for ordinary muscle tension or psychosomatic conditions;
- Transcendental meditation; and
- Electroconvulsive therapy (ECT).

Beneficiaries ineligible for partial hospitalization services:

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

Noncovered ICD-9-CM Code(s)

Any diagnosis codes not listed in the "ICD-9-CM Codes

PHPPROG: Psychiatric Partial Hospitalization Program (continued)

That Support Medical Necessity” section of this policy.

Noncovered Diagnosis

N/A

Coding Guidelines

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

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

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

- **CPT/HCPCS Coding and Line Item Date of Service Reporting (Form Locators 44 and 45)**
Hospital providers are required to utilize the CPT/HCPCS coding structure when billing for outpatient partial hospitalization services. CPT/HCPCS codes are reported in FL 44 of the UB-92 claim form. Effective June 5, 2000, CMHCs will also be responsible for claim filing utilizing CPT/HCPCS codes and line item dates of service per revenue code line for partial hospitalization claims. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45 “Service Date” (MMDDYY). The intermediary will return to provider (RTP) claims if a line item reported falls outside of the statement coverage period. The HCPCS/CPT coding structure indicated below should be reported, as appropriate.

Revenue Codes	CPT/HCPCS Codes
43x	G0129
904	G0176
910	90801, 90802, 90875*, 90876*, 90899, 97532, or 97533
914	90816, 90818, 90821, 90823, 90826, or 90828
915	90849, 90853, or 90857
916	90846, 90847, or 90849
918	96100, 96115, or 96117
942	G0177

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

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

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

- Supervisory duties, attending patient conferences, nursing assessments, psychosocial evaluations, participating in the development of the treatment plan, preparing clinical and progress reports, participating in discharge planning and in service programs, etc. are considered administrative costs of the facility and are settled at cost audit. These must not be line item billed.
- A patient who requires inpatient hospitalization for a medical condition during the course of receiving PHP services **must be discharged** from the PHP services. There is not a patient “hold” status.

The hospital must also report condition code 41 (in form locator 24-30) to indicate the claim is for partial hospitalization services. If condition code 41 is not reported, the facility will be notified. CMHCs are not required to report a condition code.

Bundling Issues

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

- Physician services that meet the criteria for payment on a fee schedule basis (in accordance with 42 CFR 414);
- Physician assistant services (as defined in section 1861(s)(2)(K)(I) of the Act);
- Clinical psychologist services (as defined in section 1861(ii) of the Act); and
- Advanced registered nurse practitioners and clinical nurse specialists (as defined in section 1861(s)(2)(K)(ii) of the Act).

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

PHPPROG: Psychiatric Partial Hospitalization Program (continued)

professional) services remain bundled. The distinction between professional and administrative services is whether the services are directly furnished to an individual patient or are performed indirectly under the partial hospitalization program (outpatient hospital or CMHC). Currently, reimbursement for administrative services is made via the provider's cost report settlement. Therefore, administrative services are not separately billable to either the Part A intermediary (via the HCFA-1450) or the Part B carrier (via the HCFA-1500). In addition, effective August 1, 2000 payment for partial hospitalization programs will be made under the hospital outpatient prospective payment system.

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

Documentation Requirements

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

PHYSICIAN CERTIFICATION – The physician certification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment. A physician trained in the diagnosis and treatment of psychiatric illness must certify that the patient being admitted to the partial hospitalization program would require inpatient psychiatric hospitalization if the partial hospitalization services are not provided. It is generally expected that the physician certification will be completed within 24 hours of the patient's admission to the partial hospitalization program.

PHYSICIAN RECERTIFICATION – The first recertification is required as of the 18th calendar day following admission to the PHP. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days. Recertification should be based on a thorough re-evaluation of the treatment plan in relation to the reason for admission and the progress of the patient.

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

Certification Language:

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

Physician signature: _____
 Date: _____

Recertification Language:

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

relapse or hospitalization."

Physician signature: _____
 Date: _____

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

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

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

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

- Referral source;
- History of substance abuse including the type of substance used, frequency, amount and duration as well as symptoms of withdrawal or other complications (e.g., hepatitis or AIDS resulting from the use of contaminated needles);
- Family, vocational, and social history, including documentation of an adequate support system to sustain/maintain the patient outside the partial hospitalization program;
- Mental status examination, including general appearance and behavior, orientation, affect, motor activity, thought content, long and short term memory, estimate of intelligence, capacity for self harm or harm to others, insight, judgment, and capacity for activities of daily living (ADLs) with examples of specifics in each category and the method of elicitation when applicable;
- Physical examination (if not done within the past 30 days and/or not available from another provider for inclusion in the medical record);
- Formulation of the patient's status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms, as a result of the active treatment provided by the partial hospitalization program;
- ICD-9-CM/DSM-IV diagnoses, including all five axes of the multiaxial assessment as described in DSM-IV, to assist in establishing the patient's baseline functioning;
- An initial treatment plan, including long and short term

PHPPROG: Psychiatric Partial Hospitalization Program (continued)

goals related to the active treatment of the reason for admission and the specific types, amount, duration, and frequency of therapy services required to address the goals; and

- Certification by the physician that the course of the patient’s current episode of illness would result in psychiatric inpatient hospitalization if the partial hospitalization services are not initiated at this time.

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

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

- Physical examination (if not done within the past 30 days and/or not available from another provider for inclusion in the medical record);
- Formulation of the patient’s status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms, as a result of the active treatment provided by the partial hospitalization program; and
- ICD-9-CM/DSM-IV diagnoses, including all five axes of the multiaxial assessment as described in DSM-IV, to assist in establishing the patient’s baseline functioning.

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

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

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

- The type of service rendered (name of the specific psychotherapy group, educational group, etc. if applicable);
- The problem/functional deficit to be addressed during the session, and how it relates to the patient’s current condition, diagnosis, and problem/deficit identified in the treatment plan;
- The content of the therapeutic session, as well as a clear description of the intervention used to assist the patient in reaching the related treatment goal;
- The patient’s status (behavior, verbalizations, mental status) during the session; and
- The patient’s response to the therapeutic intervention including benefit from the session and how it relates to progress made toward the short/long term goal in measurable and functional terms. Functional improvement is considered to be the patient’s increasing ability to function outside of the direction or support of a therapist and or therapeutic environment.

Measures of functional improvement may include, but are not limited to, patient appearance, patient participation in therapy, or the patient’s performance of activities of daily living.

PHYSICIAN SUPERVISION AND EVALUATION –

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

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

Utilization Guidelines

N/A

Other Comments

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

Sources of Information

Sources of information may be found online under LMRPs 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 the contractor’s Advisory Committee, which includes representatives from the Florida Psychiatric Society.

Start Date of Comment Period

N/A

Start Date of Notice Period

02/01/2001

Revision History

Revision Number:	4
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/01/2001 2 nd Quarter 2001 <i>Bulletin</i>
Revised Effective Date:	01/01/2001
Explanation of Revision:	HCFA clarification regarding new CPT codes 97532 and 97533. These codes replace CPT code 97770 and are applicable for PHP services. These services are to be billed under revenue code 910.

44388: Colonoscopy—Addition to Policy

The local medical review policy for Colonoscopy – 44388 was published in the October/November 2000 *Medicare A Bulletin* (pages 18-21). Since that time, the CPT codes 44397 and 45387 have been added to the policy and are subject to coverage based in the diagnosis list indicated in the “ICD-9-CM Codes that Support Medical Necessity” section of the policy. This addition was effective for claims processed on or after January 1, 2001. ❖

82108: Aluminum—Addition to Policy

The local medical review policy for Aluminum (82108) was published in the June/July 2000 *Medicare A Bulletin* (pages 25-26). Since that time, the “ICD-9-CM Codes that Support Medical Necessity” section has been revised as follows:

ICD-9-CM Codes that Support Medical Necessity

- 268.2 Osteomalacia, unspecified
- 275.49 Other disorders of calcium metabolism
- 280.9 Iron deficiency anemia, unspecified [Microcytic (hypochromic) anemia]
- 284.8 Other specified aplastic anemias [Aplasia, bone marrow (secondary)]
- 284.9 Aplastic anemia, unspecified [Aplasia, bone marrow (myeloid or idiopathic)]
- 285.1 Acute posthemorrhagic anemia [Acute microcytic anemia]
- 294.8 Other specified organic brain syndromes (chronic) [(Encephalopathy) due to dialysis]
- 348.3 Encephalopathy, unspecified (acute)
- 359.4*** **Toxic myopathy (due to drugs)**
- 428.1 Left heart failure
- 429.3 Cardiomegaly
- 585 Chronic renal failure
- 733.10-733.19 Pathologic fracture
- 965.1 Poisoning by salicylates
- 972.2 Poisoning by antilipemic and antiarteriosclerotic drugs
- 973.0 Poisoning by antacids and antigastric secretion drugs
- 976.1 Poisoning by antipruritics
- 976.2 Poisoning by local astringents and local detergents
- 976.3 Poisoning by emollients, demulcents, and protectants
- 985.9 Toxic effect of unspecified metal (industrial exposure)
- E858.3*** **Accidental poisoning by agents primarily affecting cardiovascular system**
- E858.4*** **Accidental poisoning by agents primarily affecting gastrointestinal system**

- E858.7*** **Accidental poisoning by agents primarily affecting skin and mucous membrane, ophthalmological, otorhinolaryngological, and dental drugs**
- E935.3*** **Drugs, medicinal and biological substances causing adverse effects in therapeutic use, salicylates**
- E942.2*** **Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antilipemics and antiarteriosclerotic drugs**
- E943.0*** **Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antacids and antigastric secretion drugs**
- E946.2*** **Drugs, medicinal and biological substances causing adverse effects in therapeutic use, local astringents and local detergents**
- E946.3*** **Drugs, medicinal and biological substances causing adverse effects in therapeutic use, emollients, demulcents, and protectants**
- E950.0*** **Suicide and self-inflicted poisoning by analgesics, antipyretics, and antirheumatics**
- E950.4*** **Suicide and self-inflicted poisoning by other specified drugs and medicinal substances**

** These ICD-9-CM codes require dual diagnoses. ICD-9-CM code 359.4 must be accompanied by the appropriate E diagnosis code to identify the toxic agent. Conversely, the E diagnosis codes must be billed with ICD-9-CM code 359.4 to identify the indication of toxic myopathy.*

All additional criteria listed in the policy continue to apply. For specific information, please refer to the “Indications and Limitations of Coverage and/or Medical Necessity”, “Coding Guidelines,” and “Documentation Requirements,” sections of the policy as published in the June/July 2000 *Medicare A Bulletin*

93965: Non-Invasive Evaluation of Extremity Veins—Addition to Policy

The local medical review policy for Non-Invasive Evaluation of Extremity Veins – 93965 was published in the August/September 2000 *Medicare A Bulletin* (pages 39-40). Since that time, the diagnosis code 782.3 (Edema) has been added to the “ICD-9-CM Codes that Support Medical Necessity” section of the policy. This addition was effective for claims processed **on or after January 31, 2001.** ❖

G0108: Diabetes Outpatient Self-Management Training—Revision to Policy

The local medical review policy for Diabetes Outpatient Self-Management Training – G0108 was published in the February/March 2000 *Medicare A Bulletin* (pages 39-42). With the implementation of the 2001 HCPCS update, the descriptors for G0108 and G0109 have been revised to:

- G0108 Diabetes outpatient self-management training services, individual, per 30 minutes
- G0109 Diabetes self-management training services, group session (2 or more), per 30 minutes

HCPCS codes G0108 and G0109 remain subject to coverage based on the diagnosis range indicated in the “ICD-9-CM Codes that Support Medical Necessity” section of the policy. This revision was effective for claims furnished **on or after January 1, 2001.** ❖

J1950: Leuprolide Acetate—Addition to Policy

The local medical review policy for Leuprolide Acetate – J1950 was published in the August/September 2000 *Medicare A Bulletin* (pages 45-46). With the implementation of the 2001 HCPCS update, HCPCS code J9219 (Leuprolide acetate implant, 65 mg) has been added to the policy. This code is subject to coverage based on the diagnosis list indicated in the “ICD-9-CM Codes that Support Medical Necessity” section of the policy. This addition was effective for claims furnished **on or after January 1, 2001.** ❖

J7190: Hemophilia Clotting Factors—Addition to Policy

The local medical review policy for Hemophilia Clotting Factors – J7190 was published in the June/July 2000 *Medicare A Bulletin* (pages 55-56). With the implementation of the 2001 HCPCS update, HCPCS code Q2022 (von Willebrand factor complex, human, per iu) has been added to the policy. This code is subject to coverage based on the diagnosis list indicated in the “ICD-9-CM Codes that Support Medical Necessity” section of the policy. This addition was effective for claims furnished **on or after January 1, 2001.** ❖

Percutaneous Transluminal Angioplasty and Carotid Stents

Section 50-32 of the Coverage Issues Manual (CIM) indicates that percutaneous transluminal angioplasty (PTA) to treat obstructive lesions of the carotid, vertebral, and cerebral arteries are not covered because the safety and efficacy of these procedures have not been established. Since carotid stenting is performed in conjunction with angioplasty, it has been determined this procedure is also noncovered. These services should be billed as noncovered services. ❖

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

January 2001 Update: Coding Information for Hospital Outpatient Prospective Payment System (OPPS)

The following article provides hospitals with a list of long descriptors for drugs, biologicals, and devices eligible for transitional pass-through payments, and for items classified in “new technology” ambulatory payment classifications (APCs) under the OPPS.

- Section I lists new drugs, biologicals, and devices with specific C-codes that are effective January 1, 2001, for pass-through payments.
- Section II contains a list of devices that are classified in “new technology” APCs. For specific payment rates associated with these new technology APCs, refer to the OPPS Final Rule that was published in November 2000.
- Sections III and IV contain a list of clarifications and corrections related to devices and drugs previously published.
- Section V contains a list of items no longer eligible for pass-through payments as of January 1, 2001.

Unless otherwise indicated, the effective date for payment of the new items in this article is January 1, 2001.

This article contains the latest long descriptors assigned to certain HCPCS code listed in this PM, which are indicated by an asterisk (*) next to the code. Therefore, these long descriptors supercede the long descriptors listed with the 2001 HCPCS update.

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

All of the C-codes included in this article are used exclusively for services paid under the OPPS and may not be used to bill for services under other Medicare payment systems

Drugs, Biologics, and Devices Effective January 1, 2001

HCPCS

CODE	LONG DESCRIPTOR
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 Suturing Device—Standard or Open Access <i>Note: Capio Suturing Device—Standard or Open Access will be effective January 1, 2001.</i>

The Precision Twist Transvaginal Anchor System, Precision Tack Transvaginal Anchor System, Vesica Press-In Anchor System, and the Capio CL (TVB/S) Transvaginal Suturing Device became effective August 1, 2000.

C1037* Catheter, dialysis, Boston Scientific Vaxcel Chronic Dialysis Catheter, Medcomp Bio Flex Tesio Catheter, Medcomp Silicone Tesio Catheter
Note: Medcomp Bio Flex Tesio Catheter and Medcomp Silicone Tesio Catheter will be effective January 1, 2001. Vaxcel Chronic Dialysis Catheter became effective August 1, 2000.

C1060 Stent, coronary, ACS Multi-Link Tristar Coronary Stent System and Delivery System, ACS Multi-Link Ultra Coronary Stent System
Note: ACS Multi-Link Ultra will be effective January 1, 2001. ACS Multi-link Tristar became effective August 1, 2000.

C1063 Lead, defibrillator, Endotak Endurance EZ, Endotak Endurance RX, Endotak Endurance 0134, 0135, 0136
Note: Endotak Endurance will be effective January 1, 2001. Endotak Endurance EZ and RX became effective August 1, 2000.

C1076 Defibrillator, single chamber, automatic, implantable, Ventak Mini IV, Ventak Mini IV+ 1793, 1796, Ventak Mini III HE, Ventak Mini III HE+ 1788, 1789, Ventak Mini III, Ventak Mini III+ 1783, 1786
Note: Only the Ventak Mini IV+, Ventak Mini III HE+ and Ventak Mini III+ will be effective January 1, 2001. Ventak Mini IV, Ventak Mini III HE, and Ventak Mini III became effective August 1, 2000.

C1104 Catheter, ablation, RF Conductr MC 4mm, RF Conductr MC 5mm 6042, 7544
Note: RF Conductr MC 5mm will be effective January 1, 2001. RF Conductr MC 4mm became effective 8/01/00.

C1135 Pacemaker, dual chamber, rate-responsive, Entity DR 5326, Entity DR 5326L, Entity DR 5326R
Note: Only the Entity DR 5326 will be effective January 1, 2001. Entity DR 5326L and Entity DR 5326R became effective August 1, 2000.

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

C1136	Pacemaker, dual chamber, rate-responsive, Affinity DR 5330, Affinity DR 5330L, Affinity DR 5330R <i>Note: Only the Affinity DR 5330 will be effective January 1, 2001. Affinity DR 5330L and Affinity DR 5330R became effective August 1, 2000.</i>	C1709	Needle, brachytherapy, Remington Medical Brachytherapy Needle
C1144	Pacemaker, single chamber, rate-responsive, Affinity SR 5130, Affinity SR 5130L, Affinity SR 5130R, Integrity SR 5142 <i>Note: Only the Affinity SR 5130 will be effective January 1, 2001. Affinity SR 5130L, 5130R, and Integrity SR 5142 became effective August 1, 2000.</i>	C1710	Needle, brachytherapy, US Biopsy Prostate Seeding Needle
C1145	Vascular closure device, Angio-Seal 6 French Vascular Closure Device 610091, Angio-Seal 8 French Vascular Closure Device 610089, 610097 <i>Note: Only model 610097 will be effective January 1, 2001. Models 610091 and 610089 became effective August 1, 2000.</i>	C1790	Brachytherapy seed, Nucletron Iridium 192 HDR
C1147	Lead, pacemaker, AV Plus DX 1368/52, AV Plus DX 1368/58, AV Plus DX 1368/65 <i>Note: Only the AV Plus DX 1368/65 will be effective January 1, 2001</i>	C1792	Brachytherapy seed, UroMed Symmetra I-125
C1149	Pacemaker, dual chamber, non-rate responsive, Entity DC 5226R, Entity DC 5226 <i>Note: Only Entity DC 5226 will be effective January 1, 2001. Entity DC 5226R became effective August 1, 2000.</i>	C1793	Brachytherapy seed, Bard InterSource-103 Palladium Seed 1031L, 1031C
C1172	Balloon, tissue dissector, Spacemaker Tissue Dissection Balloon, Spacemaker 1000cc Hernia Balloon Dissector <i>Note: The Spacemaker 1000cc Hernia Balloon Dissector will be effective January 1, 2001. The Spacemaker Tissue Dissection Balloon became effective August 1, 2000.</i>	C1794	Brachytherapy seed, Bard IsoSeed-103 Palladium Seed Pd3S111L, Pd3S111P
C1358	Pacemaker, dual chamber, non-rate responsive, Affinity DC 5230R, Affinity DC 5230 <i>Note: Only the Affinity DC 5230 will be effective January 1, 2001. Affinity DC 5230R became effective August 1, 2000.</i>	C1795	Brachytherapy seed, Bard BrachySource-125 Iodine Seed 1251L, 1251C
C1420	Anchor system, StapleTac2 Bone Anchor System with Dermis	C1796	Brachytherapy seed, Source Tech Medical I-125 Seed STM 1251
C1421	Anchor system, StapleTac2 Bone Anchor System without Dermis	C1797	Brachytherapy seed, Draximage I-125 Seed Model LS-1
C1450	Orthosphere Spherical Interpositional Arthroplasty	C1798	Brachytherapy seed, Syncor I-125 PharmaSeed Model BT-125-1
C1451	Orthosphere Spherical Interpositional Arthroplasty Kit	C1799	Brachytherapy seed, I-Plant Iodine 125 Model 3500
C1706	Needle, brachytherapy, Indigo Prostate Seeding Needle	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
C1707	Needle, brachytherapy, VariSource Interstitial Implant Needle	C1870	DermMatrix Surgical Mesh, per 16 square centimeters
C1708	Needle, brachytherapy, UroMed Prostate Seeding Needle	C1871	DermMatrix Surgical Mesh, per 32 or 64 square centimeters
		C1873	Bard 3DMax Mesh, medium or large size
		C1929	Catheter, Maverick Monorail PTCA Catheter, Maverick Over-the-Wire PTCA Catheter
		C1939	Catheter, Ninja _{FX} 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 <i>Note: Only the Ninja, NC Raptor, Charger, Titan, and Titan Mega PTCA Dilatation Catheter will be effective January 1, 2001. The Ninja_{FX} and Raptor PTCA Dilatation Catheters became effective October 1, 2000.</i>
		C1944	Catheter, Rapid Exchange Single-Use Biliary Balloon Dilatation Catheter
		C1945	Catheter, Cordis Savvy PTA Dilatation Catheter
		C1946	Catheter, R1s Rapid Exchange Pre-Dilatation Balloon Catheter
		C1947	Catheter, Gazelle Balloon Dilatation Catheter
		C1948	Catheter, Pursuit Balloon Angioplasty Catheter

C1949	Catheter, Endosonics Oracle MegaSonics Five-64 F/X PTCA Catheter	C2676	Catheter, Response CV Catheter <i>Note: This device was approved for the January 2001 update, however, due to new information received from the manufacturer, this device is not eligible for pass-through payment at this time.</i>
C1979	Catheter, Endosonics Visions PV 8.2F Intravascular Ultrasound Imaging Catheter, Endosonics Avamar F/X Intravascular Ultrasound Imaging Catheter	C2702	Defibrillator, single chamber, implantable, Ventak Prizm 2 VR 1860
C1980	Catheter, Atlantis SR Coronary Imaging Catheter	C2703	Defibrillator, single chamber, implantable, Ventak Prizm VR HE 1857, 1858
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 <i>Note: Only the Bonnie Monorail 30mm, Bonnie Monorail 40mm, Ranger 20mm, Long Ranger 30mm, and Long Ranger 40mm will be effective January 1, 2001. The other catheters became effective August 1, 2000.</i>	C2704	Defibrillator, single chamber, implantable, Ventak Mini IV+ 1793, 1796
C2012	Catheter, ablation, Biosense Webster Celsius Braided Tip Ablation Catheter, Biosense Webster Celsius 5mm Temperature Ablation Catheter, Biosense Webster Celsius Temperature Sensing Diagnostic/Ablation Tip Catheter, Biosense Webster Celsius Long Reach Ablation Catheter <i>Note: Only the Celsius Long Reach Ablation Catheter will be effective January 1, 2001. The other ablation catheters became effective October 1, 2000.</i>	C2803	Defibrillator, dual chamber, implantable, Ventak Prizm DR HE 1852, 1853
C2104	Catheter, electrophysiology, Lasso Deflectable Circular Tip Mapping Catheter	C2804	Defibrillator, dual chamber, implantable, Ventak Prizm 2 DR 1861
C2152	Catheter, Cordis 5F, 6F, 7F, 8F, 9F, 10F Vista Brite Tip Guiding Catheter	C2805	Defibrillator, dual chamber, implantable, Jewel AF 7250
C2300	Catheter, Varisource Standard Catheter	C2806	Defibrillator, implantable, Gem VR 7227
C2610	Catheter, Arrow FlexTip Plus Intraspinal Catheter Kit	C2807	Defibrillator, implantable, Contak CD 1823
C2611	Catheter, Medtronic PS Medical AlgoLine Intraspinal Catheter System/Kit 81102, 81192	C2808	Defibrillator, Implantable, Contak TR 1241
C2612*	Catheter, Medtronic InDura Intraspinal Catheter, Myelotec Video Guided Catheter <i>Note: The InDura Intraspinal Catheter became effective August 1, 2000, however, this was previously listed with C-code C1025. InDura Intraspinal Catheter is no longer reportable with C1025 as of January 1, 2001. It should be reported with HCPCS code C2612. The Myelotec Video Guided Catheter will be effective January 1, 2001.</i>	C3002	Lead, defibrillator, implantable, EasyTrak 4510, 4511, 4512, 4513
		C3003	Lead, defibrillator, implantable, Endotak SQ Array XP 0085
		C3004	Lead, defibrillator, implantable, Intervene 497-23, 497-24
		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
		C3554	Guide wire, Jindo Tapered Peripheral Guidewire
		C3555	Guide wire, Wholey Hi-Torque Plus Guide Wire System, 145cm, 190cm, 300cm
		C3556	Guide wire, Endosonics Cardiometrics WaveWire Pressure Guide Wire, Cardiometrics FloWire Doppler Guide Wire
		C3557	Guidewire, HyTek Guidewire
		C3801	Infusion pump, Arrow/MicroJect PCA System
		C4006	Pacemaker, single chamber, Pulsar Max II SR 1180, 1181
		C4007	Pacemaker, single chamber, Marathon SR 291-09, 292-09R, 292-09X
		C4008	Pacemaker, single chamber, Discovery II SSI 481
		C4009	Pacemaker, single chamber, Discovery II SR 1184, 1185, 1186, 1187
		C4312	Pacemaker, dual chamber, Pulsar Max II DR 1280

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

C4313	Pacemaker, dual chamber, Marathon DR 293-09, 294-09, 294-09R, 294-10	C5028	Stent, biliary, BX Velocity with Hepacoat on Raptor Stent System (18mm in length)
C4314	Pacemaker, dual chamber, Momentum DR 294-23	C5029	Stent, biliary, BX Velocity with Hepacoat on Raptor Stent System (23mm in length)
C4315	Pacemaker, dual chamber, Selection AFm 902 SLC 902C	C5047	Stent, coronary, Nitroyal Elite Premounted Stent System (15mm, 25mm, 31mm)
C4316	Pacemaker, dual chamber, Discovery II DR 1283, 1284, 1285, 1286	C5048	Stent, coronary, GR II Coronary Stent
C4317	Pacemaker, dual chamber, Discovery II DDD 981	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, and Percuflex Tail Plus Tapered Ureteral Stent <i>Note: The Contour Closed Soft Percuflex Stent, Contour Injection Soft Percuflex Stent, Soft Percuflex, and Percuflex Tail Plus Tapered Ureteral Stent will be effective January 1, 2001. The other ureteral stents became effective October 1, 2000.</i>
C4601	Lead, pacemaker, Aescula LV 1055K <i>Note: This device was approved for the January 2001 update, however, due to new information received from the manufacturer, this device is not eligible for pass-through payment at this time.</i>		
C4602	Lead, pacemaker, Tendril SDX 1488K/46, Tendril SDX 1488K/52, Tendril SDX 1488K/58		
C4603	Lead, pacemaker, Oscor/Flexion 4015, 4016, 4017, 4018		
C4604	Lead, pacemaker, Crystalline ActFix ICF09, CapsureFix Novus 5076		
C4605	Lead, pacemaker, CapSure Epi 4968	C6053	Surgisis Soft Tissue Graft, per 70cm, 105cm, 140cm
C4606	Lead, pacemaker, Flextend 4080, 4081, 4082		
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 EZ 438-25, 438-35	C6054	Surgisis Enhanced Strength Soft Tissue Graft, per 4.2cm, 20cm, 28cm, 40cm
C5000	Stent, biliary, BX Velocity with Hepacoat on Raptor Stent System (28 or 33mm in length)	C6055	Surgisis Enhanced Strength Soft Tissue Graft, per 52.5cm, 60cm, 70cm
C5019	Stent, biliary, Flexima Single Use Biliary Stent System	C6056	Surgisis Enhanced Strength Soft Tissue Graft, per 105cm, 140cm
C5020	Stent, biliary, Cordis Smart Nitinol Stent Transhepatic Biliary System (20mm in length)	C6057	Surgisis Hernia Graft, per 195cm
C5021	Stent, biliary, Cordis Smart Nitinol Stent Transhepatic Biliary System (40 or 60 mm in length)	C6058	SurgiPro Hernia-Mate Plug, medium or large
C5022	Stent, biliary, Cordis Smart Nitinol Stent Transhepatic Biliary System (80mm in length)	C6200	Vascular graft, Exxcel Soft ePTFE Vascular Graft
C5023	Stent, biliary, BX Velocity Transhepatic Biliary Stent and Delivery System (8 or 13mm in length)	C6201	Vascular graft, Impra Venaflo Vascular Graft with Carbon, Straight Graft 10cm or 20cm in length
C5024	Stent, biliary, BX Velocity Transhepatic Biliary Stent and Delivery System (18mm in length)	C6202	Vascular graft, Impra Venaflo Vascular Graft with Carbon, Straight Graft 30cm or 40cm in length
C5025	Stent, biliary, BX Velocity Transhepatic Biliary Stent and Delivery System (23mm in length)	C6203	Vascular graft, Impra Venaflo Vascular Graft with Carbon, Straight Graft (50cm in length) or CenterFlex Venaflo Stepped Graft (45cm in length)
C5026	Stent, biliary, BX Velocity Transhepatic Biliary Stent and Delivery System (28 or 33mm in length)	C6204	Vascular graft, Impra Venaflo Vascular Graft with Carbon, Stepped Graft 20cm, 25cm, 30cm, 35cm, 40cm, or 45cm in length
C5027	Stent, biliary, BX Velocity with Hepacoat on Raptor Stent System (8 or 13mm in length)	C6205	Vascular graft, Impra Carboflo Vascular Graft, Straight Graft 10 cm in length
		C6206	Vascular graft, Impra Carboflo Vascular Graft, Straight Graft 20 cm in length

C6207	Vascular graft, Impra Carboflo Vascular Graft, Straight Graft 30 cm, 35cm, or 40cm in length	C6650	Introducer, guiding, Fast-Cath Two-Piece Guiding Introducer 406869, 406892, 406893, 406904
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)	C6651	Introducer, guiding, Seal-Away CS Guiding Introducer 407508, 407510
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)	C6652	Introducer, Bard Safety Excalibur Introducer
C6210	Vascular graft, Exxcel ePTFE Vascular Graft, less than 6mm in diameter	C6700	Synthetic absorbable sealant, Focal Seal-L
C6300	Stent graft system, Vanguard III Bifurcated Endovascular Aortic Graft	C8099	Spectranetics Lead Locking Device 518-018, 518-019, 518-020
C6502	Sheath, electrophysiology, Perry Exchange Dilator	C8102	Surgi-Vision Esophageal Stylet Internal Coil
C6525	Spectranetics Laser Sheath 12F 500-001, 14F 500-012, 16F 500-013	C9011	Injection, caffeine citrate, per 1ml
		C9107	Injection, tinzaparin sodium, per 2ml vial
		C9108	Injection, thyrotropin alpha, 1.1 mg
		C9109	Injection, tirofiban hydrochloride, 6.25 mg
		J1441	Filgrastim 480 mcg injection
		J1810	Injection, fentanyl/droperidol, up to 2ml

II. Devices Eligible for New Technology Payments Effective January 1, 2001

HCPCS CODE	LONG DESCRIPTOR	APC
C8539	Wilson-Cook Quantum Dilatation Balloon	987
C8540	Flex-EZ (Esophageal) Balloon Dilator 3302, 3304, 3306	988
C8541	Carson Zero Tip Balloon Dilatation Catheters with HydroPlus Coating Kit, Passport Balloon on a Wire Dilatation Catheters with HydroPlus Coating Kit	988
C8542	UrethraMax High Pressure Urethral Balloon Dilatation Catheter/Kit	987
C8543	Amplatz Renal Dilator Set	987
C8550	Catheter, Livewire EP Catheter, 7F CSM 401935, 5F Decapolar 401938, 401939, 401940, 401941	989
C8551	Catheter, Livewire EP Catheter, 7F Duo-Decapolar 401932	990
C8552	Catheter, Santuro Fixed Curve Catheter	989
C8597	Guide wire, Cordis Wisdom ST Steerable Guidewire 537-114, 537-114J, 537-114X, 537-114Y	987
C8598	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)	987
C8599	Guide wire, Cordis Stabilizer XS Steerable Guidewire 527-914, 527-914J, 527-914X, 527-914Y	987
C8600	Guide wire, Cordis Shinobi Plus Steerable Guidewire 547-214, 547-214X	987
C8650	Introducer, Cook Extra Large Check-Flo Introducer	987
C8724	Lead, neurostimulation, Octad Lead 3898-33/389861	991
C8725	Lead, neurostimulation, SymMix Lead 3982	990
C8748	Lead, defibrillator, Endotak SQ Patch 0047, 0063	990
C8749	Lead, defibrillator, Endotak SQ Array 0048, 0049	993
C8750	Pacemaker, dual chamber, Unity VDDR 292-07	994
C8775	Lead, pacemaker, 2188 Coronary Sinus Lead	991
C8776	Lead, pacemaker, Innomedica Sutureless Myocardial 4045, 4058, 4046, 4047	990

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

HCPCS	LONG DESCRIPTOR	APC
C8777	Lead, pacemaker, Unipass 425-02, 425-04, 425-06	991
C8800	Stent, biliary, Large Palmaz Balloon Expandable Stent with Delivery System	990
C8801	Stent, biliary, Cook Z Stent Gianturco-Rosch Biliary Design	989
C8802	Stent, biliary, Cook Oasis One Action Stent Introductory System	987
C8830	Stent, coronary, Cook Gianturco-Roubin Flex-Stent Coronary Stent	991
C8990	Perfluoron, per 2ml	987
C8991	Perfluoron, per 5ml vial or 7ml vial	988
C9700	Water Induced Thermotherapy	977
C9701*	Stretta Procedure	976
C9702	Checkmate Intravascular Brachytherapy System	981

III. Clarifications/Corrections Related to Device Issues

The long descriptors listed below which were previously published in Transmittals A-00-42, A-00-61, and A-00-72 have been assigned new C-codes for the January 2001 update. The C-codes in the **left column** are the correct C-codes. Please note the C-codes in the left column along with the designated long descriptors are already in the 2001 HCPCS tape. Only the C-codes designated with asterisks (*) include revised long descriptors that were not in the 2001 HCPCS tape. The C-codes in the right column were previously assigned with these long descriptors and are listed here for reference purposes only. Note the effective dates for the C-codes listed below vary.

CORRECT

C-CODES	LONG DESCRIPTOR	
C1164*	Brachytherapy seed, Imagyn Medical Technologies I-125 Seed <i>Note: This became effective August 1, 2000.</i>	
C1325*	Brachytherapy seed, Theragenic Palladium-103 Seed <i>Note: This became effective August 1, 2000.</i>	
C1711	Needle, brachytherapy, MD Tech P.S.S. Prostate Seeding Set (needle) <i>Note: This became effective October 1, 2000.</i>	C1702
C1712	Needle, brachytherapy, Imagyn Medical Technologies IsoStar Prostate Brachytherapy Needle <i>Note: This became effective October 1, 2000.</i>	C1702
C1791	Brachytherapy seed, Nycomed Amersham I-125 (OncoSeed, Rapid Strand) <i>Note: This became effective October 1, 2000.</i>	C1803
C1864*	Bard Sperma Tex Mesh, per 13.44 square inches <i>Note: This became effective October 1, 2000.</i>	
C1872	Dermagraft, per 37.5 square centimeters <i>Note: This became effective October 1, 2000.</i>	C1859
C2022	Catheter, ablation, Cardiac Pathways Chilli Cooled Ablation Catheter 41422, 41442, 45422, 45442, 43422, 43442 <i>Note: This became effective October 1, 2000.</i>	C2017
C2023	Catheter, ablation, Cardiac Pathways Chilli Cooled Ablation Catheter, Standard Curve 3005 or Large Curve 3006 <i>Note: This became effective October 1, 2000.</i>	C2014
C2100	Catheter, electrophysiology, Cardiac Pathways CS Reference Catheter <i>Note: This became effective October 1, 2000.</i>	C2008
C2101	Catheter, electrophysiology, Cardiac Pathways RV Reference Catheter <i>Note: This became effective October 1, 2000.</i>	C2002
C2102	Catheter, electrophysiology, Cardiac Pathways 7F Radii Catheter <i>Note: This became effective October 1, 2000.</i>	C2002
C2103	Catheter, electrophysiology, Cardiac Pathways 7F Radii Catheter with Tracking <i>Note: This became effective October 1, 2000.</i>	C2009

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

HCPCS CODE	LONG DESCRIPTOR	APC
C2153	Catheter, electrophysiology, Bard Viking Fixed Curve Catheter (Bipolar, Quadrapolar, Multipolar, and ASP Models only) <i>Note: This became effective October 1, 2000.</i>	C2010
C3510	Prosthesis, AMS Sphincter 800 Urinary Prosthesis <i>Note: This became effective October 1, 2000.</i>	C3500
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, Percuflex Soft Stent, and Percuflex Tail Plus Tapered Ureteral Stent <i>Note: The Contour Closed Soft Percuflex Stent, Contour Injection Soft Percuflex Stent, Percuflex Soft Stent, and Percuflex Tail Plus Tapered Ureteral Stent will be effective January 1, 2001. The other ureteral stents became effective October 1, 2000.</i>	C5280
C5601	Vascular closure device, Vascular Solutions Duett Sealing Device 1000 <i>Note: This became effective October 1, 2000.</i>	C1000
C8535	Stent, biliary, Spiral Z Biliary Metal Expandable Stent, Za Biliary Metal Expandable Stent <i>Note: This became effective October 1, 2000.</i>	C8522
C8536	Stent, esophageal, Esophageal Z Metal Expandable Stent with Dua Anti-Reflux Valve, Esophageal Z Metal Expandable Stent with Uncoated Flanges <i>Note: This became effective October 1, 2000.</i>	C8532
C9102*	Supply of radiopharmaceutical diagnostic imaging agent, 51 Sodium Chromate, per 50 uCi <i>Note: This became effective October 1, 2000.</i>	
G0174*	Intensity modulated radiation therapy (IMRT) delivery to one or more treatment areas, multiple couch angles/fields/arc, custom collimated pencil-beams with treatment setup and verification images, complete course of therapy requiring more than one session, per session. <i>Note: This code was formerly listed in the 2001 HCPCS update with the following long descriptor: Intensity modulated radiation therapy plan, per session</i> This long descriptor has been superceded by the long descriptor noted above.	
G0178*	Intensity modulated radiation therapy (IMRT) plan, including dose volume histograms for target and critical structure partial tolerances, inverse plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, per course of treatment. <i>Note: This code was formerly listed in the 2001 HCPCS tape with the following long descriptor: Intensity modulated radiation therapy (IMRT) delivery to multiple areas with treatment setup and verification images.</i> This long descriptor has been superceded by the long descriptor noted above.	
G0179*	Physician recertification services for Medicare-covered services provided by a participating home health agency (patient not present) including review of subsequent reports of patient status, review of patient's responses to the Oasis Assessment Instrument, contact with the home health agency to ascertain the follow-up implementation plan of care, and documentation in the patient's office record, per certification period <i>Note: This code was formerly listed in the 2001 HCPCS tape with the following long descriptor: Intensity modulated radiation therapy (IMRT) planning, includes dose volume nistograms, inverse plan optimization, plan positional accuracy and dose verification.</i> This long descriptor has been superceded by the long descriptor noted above.	

IV. Clarifications/Corrections Related to Drug Issues

The payment rate associated with J1327, eptifibatid (Integrillin) injection, 5 mg, has been revised from \$6.28 to \$12.57 effective August 1, 2000. The payment rate associated with C9005 has been revised from \$2,612.50 to \$1,306.25. The HCPCS code for reteplase double bolus (J2994) is discontinued effective January 1, 2001 since this drug will be packaged as one single-use vial (C9005) only. However, J2994 is still reportable until April 1, 2001. Thereafter, reteplase (18.1mg) should be reported with HCPCS code C9005.

For doses greater than what is indicated with the associated long descriptor, indicate the appropriate units in the UB-92 (HCFA 1450) form. Please note both HCPCS codes have an effective date of August 1, 2000. For claim re-adjustment, re-submit claims for reteplase and eptifibatid if it was initially submitted in August or September 2000.

HCPCS Code	Status Ind	Descriptor	APC	Payment Amt	Copayment Amount
C9005	G	Injection, reteplase, 18.1 mg (one single-use vial)	9005	\$1,306.25	\$175.04
J1327	G	Eptifibatid injection, 5mg	1607	\$12.57	\$1.68

V. Items No Longer Eligible for Pass-Through Payments

After further clinical analysis, the items listed below have been determined ineligible for pass-through payments. Therefore, effective January 1, 2001 the following items will no longer be eligible for pass-through payments and will no longer be recognized as valid reportable codes under the OPSS.

C-CODES LONG DESCRIPTOR

- C1031 Electrode, needle, ablation, MR Compatible LeVeen, Modified LeVeen Needle Electrode
- C1146 Endotracheal tube, VETT Endotracheal Tube
- C1170 Biopsy device, breast, ABBI Device
- C1175 Biopsy device, MIBB Device
- C1176 Biopsy device, Mammotome HH Hand-Held Probe with Smartvac Vacuum System
- C1177 Biopsy device, 11-Gauge Mammotome Probe with Vacuum Cannister
- C1179 Biopsy device, 14-Gauge Mammotome Probe with Vacuum Cannister
- C1321 Electrode, disposable, Palate Somnoplasty Coagulating Electrode, Base of Tongue Somnoplasty Coagulating Electrode
- C1322 Electrode, disposable, Turbinate Somnoplasty Coagulating Electrode
- C1323 Electrode, disposable, VAPR Electrode, VAPR T Thermal Electrode
- C1324 Electrode, disposable, LigaSure Disposable Electrode
- C1329 Electrode, disposable, Gynecare VERSAPOINT Resectoscopic System Bipolar Electrode
- C1368 Infusion system, On-Q Pain Management System, On-Q Soaker Pain Management System, PainBuster Pain Management System
- C2600 Catheter, Gold Probe Single-Use Electrohemostasis Catheter

NOTE: *The HCPCS codes assigned to devices listed in this article may be used only for those specific devices. An already assigned HCPCS C-code may not be substituted for a different brand/trade name device or any other device not listed in this article, even if it is the same type of device.*

Technical Corrections to the January 2001 Update: Coding Information for Hospital Outpatient Prospective Payment System

The Health Care Financing Administration (HCFA) has issued a list of long descriptor corrections for devices eligible for transitional pass-through payments under the outpatient prospective payment system (OPPS). **The long descriptors in this publication supersede any previously published long descriptors for each C-code listed below.** Unless otherwise indicated, the effective date for the items in this article is **January 1, 2001.**

The outpatient code editor and PRICER currently contain the codes included in this document. The intermediary internal claim processing systems has revised the long descriptors to the HCPCS file to include the trade/brand names, model numbers, or the dosage information to the specific assigned C-code.

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

Note pass-through devices are determined to be eligible for pass-through payment status based on specific items. In some instances, manufacturers may sell kits that include devices (e.g., catheters) approved for pass-through payment together with supplies or other items (e.g., gauze pads) that are not devices and do not qualify for pass-through payments. If an item in a kit is individually eligible for pass-through payment, a hospital may bill for that item for a pass-through payment using the appropriate code for the individual item, but it may not bill for the kit as a whole.

HCPCS Code Long Descriptors for Pass-Through Devices

C1036	Port/reservoir, venous access device, Vaxcel Implantable Vascular Access System, R Port Premier Vascular Access System (model 45-100) <i>Note: This became effective 08/01/00. The R Port Premier Vascular Access System is currently sold under two models, 45-100 and 45-155. Of the two models, model 45-100 of the R Port Premier Vascular Access System is the only one approved for pass-through payment. Model 45-155 is not approved for pass-through payment.</i>
C1054	Catheter, thrombectomy, Hydrolyser 6F Mechanical Thrombectomy Catheter, Hydrolyser 7F Mechanical Thrombectomy Catheter, Microvena Helix Clot Buster Thrombectomy Device, 7F (60cm, 120cm) <i>Note: The Hydrolyser 6F and 7F Mechanical Thrombectomy Catheters became effective 08/01/00. The Microvena Helix Clot Buster Thrombectomy Device became effective January 01, 2001.</i>
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) <i>Note: Only the Ventak Mini III HE+ and Ventak Mini III+ are effective 01/01/01. Ventak Mini IV, Ventak Mini III HE, and Ventak Mini III became effective 08/01/00.</i>
C1325	Brachytherapy seed, Theragenics Theraseed Palladium-103 seeds <i>Note: This became effective 08/01/00.</i>
C1364	Defibrillator, dual chamber, Photon DR V-230HV <i>Note: This became effective 08/01/00. This was previously listed as Photon DR V-230HV3.</i>
C1420	Anchor system, TransFix Bone Anchor System with Dermis, StapleTac2 Bone Anchor System with Dermis. <i>Name Change Alert. This was previously listed as follows: Anchor system, StapleTac2 Bone Anchor System with Dermis. Per confirmation from the manufacturer, this device is now sold under the trade name "TransFix Bone Anchor System with Dermis." Pass-through payment will be made for either the "TransFix Bone Anchor System with Dermis" or the "StapleTac 2 Bone Achor System with Dermis."</i>
C1421	Anchor system, TransFix Bone Anchor System without Dermis, Staple Tac2 Bone Anchor System without Dermis <i>Name Change Alert. This was previously listed as follows: Anchor system, StapleTac2 Bone Anchor System without Dermis. Per confirmation from the manufacturer, this device is now sold under the trade name "TransFix Bone Anchor System without Dermis." Pass-through payment will be made for either the "TransFix Bone Anchor System without Dermis" or the "StapleTac 2 Bone Achor System without Dermis."</i>
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) <i>Note: This became effective 10/01/00. The 16/18G Central Catheter, Dual Lumen may be reportable with either HCPCS code C2597 or C2599 but not both.</i>

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

C2598	Catheter, Clinicath Peripherally Inserted <i>Central</i> Catheter (PICC) <i>Single-Lumen</i> PolyFlow Polyurethane Catheter 18G/ 20G/24G (catheter and introducer), Clinicath Peripherally Inserted <i>Midline</i> Catheter (PICC) <i>Single-Lumen</i> PolyFlow Polyurethane Catheter 20G/24G (catheter and introducer) <i>Note: This became effective 10/01/00.</i>
C2599	Clinicath Peripherally Inserted Central Catheter (PICC) Single-Lumen PolyFlow Polyurethane Catheter 16G/18G/ 19G (includes catheter and introducer) <i>Note: This became effective 10/01/00. The 16/18G Central Catheter, Dual Lumen may be reportable with either HCPCS code C2597 or C2599 but not both.</i>
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 <i>Note: The Flexima Biliary Drainage Catheters became effective 10/01/00. The Angiodynamics Abscession Biliary Drainage Catheter became effective 01/01/01.</i>
C2703	Defibrillator, single chamber, implantable, Ventak Prizm VR HE Models 1852 , 1857 <i>Note: This was previously listed with model numbers 1857 and 1858.</i>
C2803	Defibrillator, dual chamber, implantable, Ventak Prizm DR HE Models 1853, 1858 <i>Note: This was previously listed with models 1852 and 1853.</i>
C3556	Guide wire, Endosonics Cardiometrics WaveWire Pressure Guide Wire, Cardiometrics FloWire Doppler Guide Wire, Radi Pressure Wire 3 Sensor
C4603	Lead, pacemaker, Oscor PR 4015, 4016, 4017, 4018, Flexion 4015, 4016, 4017, 4018
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
C5000	Stent, coronary , BX Velocity with Hepacoat on Raptor Stent System (28 or 33mm in length)
C5027	Stent, coronary , BX Velocity with Hepacoat on Raptor Stent System (8 or 13mm in length)
C5028	Stent, coronary , BX Velocity with Hepacoat on Raptor Stent System (18mm in length)
C5029	Stent, coronary , BX Velocity with Hepacoat on Raptor Stent System (23mm in length)
C5600	Vascular Closure Device, VasoSeal ES (Extravascular Security) Device, VasoSeal Vascular Hemostasis Device (previously listed with C-code C8504). <i>Note: The VasoSeal ES Device became effective 08/01/00. Effective 01/01/01, the VasoSeal Vascular Hemostasis Device (VHD) may be reportable with either HCPCS code C5600 or C8504 but not both.</i>
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, 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 <i>Name Change Alert. These became effective 08/01/00. This was initially listed as follows: Sling fixation system for treatment of stress urinary incontinence, Male Straight-In Fixation System with Electric Inserter with Sling Material and Disposable Pressure Sensor, Male Straight-In Fixation System with Electric Inserter without Sling Material and Disposable Pressure Sensor. Per confirmation from the manufacturer, these devices are currently sold under the trade name "AMS Male InVance Fixation System with Electric Inserter with or without Sling Material and Disposable Pressure Sensor."</i> Pass-through payment will be made for either the "AMS Male InVance Fixation System with Electric Inserter with or without Sling Material and Disposable Pressure Sensor," or the "Male Straight-In Fixation System with Electric Inserter with or without Sling Material and Disposable Pressure Sensor."
C8552	Catheter, Santoro Fixed Curve Catheter
C8890	Perfluoron, per 2ml
C8891	Perfluoron, per 5ml vial or 7ml vial
C9008	Baclofen Intrathecal Refill Kit, 0.5 mg/ml, 1x20 ml amp. <i>Note: This code became effective 10/01/00. We have only clarified the long descriptor for this code.</i>
C9009	Baclofen Intrathecal Refill Kit, 2 mg/ml, 2x5 ml amp. <i>Note: This code became effective 10/01/00. We have only clarified the long descriptor for this code.</i>
C9010	Baclofen Intrathecal Refill Kit, 2 mg/ml, 4x5 ml amp. <i>Note: This code became effective 10/01/00. We have only clarified the long descriptor for this code.</i>

Items No Longer Eligible for Pass-Through Payments

After further clinical analysis, the items listed below have been determined ineligible for pass-through payments. Therefore, **effective April 1, 2001**, the following items will no longer be eligible for pass-through payments and will no longer be recognized as valid reportable codes under the OPSS.

C8100 Adhesion barrier, ADCON-L

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.

Hospital Outpatient Prospective Payment System Pass-Through Payment Corrections for Two Radiopharmaceuticals

The purpose of this Program Memorandum (PM) is to correct the transitional pass-through payment amounts for the following two radiopharmaceuticals paid under the hospital outpatient prospective payment system: A9500, supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m sestamibi, per dose, and A9502, supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m tetrofosmin, per unit dose. The two radiopharmaceuticals were approved for pass-through payment effective for services furnished on or after August 1, 2000. (Refer to Transmittal No. A-00- 42 issued July 26, 2000.) The current payment amounts for these two radiopharmaceuticals, which are sold to hospitals and radiopharmacies in the form of multi-vial kits, were based on inaccurate or incomplete information submitted by the manufacturers regarding the number of doses available per vial. We have recently received corrected information regarding the number of doses as well as distribution methods from both manufacturers that warrants correcting the current payment amounts. Therefore, based on this corrected information, we are correcting the transitional pass-through payment amounts as shown below.

HCPCS Code	APC	Current Payment Amount	Corrected Payment Amount
A9500	1600	\$109.25	\$87.86
A9502	0705	\$136.80	\$106.04

Beneficiary copayment amounts for these codes are not affected by this correction. These changes will be effective for services furnished on or after January 1, 2001. The PRICER has been revised accordingly.

www.floridamedicare.com — Florida Medicare Provider Website

The following outlines information that is available as of January 2001 on the First Coast Service Options, Inc. (FCSO) Florida Medicare provider website.

What's New

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

Part A

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

Part B

- **Draft and Final LMRPs** - FCSO's final and draft Part B Local and Focused Medical Review Policies (LMRPs/FMRPs).
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- **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)

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Extra

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A

Abortion Services, Medicare Coverage of Feb/Mar 2000 11
 Advance Beneficiary Notices for Services for
 Which Institutional Part B Claims Are
 Processed by Fiscal Intermediaries Aug/Sep 2000 52
 Ambulance Services—
 Clarification of Medicare Policies
 Concerning Ambulance Services Apr/May 2000 6
 Questions & Answers Apr/May 2000 7
 Questions & Answers Dec 1999/Jan 2000 6
 Ambulatory Surgical Center (ASC) Payments,
 Update of Rates for Oct/Nov 2000 6
 Apligraf™ (Graftskin) Services, Billing for Feb/Mar 2000 10
 Assisted Suicide Funding
 Restriction Act of 1997 Aug/Sep 1999 5

B

Beneficiary Right to Itemized Statement for
 Medicare Items and Services Jun/Jul 1999 8
 Billing Guidelines for Influenza and
 Pneumococcal Pneumonia Vaccines Oct/Nov 1999 6
 Billing for Outpatient Services, Frequency of .. Jun/Jul 2000 5
 Blood Clotting Factor Administered to
 Hemophilia Inpatients, Payment for Jun/Jul 1999 113

C

Circulator Boot System Aug/Sep 2000 47
 Claim Expansion and Line Item Processing
 Implementation Jun/Jul 2000 5
 Claim Processing Requirement Modifications .. Oct/Nov 1999 16
 Clarification of Dialysis Coverage for
 Skilled Nursing Facility Residents Oct/Nov 1999 48
 Clinical Diagnostic Laboratory Organ or
 Disease Panels Feb/Mar 2000 8
 Clinical Diagnostic Laboratory Organ or
 Disease Panels - Revision to Policy Apr/May 2000 17
 Clinical Trials, Medicare Beneficiaries
 Participating in Medicare Qualifying Oct/Nov 2000 8
 Coding Information for Hospital Outpatient
 Prospective Payment System Oct/Nov 2000 56
 First Update to the Oct/Nov 2000 71
 Continuous Subcutaneous Insulin Infusion
 (CSII) Pump Coverage Feb/Mar 2000 8
 Consolidated Billing for Skilled Nursing
 Facilities Apr/May 2000 44
 Correct Coding Initiative—Two New Versions 1st Quarter 2001 17
 Correct Coding Initiative Apr/May 2000 16
 Cost Report Change, Reopenings for Sole
 Community and Medicare Dependent Hospital
 Open Cost Reports Affected by the Jun/Jul 1999 113
 Cost Reports, More Information About the
 Extension of Due Date for Filing Provider Jun/Jul 1999 9
 Coverage Expansion of Certain Oral
 Anti-Cancer Drugs to Include FDA Approved
 Oral Anti-Cancer Prodrugs Aug/Sep 1999 9

D

Deductible and Coinsurance for Calendar
 Year 2001, Medicare 1st Quarter 2001 6
 Deductible and Coinsurance for Calendar
 Year 2000, Medicare Feb/Mar 2000 5
 Description of OCE Edits/Claim Reasons Jun/Jul 2000 10
 Disclosure of Itemized Statement to an Individual
 for Items or Services Provided Jun/Jul 2000 6

E

Edits Requiring Providers to Submit Home
 Health Claims in Sequence, Removal of Jun/Jul 1999 6
 Electronic Health Care Transaction Formats,
 Adoption of Standard Oct/Nov 1999 46
 End of Grace Period for 2000 HCPCS
 Update Apr/May 2000 14
 End Stage Renal Disease Blood Pricing Feb/Mar 2000 13
 End Stage Renal Disease Drug
 Pricing Update Dec 1999/Jan 2000 32
 Pricing Update Aug/Sep 2000 60
 Enhanced External Counterpulsation (EECP) –
 Revision to Coverage and Billing Guidelines . Aug/Sep 1999 12
 Evacuation, Billing for Services During the
 Time of Apr/May 2000 52
 ESRD Claims Processed under Outpatient
 Prospective Payment System 1st Quarter 2001 12
 ESRD Facilities – Billing for Iron Dextran Jun/Jul 2000 68
 Extracorporeal Immunoabsorption (ECI)
 Using Protein A Columns 1st Quarter 2001 7

F

Factor VIIa (Coagulation Factor, Recombinant),
 Processing Guidelines for Dec 1999/Jan 2000 10
Fraud and Abuse:
 Caveat Emptor - Let the Buyer Beware Jun/Jul 2000 69
 DHHS Announces Expanded “Senior Patrol”
 Grants to Help Spot Waste, Fraud, and
 Abuse in Medicare and Medicaid Aug/Sep 1999 38
 Floridians Can Help Fight Medicare
 Fraud and Abuse Oct/Nov 1999 17
 Fraud and Abuse in the Medicare Program Feb/Mar 2000 15
 Office of Inspector General - Special
 Fraud Alert Apr/May 2000 47
 Reassignment of Benefits Aug/Sep 2000 70

H

HCFA Announces New Medicare Hospital
 Outpatient Payment System Jun/Jul 2000 7
 HCFA Promotes Eye Exams for Peoplee
 with Diabetes 1st Quarter 2001 8
 HCFA Web Site for Beneficiary
 Outreach Events Dec 1999/Jan 2000 8
 Health Care Related Web Sites Aug/Sep 1999 6
 Health Insurance Portability and Accountability
 Act (HIPAA), The 1st Quarter 2001 14
 Health Insurance Portability and Accountability
 Act (HIPAA) Web Site—Correction Dec 1999/Jan 2000 15
 Hemodialysis Flow Studies Aug/Sep 2000 69
 Hepatitis C Lookback, Qualified Candidates for ... Jun/Jul 1999 110
 Home Dialysis Method Election and Claim
 Processing, Clarification of Fiscal Intermediary
 and DMERC Responsibilities 1st Quarter 2001 11
 Home Health Agency, Fifteen-Minute
 Increment Reporting Update Aug/Sep 1999 39
 Hospital Services, Use of Modifiers
 for Reporting Dec 1999/Jan 2000 11
 Hospital Outpatient Radiology Service Fee
 Schedule Jun/Jul 2000 14

I

ICD-9-CM Coding Changes – Year 2001
 Medical Policy Changes relating to the
 2001 ICD-9-CM Update Oct/Nov 2000 53
 ICD-9-CM Coding Changes – Year 2001 Aug/Sep 2000 57
 ICD-9-CM Millennium Edition Feb/Mar 2000 7
 Immunosuppressive Drugs, Extension of
 Medicare Benefits for Feb/Mar 2000 8
 Implementation of Outpatient Prospective
 Payment System – Guidelines Revisions .. Aug/Sep 2000 5
 Implementation Guidelines of Outpatient
 Prospective Payment System for Multi-
 Purpose Hospital Outpatient Facilities Aug/Sep 2000 6
 Influenza Virus Vaccine Benefit,
 1999 Medicare Oct/Nov 1999 7
 Influenza Vaccine Benefit Questions &
 Answers, 1999 Medicare Oct/Nov 1999 7
 Influenza Vaccine Roster, 1999 Medicare Oct/Nov 1999 55
 “Inpatient Only” Code Changes,
 Interim Process for Certain Oct/Nov 2000 12
 Instructions for Cost Outlier Bills with
 Benefits Exhausted Dec 1999/Jan 2000 13
 Interest Rate for Overpayments and
 Underpayments, Notice of New Jun/Jul 1999 7
 Intermittent Catheterization,
 Clarification to Coverage of Dec 1999/Jan 2000 9
 Intrathecal Baclofen under the Outpatient
 Prospective Payment System, Proper
 Billing of Units for Oct/Nov 2000 12
 Is Your Office Ready to Process
 Claims in the Year 2000? Dec 1999/Jan 2000 15

L

Laboratory Tests and Venipunctures
 Performed in a RHC Jun/Jul 1999 114
 Line Item Date of Service Jun/Jul 1999 7
 Liver Transplant Centers,
 Addition to List of Approved Oct/Nov 1999 16
 Liver Transplantation (Adult),
 Clarification to Policy Apr/May 2000 19

M

Mammography Screening Payment Limit
 for Calendar Year 2001 1st Quarter 2001 5
 Medical Policy Changes Relating to the
 Outpatient Prospective Payment System .. Aug/Sep 2000 48
 Medicare Coverage of Noninvasive Vascular
 Studies when Used to Monitor the Access
 Site of End Stage Renal Disease (ESRD)
 Patients Aug/Sep 2000 68
 Medicare Contractors Applying Deductible,
 Coinsurance and Payment Updates
 Beginning January 10, 2000 Feb/Mar 2000 5
 Medicare Remarks Codes, Additions and
 Changes to the Jun/Jul 1999 9
 Millennium Rollover Year-End Claim
 Processing, Notification of Dec 1999/Jan 2000 5
 Modifiers for Reporting Outpatient Hospital
 Services, Addition to Apr/May 2000 41
 Modifier 25 in Reporting Hospital
 Outpatient Services, Further Information on
 the Use of Aug/Sep 2000 12

N

Need to Reprocess Inpatient or Hospice Claims
 in Sequence When Liability Changes Jun/Jul 1999 7
 New Electronic Mailing Listservs for Outpatient
 Prospective Payment Initiative Aug/Sep 2000 20
 New Form to Report Unsolicited/
 Voluntary Refund Checks Aug/Sep 1999 7
 New CLIA Waived Test Aug/Sep 2000 58
 New Waived Tests Jun/Jul 1999 110
 New Waived Tests Aug/Sep 1999 11
 New Waived Tests Apr/May 2000 17
 Noncovered Charges and Related
 Revenue Codes, Reporting of Feb/Mar 2000 7

O

Ocular Photodynamic Therapy (OPT) Oct/Nov 2000 7
 Ocular Photodynamic Therapy (OPT) Aug/Sep 2000 57
 Outpatient Code Editor Modifications for the
 Outpatient Prospective Payment System Jun/Jul 2000 8
 Outpatient Pathology Services under the
 Outpatient Prospective System, Proper
 Billing of 1st Quarter 2001 9
 Outpatient Prospective Payment System
 Initiative Questions and Answer Aug/Sep 2000 13
 Outpatient Prospective Payment System
 Initiative HCFA Website Aug/Sep 2000 20
 Outpatient Rehabilitation Medicare
 Fee Schedule, 2000 Feb/Mar 2000 16
 Overpayment Interest Rate 1st Quarter 2001 5
 Overpayment Interest Rate Oct/Nov 2000 6
 Overpayment Interest Rate Jun/Jul 2000 6
 Overpayment Interest Rate Apr/May 2000 14
 Overpayment Interest Rate Dec 1999/Jan 2000 8
 Overpayment Interest Rate Oct/Nov 1999 16
 Overpayment Refund Form Aug/Sep 1999 8

P

PAINREH: Pain Rehabilitation Oct/Nov 1999 41
 PAINREH: Pain Rehabilitation –
 Revision to Policy Feb/Mar 2000 20
 Payment of Skilled Nursing Facility Claims for
 Beneficiaries Disenrolling from Terminating
 Medicare+Choice (M+C) Plans Who Have
 Not Met the 3-Day Stay Requirement Oct/Nov 2000 14
 Jun/Jul 2000 67
 Implementation Rescinded by HCFA Aug/Sep 2000 51
 Physical Medicine –
 Clarification on Current Procedural
 Terminology (CPT) Coding Guidelines Apr/May 2000 12
 Pneumococcal Pneumonia Vaccine,
 Coverage Revision Jun/Jul 2000 12
 Pneumococcal Vaccine (PPV) Benefit,
 1999 Medicare Oct/Nov 1999 11
 Pneumococcal Vaccine (PPV) Benefit
 Questions & Answers, 1999 Medicare Oct/Nov 1999 12
 Pneumococcal Vaccine Roster,
 1999 Medicare Oct/Nov 1999 56
 Pre-Discharged Delivery of Durable Medical
 Equipment and Prosthetic and Orthotics
 Devices for Fitting and Training Apr/May 2000 42
 Promoting Influenza and
 Pneumococcal Vaccinations Aug/Sep 1999 7

P (continued)

Prospective Payment System—
 Assessment Indicators, Corrections 1st Quarter 2001 13
 Claim Expansion and Line Item Processing Apr/May 2000 8
 Comprehensive Outpatient Rehabilitation Facility Services, All Apr/May 2000 46
 Outpatient Rehabilitation Services and the Financial Limitation Aug/Sep 2000 7
 Outpatient Rehabilitation Services, Questions and Answers, Regarding Apr/May 2000 8
 Background, Outpatient Services Apr/May 2000 39
 Technical Corrections to Coding Information for Hospital Outpatient 1st Quarter 2001 15
 Workshops for Home Health Agencies Aug/Sep 2000 21
 Prostate Screening Billing Correction .. Dec 1999/Jan 2000 9
 Provider Billing Issues - Outpatient Rehabilitation Services Aug/Sep 2000 56
 Provider Y2K Testing— Myth Versus Reality Dec 1999/Jan 2000 16

R

Radiochemicals not Covered Jun/Jul 1999 110
 Reason Code, 30715 – The Common (but Avoidable) RTP Feb/Mar 2000 7
 Reclassification of Certain Urban Hospitals as Rural Hospitals – Application Procedures . Jun/Jul 2000 13
 Religious Nonmedical Health Care Institutions (RNHCIs), Services Provided in Apr/May 2000 15
 Remittance Advice Notice, Changes to the ... Oct/Nov 2000 6
 Reporting Of Noncovered Charges and Related Revenue Codes Aug/Sep 2000 51
 Requirement to Submit Bills in Sequence for a Continuous Inpatient Stay or Course of Treatment Jun/Jul 1999 6
 Reporting of Noncovered Charges and Related Revenue Codes – Change in Implementation Date Jun/Jul 2000 6
 Revision and Clarification of Final Rule on Ambulance Services Oct/Nov 1999 44
 Revisions to Previously Published Policies: 64573, 72192, 76075, J9000 Aug/Sep 1999 14

S

Sanctioned Provider Information Available on the Internet Aug/Sep 1999 6
 Dec 1999/Jan 2000 8
 Settlement Agreement – INNAMED Apr/May 2000 16
 Skilled Nursing Facility Adjustment Billing: Adjustments to HIPPS Codes Resulting from MDS Corrections Oct/Nov 2000 13
 SNF Prospective Payment Rates, Special Adjustment for Feb/Mar 2000 12
 Stem Cell Transplantation, Additional Coverage for Autologous 1st Quarter 2001 8
 Stem Cell Transplantation, Additional Coverage for Autologous Oct/Nov 2000 7
 Submitting, Processing, and Paying Medicare Claims in the Year 2000 Oct/Nov 1999 5

T

Timely Filing Guidelines for All Medicare A Providers 1st Quarter 2001 5
 Timely Filing Guidelines for All Medicare A Providers Aug/Sep 2000 49

T (continued)

Tips to Submit Medical Review Documentation After a Utilization Audit Apr/May 2000 15
 Transitional Corridor Payments Aug/Sep 2000 11
 Transmyocardial Revascularization (TMR) for Treatment of Severe Angina Jun/Jul 1999 109
 Two-Year Moratorium on Financial Limitation for Outpatient Rehabilitation Services Feb/Mar 2000 6

U

UPIN Directory Available on the Internet Apr/May 2000 16
 Urokinase (Abbokinase®) Shortage 1st Quarter 2001 7

W

Web Site for Prompt Payment Interest Rate, New Jun/Jul 2000 5
 Wheels of Justice Do Turn, The Dec 1999/Jan 2000 36
 Written Statement of Intent (SOI) to Claim Medicare Benefits Aug/Sep 2000 49

Y

Y2K Future Date Testing Available Aug/Sep 1999 5
 Y2K Outreach Toll-Free Line Implementation of HCFA Jun/Jul 1999 6
 Y2K Provider Readiness Survey Results Reveal Providers Have Some Work to Do . Aug/Sep 1999 5
 Y2K Readiness for PC-ACE™ Software Oct/Nov 1999 6
 Year 2000, Are You Ready for the Jun/Jul 1999 5

Procedure Codes

CPT Codes

Anesthesia/Surgery, 00100-69979

20974: Osteogenic Stimulator for Fracture Healing .. Jun/Jul 2000 12
 33216: Implantation of Automatic Defibrillators Jun/Jul 2000 16
 33223: Implantation of Automatic Defibrillators .. Oct/Nov 1999 19
 33246: Implantation of Automatic Defibrillators Jun/Jul 1999 107
 44388: Colonoscopy Oct/Nov 2000 18
 48554: Pancreas Transplantation Jun/Jul 1999 108
 48554: Revision to Pancreas Transplantation Coverage Jun/Jul 2000 12
 48554: Revision to Pancreas Transplantation Coverage Oct/Nov 1999 45
 53850: Prostate Treatments Jun/Jul 2000 18
 53850: Prostate Treatments Oct/Nov 1999 20
 59840, 59841, 59850-59852, 59855-59857, 59866: Elective Abortion Jun/Jul 1999 31
 61885, 64573, 64585, 64590, 64595, 95970, 95971, 95974, 95975: Vagus Nerve Stimulation Jun/Jul 1999 33
 62263: Percutaneous Lysis of Epidural Adhesions Jun/Jul 2000 65

Diagnostic Tests, 70010-89399

70450: Computerized Tomography Scans .. Aug/Sep 1999 15
 70541: Magnetic Resonance Angiography (MRA) Jun/Jul 2000 21
 70541: Magnetic Resonance Angiography (MRA) Aug/Sep 1999 18
 71010: Chest X-ray Aug/Sep 2000 24
 Addition to Policy 1st Quarter 2001 19
 72192-72194: Computed Tomography of the Pelvis Jun/Jul 1999 37

Diagnostic Tests, 70010-89399 (continued)

77336: Radiation Physics Consultation	Aug/Sep 2000	32
78472: Cardiac Blood Pool Imaging	Oct/Nov 2000	22
.....	Feb/Mar 2000	21
80100-80102: Qualitative Drug Screen	Oct/Nov 2000	25
.....	Jun/Jul 1999	44
82108: Aluminum	Jun/Jul 2000	25
82270: Fecal Occult Blood Testing	Jun/Jul 1999	47
82607: Vitamin B-12 (Cyanocobalamin) Assay	Feb/Mar 2000	24
82728: Serum Ferritin	Aug/Sep 2000	34
83540: Iron	Oct/Nov 2000	28
83735: Magnesium	Jun/Jul 2000	27
84153: Prostate Specific Antigen	Dec 1999/Jan 2000	20
84154: Free Prostate Specific Antigen	Jun/Jul 1999	52
84436: Thyroid Function Test	December 1999	29
84436: Thyroid Function Test - Revision to Policy	Feb/Mar 2000	20
84436: Thyroid Function Test - Revision to Policy	Apr/May 2000	21
84484: Troponin	Oct/Nov 2000	30
85044: Reticulocyte Count	Aug/Sep 1999	20
86235: Extractable Nuclear Antigen	Jun/Jul 1999	54
86706: Hepatitis B Surface Antibody and Surface Antigen	Oct/Nov 1999	23
86781: Fluorescent Treponemal Antibody Absorption (FTA-abs)	Aug/Sep 1999	21
87086: Urine Bacterial Culture	Dec 1999/Jan 2000	22
87621: Human Papillomavirus DNA Assay, Amplified Probe Technique	Jun/Jul 2000	30
Revision to Policy	Aug/Sep 2000	47
88142-88155, 88164-88167, G0123, G0143-G0145, G0147, G0148, P3000: Pap Smears	Jun/Jul 1999	56
88155: Pap Smears—Revision to Policy .	Dec 1999/Jan 2000	18
88230: Cytogenetic Studies	Oct/Nov 1999	27

Medicine, 90281-99199

90846, 90847, 90849: Family Psychotherapy ..	Jun/Jul 1999	61
92081-92083: Visual Field Examination	Jun/Jul 1999	64
92135: Scanning Computerized Ophthalmic Diagnostic Imaging	Aug/Sep 2000	36
92225, 92226: Ophthalmoscopy	Jun/Jul 1999	70
92235: Fluorescein Angiography	Jun/Jul 1999	74
92240: Indocyanine-Green Angiography	Jun/Jul 1999	78
93000: Electrocardiography	Aug/Sep 1999	22
93000: Electrocardiography - Revision to Policy	Apr/May 2000	21
93012, 93268, 93270, 93271, G0004-G0006, G0015: Patient Demand Single or Multiple Event Recorder	Jun/Jul 1999	84
93224-93227, 93231-93237: Holter Monitoring ...	Jun/Jul 1999	80
93268: Patient Demand Single or Multiple Event Recorder - Revision to Policy	Feb/Mar 2000	20
93303: Transthoracic and Doppler Echocardiography and Doppler Color Flow Velocity Mapping	Jun/Jul 2000	32
93333: Electrocardiography - Revision to Policy	Feb/Mar 2000	20
93501, 93510, 93511, 93514, 93524, 93527-93529, 93530-93533: Cardiac Catheterization	Jun/Jul 1999	89
93501: Cardiac Catheterization	Feb/Mar 2000	26
93501: Cardiac Catheterization - Revision to Policy	Apr/May 2000	21

Medicine, 90281-99199 (continued)

93875: Noninvasive Extracranial Arterial Studies	Oct/Nov 2000	33
.....	Oct/Nov 1999	29
93886: Transcranial Doppler Studies ...	Dec 1999/Jan 2000	24
93922: Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries	Apr/May 2000	22
93925: Duplex Scan of Lower Extremity Arteries	Feb/Mar 2000	30
93930: Duplex Scan of Upper Extremity Arterial By-pass Grafts	Feb/Mar 2000	32
93965: Noninvasive Evaluation of Extremity Veins	Feb/Mar 2000	33
93965: Noninvasive Evaluation of Extremity Veins	Aug/Sep 2000	39
93965: Noninvasive Evaluation of Extremity Veins - Addition to Policy	Apr/May 2000	21
93975-93979: Duplex Scanning	Jun/Jul 1999	95
94010: Spirometry	Jun/Jul 2000	37
94642: Aerosolized Pentamidine Isethionate	Aug/Sep 2000	41
94664: Diagnostic Aerosol or Vapor Inhalation	Dec 1999/Jan 2000	26
94760: Noninvasive Ear or Pulse Oximetry for Oxygen Saturation	Feb/Mar 2000	35
95004: Allergy Skin Test	Oct/Nov 2000	37
.....	Jun/Jul 2000	41
95115: Allegen Immunotherapy	Oct/Nov 2000	39
95930: Visual Evoked Potential (VEP) Testing ..	Feb/Mar 2000	37
95934: H-Reflex Study	Oct/Nov 2000	41
97016: Coverage and Billing Guidelines for Enhanced External Counterpulsation (EECP) ...	Jun/Jul 1999	108
99183: Hyperbaric Oxygen (HBO) Therapy	Jun/Jul 1999	101
Delay in Implementation of	Aug/Sep 1999	14
Delay in Coverage Policy	Apr/May 2000	21
Revision to National Policy	1st Quarter 2001	20

HCPCS Codes

A0320: Ground Ambulance Services	Jun/Jul 2000	43
A9270: Arthroscopic Laser Arthrodesis	Jun/Jul 2000	65
G0030-G0047, G0125, G0126, G0163-G0165: PET Scan	Jun/Jul 1999	13
G0102: Prostate Cancer Screening	Oct/Nov 2000	43
G0102-G0103: Coverage for Prostate Cancer Screening	Oct/Nov 1999	45
G0104: Colorectal Cancer Screening	Aug/Sep 1999	24
G0108: Diabetes Outpatient Self- Management Training	Feb/Mar 2000	39
G0160, G0161: Cryosurgery of Prostate	Jun/Jul 1999	107
G0160, G0161: Cryosurgical Ablation of the Prostate	Jun/Jul 1999	20
G0166: Enhanced External Counterpulsation	Dec 1999/Jan 2000	28
G0166: External Counterpulsation for Severe Angina - Revision to Policy	Apr/May 2000	17
J0001: Self-Administered Drugs	Oct/Nov 2000	45
J0205, J1785:Ceredase/Cerezyme	Jun/Jul 1999	22
J0207: Amifostine	Jun/Jul 2000	47
J0585: Botulinum Toxin Type A (Botox)	Oct/Nov 1999	32
J0850: Cytomegalovirus Immune Globulin (Human), Intravenous (CMV-IGIV)	Aug/Sep 1999	26
J1440: G-CSF (Filgrastim, Neopogen®)	Oct/Nov 2000	47
J1561: Intravenous Immune Globulin	Oct/Nov 1999	35
J1561: Intravenous Immune Globulin	Apr/May 2000	25

HCPSC Codes (continued)

J1745: Infliximab (Remicade™)	Aug/Sep 2000	43
J1950: Leuprolide Acetate	Oct/Nov 1999	39
.....	Oct/Nov 2000	45
J2355: Oprelvekin (Neumega®)	Dec 1999/Jan 2000	30
J2430: Pamidronate (Aredia®, APD)	Jun/Jul 2000	49
Addition to Policy	Aug/Sep 2000	47
J2792: Rho (D) Immune Globulin Intravenous	Jun/Jul 2000	51
J3240: Thyroprotin Alfa Thyrogen®)	Jun/Jul 2000	53
J7190: Hemophilia Clotting Factors	Jun/Jul 2000	55
J9000, J9170, J9350, J9999:		
Antineoplastic Drugs	Jun/Jul 1999	24
J9999: Antineoplastic Drugs	Jun/Jul 2000	57
J9999: Antineoplastic Drugs—Irinotecan		
(Camptosar®)— Addition to Policy	Oct/Nov 2000	53
J9999: Antineoplastic Drugs—		
Addition to Policy	Dec 1999/Jan 2000	19
L8614: Cochlear Device System—		
Correction to Fee Schedule	Apr/May 2000	16
M0302: Cardiac Output Monitoring by		
M0302: Cardiac Output Monitoring by		
Electrical Bioimpedance	Jun/Jul 1999	107
Q0136: Non-ESRD Epoetin (Procrit)	Oct/Nov 2000	50
Revision to Policy	1st Quarter 2001	19
Q0163-Q0181: Coverage Modification for		
Oral Antiemetic Drugs	Aug/Sep 1999	9
Q9920: Chronic Renal Failure		
Erythropoietin (Epogen)	Aug/Sep 1999	27
PHPPROG: Psychiatric Partial		
Hospitalization Program	Apr/May 2000	29

Special Bulletins

<i>Biomedical Equipment Year 2000 (Y2K)</i>	
<i>Compliance</i>	<i>August 9, 1999</i>
<i>HCFA Requires Mitigation Plans for Immediate</i>	
<i>PRO Review Requests During Possible</i>	
<i>Y2K-Induced Telecommunication</i>	
<i>Disruption</i>	<i>August 16, 1999</i>
<i>2000 HCFA Common Procedure Coding</i>	
<i>System and Medicare Outpatient</i>	
<i>Services</i>	<i>December 1999</i>
<i>2000 Outpatient Fee Schedule for Clinical</i>	
<i>Laboratory Services</i>	<i>February 25, 2000</i>
<i>Implementation of Outpatient Prospective</i>	
<i>Payment System</i>	<i>May 1, 2000</i>
<i>June 5, 2000 Implementation of Claim</i>	
<i>Expansion and Line Item Processing</i>	
<i>Initiative</i>	<i>*June 1, 2000</i>
<i>Implementation Delay Hospital Outpatient</i>	
<i>Prospective Payment System Initiative</i>	
<i>Effective August 1, 2000</i>	<i>*June 12, 2000</i>
<i>New Electronic Mailing Listservs for Outpatient</i>	
<i>Prospective Payment Initiative</i>	<i>*June 28, 2000</i>
<i>2001 ICD-9-CM Coding Update</i>	<i>*August 10, 2000</i>

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EMC Start-Up:

904-791-8767

Electronic Eligibility

904-791-8131

Electronic Remittance Advice

904-791-6865

Direct Data Entry (DDE) Support:

904-791-8131

PC-ACE Support

904-355-0313

Testing:

904-791-6865

Help Desk (Confirmation/Transmission)

904-905-8880

Medicare Websites

PROVIDERS

Florida Medicare Contractor

www.floridamedicare.com

Health Care Financing Administration

www.hcfa.gov

BENEFICIARIES

Florida Medicare Contractor

www.medicarefla.com

Health Care Financing Administration

www.medicare.gov



MEDICARE A BULLETIN

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