Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Special Issue...

Health Care Financing Administration

FIRST COAST SERVICE OPTIONS, INC.

A HCFA Contracted Carrier & Intermediary

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
- ☐ _____
- ☐ _____
- ☐ _____

INPATIENT HOSPITAL SERVICES

Clarification on Reporting Patient Status Code for Discharge Services to an Inpatient Rehabilitation Facility (IRF)

Section 4421 of the Balanced Budget Act (BBA) of 1997, as amended by the Balanced Budget Refinement Act (BBRA) of 1999, authorized the implementation of a prospective payment system (PPS) for inpatient rehabilitation facilities (IRFs) and inpatient rehabilitation units of a hospital.

The IRF PPS initiative is effective with **cost reporting periods beginning on or after January 1, 2002.**

As the IRF PPS initiative is being implemented, IRFs will continue to be reimbursed under the current reasonable cost based system until the facility transitions to a new cost reporting period beginning on or after January 1, 2002.

With the implementation of PPS for IRFs, transferring of a patient from an inpatient hospital to an IRF requires the facility that is billing for the patient discharge claim to use the appropriate patient status code. The reporting of this code may affect the reimbursement of the IRF claim. Prior to transferring the patient to an IRF, the hospital must determine if the IRF has transitioned to PPS.

- **If the IRF *has* transitioned to PPS,** then the hospital discharging the patient must report **patient status code 62** – discharged/transferred to another rehabilitation facility including rehabilitation distinct part units of a hospital.*
- **If the IRF has *not* transitioned to PPS,** then the hospital discharging the patient should continue to report **patient status code 05** – discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution.

For the purpose of the IRF PPS initiative, patient status code 02 – discharged/transferred to another short-term general hospital for inpatient care – is not a valid patient status code to be reported by the discharging hospital.

***Note:** The Centers for Medicare & Medicaid Services is in the process of revising the descriptor for patient status code 62. ❖

MEDICAL POLICIES

PulmRehab: Outpatient Pulmonary Rehabilitation Services in Chronic Respiratory Disease

Revision Overview: The Outpatient Pulmonary Rehabilitation Services in Chronic Respiratory Disease local medical review policy (LMRP) reflects the most current standards of care regarding pulmonary rehabilitation services for those patients with chronic respiratory disease. This policy replaces the existing LMRP for Pulmonary Rehabilitation Services – 94799 that was established in April 1998.

Policy Number
PulmRehab

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Outpatient Pulmonary Rehabilitation Services in Chronic Respiratory Disease

AMA CPT Copyright Statement

CMS National Coverage Policy
- Section 1862(a)(1)(A) of Title XVIII of the Social Security Act. This section excludes expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- Section 1833(e) of Title XVIII of the Social Security Act. This section prohibits Medicare payment for any claim, which lacks the necessary information to process the claim.
- Section 1835(a)(2)(c) of Title XVIII of the Social Security Act. This section addresses physician certification.
- CMS Publication 6, Medicare Coverage Issues Manual, Section 80-1 addresses patient education programs.
- CMS Publication 9, Medicare Outpatient Physical Therapy Provider Manual, Section 210.21 details Department of Labor pulmonary rehabilitation therapy services; Section 252 describes coverage of services rendered in CORF facilities; Section 253.3 defines respiratory therapy services.
- CMS Publication 10, Medicare Hospital Manual, Section 210.10(A) defines respiratory therapy services.
- CMS Publication 10, Medicare Hospital Manual, Section 282 outlines certification/recertification requirements for physical and occupational therapy services.
- CMS Publication 12, Medicare Skilled Nursing Facility Manual, Section 230.10(C) defines respiratory therapy services.
- CMS Publication 13, Medicare Intermediary Manual, Section 3101.10(A) defines respiratory therapy services.
- CMS Transmittal No. AB-00-39, May 1, 2000, consolidates CMS Program Memoranda for outpatient rehabilitation therapy services.
- CMS Transmittal Nos. AB-98-14 (April 1998) and A-99-5 (February 1999) address The National Institute of Health's National Emphysema Treatment Trial (NETT).

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
04/09/1998

Original Policy Ending Date
N/A

Revision Effective Date
04/22/2002

Revision Ending Date
04/21/2002

LMRP Description
Introduction:

Patients with diagnosed Chronic Respiratory Diseases have a progressive increase in the mechanical work of breathing and limited respiratory reserve capacities. These factors may lead to symptoms of chronic dyspnea on exertion, wheezing, chronic cough, and debilitating functional disabilities, which limit exercise and Activities of Daily Living (ADLs) due to chronic respiratory inflammation, edema, mucous plugging, hypoxemia, carbon dioxide retention, pulmonary hypertension, or cor pulmonale. Services to ameliorate these symptoms, improve functional capacity and enhance the effective management of pulmonary diseases may be provided through a physician directed, individualized plan of care using multidisciplinary qualified heath professionals.

PulmRehab: Outpatient Pulmonary Rehabilitation Services in Chronic Respiratory Disease (continued)

The goal of these services is not to achieve a maximum exercise tolerance, but to ultimately transfer the responsibility of treatment from the clinic, hospital, or doctor to self-care in the home by the patient, the patient's family, or the patient's caregiver. Unless the patient will be able to conduct ongoing self care at home, there will be only a temporary benefit. The endpoint of treatment, therefore, is not when the patient achieves maximal exercise tolerance or stabilizes, but when the patient or his or her caregiver is able to continue the treatment modalities at home. Treatment is individualized and supervised by the patient's attending physician (referring physician or facility Medical Director). Medicare does not cover services of a maintenance exercise program where a skilled therapist's services are not medically necessary.

Medicare beneficiaries may receive Pulmonary Rehabilitation (PR) services in the outpatient (OP) departments of acute hospitals and Comprehensive Outpatient Rehabilitation Facilities (CORFs).

PR services incorporate the following:

1. Assessment by the physician and multidisciplinary qualified health professionals.
2. Development of an individualized treatment program (Plan of Care).
3. Therapeutic exercise and activities including breathing retraining.
4. Bronchial hygiene and aerosol medications.
5. Activities of Daily Living (ADLs) training.
6. Clinical monitoring of the patient's pulmonary functioning during rehabilitation services.

Purpose:

The three primary objectives of PR services are:

1. To control, reduce, and alleviate the symptoms and pathophysiologic complications of chronic pulmonary diseases;
2. To train the patient how to reach the highest possible level of independent functioning for his/her Activities of Daily Living (ADLs) within the limitations of the pulmonary disease; and
3. To train the patient to self-manage his/her daily activities consistent with the functional impairments of his/her pulmonary disease process.

Indications and Limitations of Coverage and/or Medical Necessity

Indications for Pulmonary Rehabilitation (PR) Services:

Services must be reasonable and medically necessary. Patients who require PR treatment must meet all of the following criteria:

1. Diagnosis of a chronic, yet not acutely decompensated, respiratory system impairment that is under optimal medical management. (See "ICD-9-CM Codes That Support Medical Necessity");
2. Pulmonary Function Tests (PFTs) revealing DLCO, FVC or FEV1 <60% within one year of initiating PR services. If symptoms due to pulmonary disease are very disabling and significantly impair the patient's level of functioning, other objective evidence of impaired pulmonary physiology may be allowed on an individual consideration basis;
3. Exhibit symptoms such as breathlessness or fatigue that produce significant disability or handicap, as defined by the ATS Position Statement, 1999. Disability may include significant limitation of social activities, leisure, employment, home chores, or basic or instrumental activities of daily living or loss of personal independence;
4. Expectation of measurable improvement in a reasonable and predictable timeframe; and
5. Be physically able, motivated and willing to participate in PR.

Coverage of Services:

PR services are defined as those services that are medically necessary for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies and abnormalities of pulmonary function. **After the initial assessment is performed, treatments are usually administered three or more days a week. Such services are generally medically necessary for a period of six to ten weeks.**

A treatment program addressing pulmonary rehabilitative services generally occurs once in a lifetime. It is recognized that some patients, because of an exacerbation or new complications (e.g., disease worsening, beginning use of supplemental oxygen, chronic hypercapnia, respiratory failure, use of oxygen at night or non-invasive ventilation, etc.), may benefit from additional therapeutic encounters. Medical record documentation must support the need for the additional PR sessions.

All PR services must meet the following criteria:

1. Be ordered by a physician.
2. Qualify as a covered service.
3. Be reasonable and necessary for the diagnosis and/or treatment of a pulmonary illness listed below.
4. Be consistent with the nature and severity of the individual's symptoms and diagnosis.
5. Be reasonable in terms of procedure/modality, amount, frequency and duration and be part of an individualized physician directed Plan of Care.
6. Be generally accepted by the professional community as being a safe and effective treatment for the purpose used.
7. Be of a level of complexity, or the patient's condition must be such, that the services can be rendered only by a skilled clinician.
8. Be delivered by qualified health professionals in accordance with state and federal regulations.
9. Patient training may occur in groups of four (4) conducted by a qualified health professional or groups of six if an assistant is also present.
10. Not exceed the patient's particular PR needs.

PulmRehab: Outpatient Pulmonary Rehabilitation Services in Chronic Respiratory Disease (continued)

11. Promote recovery, restore function, and ensure safety affected by illness or injury.
12. Have an expectation that there will be measurable improvement of the patient's condition in a reasonable and generally predictable period of time, and
13. Demonstrate practical improvement as evidenced by increased exercise tolerance, improved Activities of Daily Living (ADL's), and decreased symptoms (e.g., cough, dyspnea, wheezing).

Physician Orders and Certification:

A licensed physician*, who has training and experience in the treatment of patients with pulmonary disease will order, supervise, guide, and direct each patient's PR plan of care. All treatment orders for PR therapies must include the following:

1. Be specific as to type, frequency, and duration of the procedure, modality, activity and individualized for the patient.
2. Verbal and telephone orders must be co-signed and dated by the physician prior to billing the claim.
3. A blanket pulmonary rehabilitation (PR) order is not acceptable.

The patient's attending physician (referring physician or facility Medical Director) will attest to the following prior to the initiation of PR services:

1. That a physical examination performed within the last ninety (90) days indicates that the patient is capable of participating in the plan of care.
2. That the patient is willing to cooperate and participate in the plan of care.
3. That the patient has quit smoking or will participate in smoking cessation activities prior to or during the course of PR services.

For Physical Therapy (PT) and Occupational Therapy (OT) services billed under revenue codes 42x and 43x in a hospital outpatient setting, the initial order will serve as certification for the first thirty days. Thereafter, recertification for OT and PT services is required every thirty days. If the patient is still receiving PR services in a hospital outpatient setting beyond thirty days, the physician must document that the patient remains capable of participation and continues to benefit from the services.

All services rendered to Medicare beneficiaries in Comprehensive Outpatient Rehabilitation Facilities (CORFs) must be certified by a physician prior to initiation of those services and must be recertified at intervals of at least once every 60 days.

In the hospital outpatient setting, PR services may be ordered by non-physicians (i.e., Physician Assistants, Advanced Registered Nurse Practitioners, or Clinical Nurse Specialists).

Typical Components of Pulmonary Rehabilitation Services:

PR services use a physician-directed multidisciplinary approach with Respiratory Therapists (RTs), Registered Nurses (RNs), Physical Therapists (PTs), Occupational Therapists (OTs), and other qualified personnel, and may include any combination of these services. A duplication of services occurs when there is a direct overlap of services, or where a single discipline can provide the care. When there is an order for the same treatment modality or procedure for multiple clinicians (e.g., therapeutic exercise, breathing retraining), each clinician is expected to provide skilled treatment that reflects his or her unique skills and knowledge without exceeding the patient's skilled care needs. The treatment is directed toward each clinician's patient-specific goals. This is critical to establish that the services provided by various disciplines are reasonable, necessary, and distinct from each other. Frequency, duration, goals, and measurable objectives of each service provided are to be clearly documented.

The primary components of PR services typically include the following:

1. Assessment/Reassessment (CPT codes 97001, 97002, 97003, or 97004). An initial evaluation by rehabilitation personnel is required. Components of this assessment include the patient history, relevant review of systems, pertinent physical assessment and tests/measurements, and the reason for the initial referral

   It will also include determination of functional limitations, assessment of strength, flexibility, posture, and gait, and determination of the initial intensity for exercise training. This should include a history and physical examination by a physical/occupational therapist. An assessment, determination of goals, and therapeutic prescription for strength, flexibility, posture, and gait should be completed. Only one initial evaluation for PR services will be reimbursed per patient. Re-evaluations are covered only if the documentation shows significant change in the patient's condition that supports the need to perform a formal re-evaluation of the patient's status.

   Routine screening and evaluations during admission to care, and routine re-evaluations are not covered.

2. **Education/Instruction (CPT code 97535):** Education and instruction are key components of training the patient for independent, or modified, self-care and to maximize his or her rehabilitation potential. The patient, and his or her family or caretakers, should have a basic understanding of the specific therapeutic interventions they will be asked to follow. Patient education and instruction must:

   - be individualized to the patient's specific medical needs as identified in the initial assessment(s);
   - be part of the therapy treatment session;
   - be reasonable and necessary for the treatment and effective management of the patient's illness; and
   - not exceed the patient's need.

For example, while it is recognized that general pathology of respiratory illnesses may be of interest to patients, such generalized knowledge is not essential to the effective management of a patient's particular condition, and would be considered excessive. However, when education

PulmRehab: Outpatient Pulmonary Rehabilitation Services in Chronic Respiratory Disease (continued)

is directed to the patient specific respiratory illness, education about the illness may be necessary to help the patient understand the medical need for compliance with his or her medications and treatment program including compensatory breathing techniques. Individualized instruction and training in the proper and effective use of bronchial hygiene therapy, effective coughing techniques, oxygen therapy, aerosol medications, and respiratory care equipment are frequently components of the rehabilitation process. Clinicians must document the patient's carry over of education, instruction, and training into his or her daily activities.

In order to be covered by Medicare, patient education services must be rendered via direct, one-on-one contact with the clinician. For example, viewing of films or videotapes, listening to audiotapes, and completing interactive computer programs do not qualify as covered PR services. Likewise, group sessions that only offer generalized (i.e., non-individualized) education and training are not covered.

3. **Therapeutic Procedures to Improve Respiratory Function (HCPCS codes G0238 and G0239):** An individualized physical conditioning and exercise program using proper breathing techniques, and a home functional maintenance program (FMP), should be considered for any patient with exercise limitations.

   The objectives of exercise training are to: 1) advance the intensity and duration of exercise as tolerated by the patient and 2) assure the patient's understanding of the nature and role of continued lifelong exercise. Clinicians must clearly document the rationale for continued skilled intervention for any exercise program. Routine exercise, or any exercise, without a documented need for skilled care, is not covered.

4. **Bronchial Hygiene/Aerosol Medications (CPT codes 94640, 94664, 94665, 94667, and 94668).** These diagnostic and therapeutic procedures are not routinely rendered to all patients receiving PR services. Documentation in the medical record must support the medical necessity for the individual services for the particular patient receiving these services.

5. **Therapeutic Procedures to Increase Strength or Endurance of Respiratory Muscles (HCPCS code G0237):** When problems with strength or endurance of respiratory muscles are identified in the initial assessment, an individualized program of exercise and ADLs (using compensatory techniques, breathing retraining, and energy conservation) may be reasonable and necessary. Breathing retraining, energy conservation, and relaxation techniques are often used.

   Inspiratory muscle resistance training (IMT) may be considered reasonable and necessary in a very select population of pulmonary patients who demonstrate significantly decreased respiratory strength and who remain symptomatic despite optimal therapy.

6. **Psychological Services:** Psychological services are **not** routinely reasonable or necessary; the research to date does not support the benefits of short-term psychological interventions for PR therapy patients. Medically necessary psychological services of physicians, clinical psychologists, clinical nurse specialists, advanced registered nurse practitioners, and licensed clinical social workers are billed to the carrier.

Plan of Care:

An individualized plan of treatment is developed for each patient based on the identified problems. All treatment orders for PR services must be specific as to the type, frequency, and duration of activity. The treatment orders must specify which clinicians will render the services that are unique to their area of expertise. The treatment plan must be reasonable and directed at achieving specific goals established for each patient. Specific goals must be individualized to each patient's specific needs and capabilities, stated in objective, measurable, functional terms, and developed mutually by the patient and clinical team. Clinicians should specify the time frame, or target date for achievement, for both short-term and long-term goals. The discharge plan is an integral part of the plan of care. The discharge plan is addressed from the start of care. An important part of the discharge plan is a post-discharge functional maintenance program (FMP) that the clinicians develop for the patient during the course of PR services.

Discharge Criteria and Follow-Up:

A patient should be discharged from PR services when the documentation shows any of the following:

1. The PR treatment goals are achieved or the patient has reached maximum medical benefit;
2. There is minimal or no potential for further significant progress;
3. The patient is non-compliant with the established plan of care; and/or
4. The patient no longer requires skilled PR services (See "Coverage of Services").

If the patient's condition changes, new components of PR treatment may be ordered for the patient. If new components are repetitive of prior services rendered, documentation must support the need for such additional service. Under the Medicare Program, it is not considered reasonable or necessary for clinicians to routinely screen patients for a potential need for skilled services.

CPT/HCPCS Section & Benefit Category

Medicine/Pulmonary/Physical Medicine and Rehabilitation

Type of Bill Code

Hospital – 13x
Comprehensive Outpatient Rehabilitation Facility – 75x
Critical Access Hospital – 85x

Revenue Codes

41x Respiratory Services
42x Physical Therapy
43x Occupational Therapy
46x Pulmonary Function

CPT/HCPCS Codes

94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

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94060	Bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator (aerosol or parenteral)
94640	Nonpressurized inhalation treatment for acute airway obstruction
94664	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation
94665	subsequent
94667	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation
94668	subsequent
94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination
94761	multiple determinations (eg, during exercise)aration, safety procedures, and instructions in use of assistive technology devices/ adaptive equipment) direct one-on-one contact by provider, each 15 minutes
G0237	Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)
G0238	Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)
G0239	Therapeutic procedures to improve respiratory function, other than services described by G0237, two or more (includes monitoring)

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

The following are acceptable medical diagnoses for patients receiving PR services:

135	Sarcoidosis
277.00	Cystic fibrosis without mention of meconium ileus
491.0-491.8	Chronic bronchitis
492.8	Other emphysema
493.00-493.92	Asthma
494.0-494.1	Bronchiectasis
496	Chronic airway obstruction (COPD), not elsewhere classified
500	Coal workers' pneumoconiosis
501	Asbestosis
502	Pneumoconiosis due to other silica or silicates
503	Pneumoconiosis due to other inorganic dust
504	Pneumonopathy due to inhalation of other dust
505	Pneumoconiosis, unspecified
506.4	Chronic respiratory conditions due to fumes and vapors
508.1	Chronic and other pulmonary manifestations due to radiation
515	Postinflammatory pulmonary fibrosis
516.0	Pulmonary alveolar proteinosis
516.2	Pulmonary alveolar microlithiasis
516.3	Idiopathic fibrosing alveolitis
516.8	Other specified alveolar and parietoalveolar pneumonopathies
518.89	Other diseases of lung, not elsewhere classified
519.00-519.9	Other diseases of respiratory system
V42.6	Lung replacement by transplant

This policy does not apply to those individuals in the National Institute of Health National Emphysema Treatment Trial (NETT). Those individuals are covered under NETT.

It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM code listed above does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in the policy.

Diagnoses that Support Medical Necessity

N/A

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

N/A

Diagnoses that DO NOT Support Medical Necessity

N/A

Reasons for Denials

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

Pulmonary rehabilitation services will be denied for:

1. PR services to a patient who would be expected to spontaneously return to his or her prior level of function without skilled therapeutic intervention.
2. Services for maintenance of a chronic baseline condition or functional level.
3. Patients with acute and/or unstable disease.
4. Patients incapable of participating in PR due to mental or physical limitations.
5. Patients where documentation does not support measurable benefit.
6. Patients who are unable or unwilling to use training.
7. Patients who continue to smoke and refuse a smoking cessation program.

Non-Covered Services:

1. Non-individualized (i.e., generalized) treatment, education and training.
2. Routine psychological screening and/or routine psychological therapy.
3. Duplication of services between occupational therapists, physical therapists, respiratory therapists, and/or registered nurses.

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4. Treatment that exceeds the patient's needs for the identified condition.
5. Routine, non-skilled and/or maintenance care, such as:
   - repetitive services for chronic baseline conditions
   - plateau in patient's progress toward goals
   - inability to sustain gains
   - no overall improvement
   - generalized exercise
6. Services delivered to patients who have poor rehabilitation potential, as evidenced by poor motivation to quit smoking and/or failure to meet indicators listed above for participation in PR services.
7. Treatment that is not reasonable and necessary due to a lack of significant objective findings in preliminary pulmonary diagnostic testing.
8. Therapy groups with greater than six (6) patients and/or that are not individualized to each patient's goals.
9. Routine follow-up visits.
10. Viewing of films or videotapes; listening to audio tapes; completing interactive computer programs; any supervised or independent technology-based instruction.

Exclusions:

The following are excluded from coverage under the Medicare Program and are not reimbursable directly or indirectly:

1. Exercise equipment or supplies.
2. Biofeedback services for relaxation.
3. General education and training not related to the patient's illness.

Noncovered ICD-9-CM Codes

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

General Information:

- Each clinician's services are billed separately for the modalities or procedures delivered.
- Itemize the UB-92 by discipline using Revenue Code 41x, 42x, 43x, and 46x, Date of Service, HCPCS/CPT Codes, and Units.
- Each treatment procedure or modality billed must match the documentation in the daily therapy notes.
- A global daily billing fee is not acceptable.
- Effective 01/01/2000, procedure codes 94760 and 94761 are considered bundled services and, therefore, are not separately reimbursable when billed with other physician fee schedule services by the same provider on the same day. CPT codes 94760 and 94761 are packaged in accordance with OP PPS implementation. Separate reimbursement cannot be made for dates of service on or after August 1, 2000.

For 41x, use HCPCS/CPT Codes as follows:

97535 Self care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one-on-one contact by provider, each 15 minutes

G0237 Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)

G0238 Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)

G0239* Therapeutic procedures to improve respiratory function, other than services described by G0237, two or more (includes monitoring)

*G0239 is to be billed only once per day.

For 42x and 43x, use HCPCS/CPT Codes as follows:

97001 Physical therapy evaluation

97002 Physical therapy re-evaluation

97003 Occupational therapy evaluation

97004 Occupational therapy re-evaluation

97535 Self care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one-on-one contact by provider, each 15 minutes

G0237 Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)

G0238 Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)

G0239* Therapeutic procedures to improve respiratory function, other than services described by G0237, two or more (includes monitoring)

*G0239 is to be billed only once per day.

- Physical therapy evaluation (code 97001) and re-evaluation (code 97002) are to be billed with revenue code 424.
- Occupational therapy evaluation (code 97003) and re-evaluation (code 97004) are to be billed with revenue code 434.
- For revenue codes 42x and 43x, providers are required to report one of the following modifiers to distinguish the type of therapist who performed the service, or if the services was not delivered by a therapist, the discipline of the plan of treatment under which the service is delivered should be reported:

  GO Service delivered personally by an occupational therapist or under an outpatient occupational therapy plan of care; or

  GP Service delivered personally by a physical therapist or under an outpatient physical therapy plan of care.

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For 46x, use CPT/HCPCS codes as follows**:

94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
94060 Bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator (aerosol or parenteral)
94640 Nonpressurized inhalation treatment for acute airway obstruction
94664 Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation
94665 subsequent
94667 Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation
94668 subsequent
94760 Noninvasive ear or pulse oximetry for oxygen saturation; single determination
94761 multiple determinations (eg, during exercise)

** The above diagnostic and therapeutic codes are not routinely rendered to all patients receiving PR services. Documentation in the medical record must support the medical necessity for the individual services for the particular patient receiving these services. Please refer to applicable existing Local Medical Review Policies (LMRPs) for coverage requirement information and applicable ICD-9-CM codes regarding these procedure codes.

Documentation Requirements

Initial Assessment/Evaluation:

The initial evaluation will identify the problems, develop a specific plan of treatment, and set specific goals. The assessment should include the following information:

1. Physician's evaluation of the history of the respiratory illness, patient's rehabilitation potential, treatment diagnosis, and any relevant secondary diagnoses.
2. Physician's review of recent pulmonary function tests, arterial blood gases, treadmill stress tests, or other relevant tests as indicated for a particular patient.
3. Review of any other diagnostic tests necessary to identify the patient's specific pulmonary need and potential for rehabilitation.
4. Past medical history, including any prior PR services.
5. Prior functional level (at baseline, or before the most recent exacerbation of the respiratory illness).
6. Psychosocial status. Patients with rehabilitation potential will have sufficient motivation, willingness, and cognitive skills to fully participate in his or her rehabilitation process. This includes a carry over of learned skills to make lifestyle changes.
7. Identification of specific problems and functional deficits in performing activities, tasks, or ADLs. These problems must be described in measurable, objective, and functional terms. These identified problems must be amenable to skilled therapy in order for these services to be medically necessary.
8. The patient's rehabilitation potential must be documented in measurable terms.

Daily Notes:

Clinicians are required to document all activities, tasks, instruction, and treatment rendered. This documentation must be done each time the patient receives any PR service. The content of this documentation is more important than the format. The clinician must include the following with each daily note:

1. The treatment time, procedure or modality, date of service, signature, and clinician's credentials.
2. Notes that match the revenue codes, CPT and/or HCPCS codes, units, and charges billed on the UB-92 (see "Coding Guidelines").
3. Content that addresses each individual patient's specific response to treatment, progress toward the stated goals, and the rationale for the continued need of the unique skilled PR services.

Specific documentation of progress toward the stated goals would include patient demonstration of proper breathing techniques, proper cleaning procedure of respiratory equipment, proper self-administration of aerosol medication, increasing exercise tolerance with effective use of compensatory breathing skills, and carry over of learned activities to specific goals in the home and community. The documentation should reflect when the patient reaches each goal.

All documentation must demonstrate clinical rationale for skilled intervention. Clinicians are required to document all activities, tasks, instruction, and treatment provided. This documentation must be done each time the patient receives any PR service.

The patient's medical record must contain documentation that fully supports the medical necessity for Pulmonary Rehabilitation services as covered by Medicare (see "Indications and Limitations of Coverage and/or Medical Necessity"). This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Utilization Guidelines

N/A

Other Comments

Administrative Costs:

The following costs are not covered separately; they are considered indirect costs of providing PR services:

1. Teaching and education done by a pharmacist or dietitian;
2. General nutritional counseling;
3. Medical social services;
4. Team and/or family conferences;
5. Documentation time;

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6. Discharge summaries; and
7. Educational books, pamphlets, audio/video tapes, CDs, DVDs, other computer software, or any other materials not considered medical supplies.

Limitation of liability and refund requirements apply when denials are based on medical necessity. They do not apply when the test, item or procedure is done for screening purposes. The provider must notify the beneficiary if the provider is aware that Medicare may not cover the test, item or procedure.

Sources of Information and Basis for Decision

American Thoracic Society (ATS), Pulmonary Rehabilitation. (1999). *American Journal of Respiratory Critical Care Medicine*, 159, 1666-1682. Eligibility criteria in our policy have been drawn from this ATS Position Statement.

The National Institute of Health, National Emphysema Treatment Trial (NETT) Manual, Sections 4.3.4 - 4.3.6, September 1999. The components of PR services and the usual duration of those services noted in our policy reflect those found in the NETT Manual.

Advisory Committee Notes

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

Start Date of Comment Period

08/17/2001

End Date of Comment Period

10/01/2001

Start Date of Notice Period

02/28/2002

Revision History

Revision Number	5
Start Date of Comment Period	08/17/2001
Start Date of Notice Period	02/28/2002 February 2002 Special Issue *Bulletin*
Revised Effective Date	04/22/2002

Explanation of Revision: Multiple revisions were made to the policy. Therefore, notice and comment was required. Complete deletion of existing A94799 Pulmonary Rehabilitation Services policy.

Revision Number	4
Start Date of Comment Period	N/A
Start Date of Notice Period	10/01/2000 Oct-Nov 2000 *Bulletin*
Revised Effective Date	10/01/2000

Explanation of Revision: Annual ICD-9-CM Update.

Revision Number	3
Start Date of Comment Period	N/A
Start Date of Notice Period	02/25/2000 Special Issue 2000 Bulletin
Revised Effective Date	08/01/2000

Explanation of Revision: Outpatient PPS Implementation.

Revision Number	2
Start Date of Comment Period	N/A
Start Date of Notice Period	10/01/1998
Revised Effective Date	

Explanation of Revision: 1999 ICD-9-CM Update.

Revision Number	1
Start Date of Comment Period	N/A
Start Date of Notice Period	06/17/1998
Revised Effective Date	08/01/1998

Explanation of Revision: Policy has been revised to update ICD-9-CM codes 277.0, 493.0-493.9, and 495 to highest level of specificity.

Revision Number:	Original
Start Date of Comment Period:	11/01/1997
Start Date of Notice Period:	02/23/1998
Original Effective Date	04/09/1998 ❖

2002 Outpatient Services Fee Schedule

Outpatient Medicare Services Fee Schedule for 2002

The Centers for Medicare & Medicaid Services (CMS) in conjunction with the Medicare Part B carrier, develops the Medicare Part A annual outpatient fee schedule. The fee schedule reimbursement amounts published in this bulletin are effective for services furnished **on or after January 1, 2002.** CMS extends a 90-day grace period where either 2001 or 2002 HCPCS codes are accepted.

Effective January 1, 2002 through March 31, 2002, providers may use either the 2001 or the 2002 HCPCS codes. **Effective April 1, 2002,** only the 2002 HCPCS codes will be accepted by Medicare.

Fee Schedule Lists

The following fee schedule reimbursement amounts are included in this publication:

- Surgical Dressings
- Orthotic/Prosthetic Devices

Surgical dressings, and orthotic and prosthetic devices are reimbursed based on the standard fee schedule for the state of Florida. All providers are reimbursed at the same fee scheduled allowance for these services, regardless of geographical location. ❖

Surgical Dressing Fee Schedule

CODE/MD	FEE	CODE/MD	FEE	CODE/MD	FEE	CODE/MD	FEE	CODE/MD	FEE
A4460	1.00	A6202	34.50	A6222	2.11	A6241	2.54	A6257	1.51
A4462	3.25	A6203	3.31	A6223	2.39	A6242	6.00	A6258	4.25
A6010	30.62	A6204	6.16	A6224	3.57	A6243	12.18	A6259	10.82
A6021	20.79	A6207	7.26	A6229	3.57	A6244	38.85	A6263	0.29
A6022	20.79	A6209	7.40	A6231	4.61	A6245	7.19	A6264	0.48
A6023	188.23	A6210	19.70	A6232	6.81	A6246	9.81	A6265	0.12
A6024	6.12	A6211	29.05	A6233	18.98	A6247	23.52	A6266	1.90
A6154	13.78	A6212	9.59	A6234	6.47	A6248	16.06	A6402	0.12
A6196	7.27	A6214	10.18	A6235	16.64	A6251	1.97	A6403	0.43
A6197	16.26	A6216	0.05	A6236	26.95	A6252	3.21	A6405	0.33
A6199	5.23	A6217	**	A6237	7.82	A6253	6.27	A6406	0.79
A6200	9.40	A6219	0.94	A6238	22.54	A6254	1.20		
A6201	20.57	A6220	2.55	A6240	12.11	A6255	3.00		

Orthotic/Prosthetic Fee Schedule

CODE/MD	FEE	CODE/MD	FEE	CODE/MD	FEE	CODE/MD	FEE	CODE/MD	FEE
A4214	1.73	A4325	1.78	A4352	5.40	A4370	3.39	A4386	6.65
A4280	4.93	A4326	10.67	A4353	6.91	A4371	3.61	A4387	3.97
A4290	138.29	A4327	41.81	A4354	9.92	A4372	4.13	A4388	4.31
A4310	6.49	A4328	9.75	A4355	7.49	A4373	6.21	A4389	6.15
A4311	12.48	A4330	7.07	A4356	45.13	A4374	8.35	A4390	9.51
A4312	17.84	A4331	3.15	A4357	9.59	A4375	16.99	A4391	6.99
A4313	15.57	A4332	0.12	A4358	6.56	A4376	47.06	A4392	6.57
A4314	21.26	A4333	2.18	A4359	28.69	A4377	4.24	A4393	9.07
A4315	22.19	A4334	4.88	A4361	18.17	A4378	30.42	A4394	2.55
A4316	23.88	A4338	12.13	A4362	3.35	A4379	14.86	A4395	0.05
A4319	6.26	A4340	31.40	A4363	3.89	A4380	36.92	A4396	40.04
A4320	5.27	A4344	15.85	A4364	2.59	A4381	4.56	A4397	4.09
A4321	1.99	A4346	19.38	A4365	11.20	A4382	24.35	A4398	13.66
A4322	2.79	A4347	17.11	A4367	7.27	A4383	27.88	A4399	12.13
A4323	7.96	A4348	27.53	A4368	0.26	A4384	9.52	A4400	41.09
A4324	2.15	A4351	1.79	A4369	2.39	A4385	5.04	A4402	1.40

** Pricing for this code not established at printing time.

Orthotic/Prosthetic Devices Fee Schedule (continued)

CODE/MD	FEE	CODE/MD	FEE	CODE/MD	FEE	CODE/MD	FEE	CODE/MD	FEE
A4404	1.67	L0150	93.20	L0978	143.33	L1834	710.07	L2200	35.40
A4454	2.58	L0160	132.69	L0980	13.00	L1840	746.41	L2210	57.45
A4455	1.20	L0170	561.53	L0982	14.16	L1843	718.36	L2220	65.95
A4481	0.37	L0172	113.86	L0984	45.20	L1844	1244.75	L2230	57.13
A4483	**	L0174	204.54	L0986	111.20	L1845	749.90	L2240	62.27
A4561	19.01	L0180	278.18	L1000	1511.64	L1846	939.88	L2250	264.57
A4562	47.26	L0190	418.74	L1005	2562.47	L1847	460.49	L2260	149.26
A4622	56.65	L0200	384.50	L1010	60.87	L1850	214.32	L2265	87.68
A4623	6.48	L0210	39.91	L1020	83.17	L1855	917.08	L2270	39.99
A4625	6.85	L0220	91.19	L1025	94.53	L1858	1007.89	L2275	97.29
A4626	2.69	L0300	150.54	L1030	63.15	L1860	831.25	L2280	361.45
A4629	4.58	L0310	281.32	L1040	76.02	L1870	854.28	L2300	204.03
A5051	2.16	L0315	195.80	L1050	65.83	L1880	527.00	L2310	91.60
A5052	1.65	L0317	265.63	L1060	74.24	L1885	828.46	L2320	153.19
A5053	1.66	L0320	306.01	L1070	75.90	L1900	225.19	L2330	292.36
A5054	1.66	L0321	327.38	L1080	52.59	L1902	61.16	L2335	171.99
A5055	1.42	L0330	383.66	L1085	146.11	L1904	350.13	L2340	405.86
A5061	2.68	L0331	381.67	L1090	68.25	L1906	102.31	L2350	663.45
A5062	2.07	L0340	611.28	L1100	120.48	L1910	199.11	L2360	38.53
A5063	2.15	L0350	851.35	L1110	204.07	L1920	260.30	L2370	191.14
A5071	3.66	L0360	1256.20	L1120	32.51	L1930	176.14	L2375	84.13
A5072	2.96	L0370	342.86	L1200	1293.97	L1940	398.05	L2380	91.66
A5073	2.71	L0380	481.18	L1210	194.82	L1945	730.98	L2385	99.73
A5081	3.26	L0390	1060.22	L1220	64.95	L1950	554.59	L2390	81.50
A5082	10.00	L0391	499.51	L1230	423.25	L1960	412.71	L2395	124.44
A5093	1.93	L0400	1215.39	L1240	72.84	L1970	610.41	L2397	87.27
A5102	22.33	L0410	1417.12	L1250	71.72	L1980	273.26	L2405	69.81
A5105	34.27	L0420	1403.83	L1260	73.70	L1990	351.10	L2415	97.25
A5112	34.24	L0430	1113.63	L1270	73.60	L2000	755.20	L2425	114.75
A5113	4.65	L0440	908.21	L1280	65.62	L2010	688.44	L2430	114.75
A5114	7.97	L0500	112.21	L1290	74.40	L2020	869.39	L2435	135.35
A5119	10.73	L0510	228.43	L1300	1243.74	L2030	754.28	L2492	75.92
A5121	6.27	L0515	136.27	L1310	1279.82	L2035	138.69	L2500	234.89
A5122	12.71	L0520	335.14	L1500	1414.28	L2036	1381.41	L2510	628.90
A5123	4.77	L0530	308.47	L1510	894.73	L2037	1273.06	L2520	343.00
A5126	1.11	L0540	332.89	L1520	2125.14	L2038	1064.53	L2525	1176.79
A5131	13.34	L0550	998.93	L1600	95.95	L2039	1779.27	L2526	634.29
A5200	11.17	L0560	1093.00	L1610	32.69	L2040	135.97	L2530	174.94
A7501	103.89	L0561	276.37	L1620	107.65	L2050	362.13	L2540	314.79
A7502	49.37	L0565	1089.93	L1630	128.45	L2060	464.77	L2550	213.84
A7503	11.21	L0600	71.38	L1640	343.57	L2070	133.51	L2570	472.86
A7504	0.66	L0610	193.57	L1650	182.19	L2080	284.71	L2580	448.24
A7505	4.63	L0620	322.76	L1660	127.42	L2090	350.95	L2600	152.91
A7506	0.33	L0700	1723.73	L1680	1047.60	L2106	506.24	L2610	180.82
A7507	2.46	L0710	1881.57	L1685	1105.39	L2108	795.53	L2620	199.08
A7508	2.84	L0810	1998.88	L1686	741.57	L2112	377.73	L2622	228.33
A7509	1.39	L0820	1617.01	L1690	1548.19	L2114	432.17	L2624	310.41
E0752	368.47	L0830	2334.80	L1700	1287.99	L2116	569.41	L2627	1278.84
E0754	906.03	L0860	907.05	L1710	1513.96	L2126	1013.10	L2628	1502.25
E0756	6693.38	L0900	148.58	L1720	1118.36	L2128	1276.73	L2630	184.37
E0757	4782.29	L0910	296.79	L1730	843.79	L2132	600.62	L2640	250.22
E0758	4209.50	L0920	168.49	L1750	146.49	L2134	720.13	L2650	89.35
E0759	552.80	L0930	345.02	L1755	1228.13	L2136	880.52	L2660	138.77
K0112	238.24	L0940	119.04	L1800	66.04	L2180	87.19	L2670	127.01
K0113	145.31	L0950	305.46	L1810	96.93	L2182	68.24	L2680	116.51
L0100	452.99	L0960	68.58	L1815	88.83	L2184	122.98	L2750	62.24
L0110	133.64	L0970	85.10	L1820	96.54	L2186	136.27	L2755	104.63
L0120	22.40	L0972	86.98	L1825	43.04	L2188	297.32	L2760	45.24
L0130	161.97	L0974	177.74	L1830	80.76	L2190	77.22	L2768	104.33
L0140	55.89	L0976	158.74	L1832	603.56	L2192	265.48	L2770	45.97

** Pricing for this code not established at printing time.

Orthotic/Prosthetic Devices Fee Schedule (continued)

CODE/MD	FEE	CODE/MD	FEE	CODE/MD	FEE	CODE/MD	FEE	CODE/MD	FEE
L2780	53.51	L3944	89.21	L5400	1080.27	L5662	448.73	L5845	1437.79
L2785	31.46	L3946	73.21	L5410	331.43	L5663	546.61	L5846	4348.31
L2795	63.26	L3948	49.02	L5420	1323.84	L5664	526.64	L5847	12423.79
L2800	79.42	L3950	115.42	L5430	399.17	L5665	406.16	L5850	101.48
L2810	58.16	L3952	127.92	L5450	324.74	L5666	55.53	L5855	272.68
L2820	64.66	L3954	80.46	L5460	432.64	L5668	89.56	L5910	287.29
L2830	72.71	L3956	**	L5500	1018.79	L5670	215.25	L5920	420.88
L2840	40.57	L3960	600.59	L5505	1409.01	L5671	456.12	L5925	355.38
L2850	46.10	L3962	625.35	L5510	1154.86	L5672	236.54	L5930	2700.02
L3224	43.78	L3963	1581.98	L5520	1140.73	L5674	52.39	L5940	397.90
L3225	50.37	L3980	225.24	L5530	1370.12	L5675	75.98	L5950	622.15
L3650	43.61	L3982	278.29	L5535	1345.19	L5676	287.45	L5960	764.72
L3660	74.88	L3984	297.05	L5540	1435.74	L5677	391.11	L5962	503.26
L3670	104.38	L3985	440.84	L5560	1541.73	L5678	31.50	L5964	742.89
L3675	127.87	L3986	509.85	L5570	1602.86	L5680	262.91	L5966	946.62
L3700	50.86	L3995	24.94	L5580	1871.22	L5682	496.09	L5968	2915.04
L3710	105.64	L4000	971.32	L5585	2302.85	L5684	38.18	L5970	161.10
L3720	527.04	L4010	546.60	L5590	1906.90	L5686	40.52	L5972	300.92
L3730	693.80	L4020	682.75	L5595	3368.81	L5688	48.45	L5974	184.85
L3740	779.70	L4030	375.92	L5600	3621.31	L5690	77.62	L5975	371.89
L3760	364.38	L4040	303.93	L5610	1642.32	L5692	105.40	L5976	444.23
L3800	145.69	L4045	244.24	L5611	1278.05	L5694	143.91	L5978	231.49
L3805	233.11	L4050	307.39	L5613	1998.18	L5695	132.85	L5979	1809.99
L3807	182.19	L4055	199.04	L5614	1353.63	L5696	146.77	L5980	2941.11
L3810	47.22	L4060	236.62	L5616	1079.81	L5697	63.68	L5981	2376.01
L3815	43.83	L4070	225.77	L5617	448.82	L5698	104.13	L5982	458.58
L3820	75.29	L4080	79.58	L5618	237.44	L5699	187.59	L5984	451.89
L3825	53.46	L4090	70.45	L5620	220.53	L5700	2272.79	L5985	226.51
L3830	61.68	L4100	79.46	L5622	287.57	L5701	2729.45	L5986	502.66
L3835	66.87	L4110	63.14	L5624	288.39	L5702	3453.17	L5987	5770.64
L3840	45.80	L4130	434.57	L5626	378.21	L5704	425.18	L5988	1602.49
L3845	59.15	L4350	78.30	L5628	404.40	L5705	759.72	L5989	2484.77
L3850	84.49	L4360	219.04	L5629	252.09	L5706	744.74	L5990	1455.31
L3855	91.31	L4370	140.56	L5630	356.00	L5707	981.83	L6000	1053.97
L3860	124.15	L4380	86.18	L5631	348.53	L5710	296.66	L6010	1172.90
L3900	1138.24	L4392	18.85	L5632	194.52	L5711	414.62	L6020	1093.54
L3901	1276.27	L4394	13.76	L5634	241.29	L5712	347.42	L6050	1506.86
L3902	1964.04	L4396	134.37	L5636	202.12	L5714	356.85	L6055	2100.17
L3904	2598.13	L4398	61.83	L5637	229.16	L5716	578.15	L6100	1526.68
L3906	307.38	L5000	419.80	L5638	399.19	L5718	722.62	L6110	1619.30
L3907	413.66	L5010	1013.90	L5639	889.37	L5722	763.42	L6120	1887.07
L3908	43.65	L5020	1721.87	L5640	507.23	L5724	1197.33	L6130	2053.48
L3910	322.50	L5050	1904.70	L5642	491.47	L5726	1379.90	L6200	2164.03
L3912	70.04	L5060	2190.94	L5643	1234.64	L5728	1887.52	L6205	2888.64
L3914	70.53	L5100	1908.89	L5644	468.52	L5780	908.19	L6250	2267.41
L3916	92.54	L5105	2755.68	L5645	632.92	L5785	510.51	L6300	2955.32
L3918	62.57	L5150	2785.62	L5646	434.63	L5790	570.36	L6310	2551.79
L3920	74.61	L5160	3029.86	L5647	630.99	L5795	1135.60	L6320	1394.00
L3922	85.58	L5200	2901.52	L5648	522.25	L5810	386.20	L6350	3107.07
L3923	28.36	L5210	1924.87	L5649	1892.40	L5811	578.52	L6360	2794.32
L3924	91.47	L5220	2187.96	L5650	387.25	L5812	448.41	L6370	1672.04
L3926	75.21	L5230	3017.63	L5651	952.62	L5814	2979.18	L6380	968.90
L3928	44.42	L5250	4115.78	L5652	345.84	L5816	678.66	L6382	1457.69
L3930	45.87	L5270	4097.52	L5653	461.66	L5818	761.77	L6384	2016.54
L3932	39.78	L5280	4066.13	L5654	263.07	L5822	1350.81	L6386	318.55
L3934	35.11	L5301	2181.98	L5655	222.94	L5824	1216.49	L6388	348.73
L3936	64.90	L5311	3123.36	L5656	299.08	L5826	2505.10	L6400	1840.64
L3938	68.27	L5321	3162.84	L5658	288.42	L5828	2240.06	L6450	2459.05
L3940	78.33	L5331	4030.10	L5660	482.75	L5830	1505.20	L6500	2572.67
L3942	54.17	L5341	4195.35	L5661	482.72	L5840	2783.13	L6550	3092.39

** Pricing for this code not established at printing time.

Orthotic/Prosthetic Devices Fee Schedule (continued)

CODE/MD	FEE	CODE/MD	FEE	CODE/MD	FEE	CODE/MD	FEE	CODE/MD	FEE
L6570	3471.92	L6750	295.74	L7025	2724.03	L8400	15.03	V2201	44.32
L6580	1325.51	L6755	296.49	L7030	4165.46	L8410	17.10	V2202	52.16
L6582	1200.55	L6765	313.27	L7035	2789.72	L8415	17.01	V2203	41.03
L6584	1882.77	L6770	297.19	L7040	2236.30	L8417	60.32	V2204	44.49
L6586	1761.97	L6775	332.16	L7045	1282.14	L8420	19.88	V2205	48.81
L6588	2315.19	L6780	371.65	L7170	5903.45	L8430	21.86	V2206	59.43
L6590	2199.09	L6790	358.44	L7180	25912.94	L8435	19.62	V2207	49.60
L6600	148.79	L6795	1000.60	L7185	5829.74	L8440	41.59	V2208	50.21
L6605	146.92	L6800	803.72	L7186	7016.67	L8460	57.87	V2209	55.23
L6610	141.09	L6805	269.89	L7190	6123.22	L8465	51.59	V2210	71.06
L6615	152.03	L6806	1297.37	L7191	7332.01	L8470	5.30	V2211	60.59
L6616	56.33	L6807	1045.29	L7260	1561.12	L8480	7.30	V2212	65.93
L6620	243.23	L6808	892.57	L7261	2841.84	L8485	8.82	V2213	67.62
L6623	678.45	L6809	313.28	L7266	1047.16	L8490	105.40	V2214	72.48
L6625	482.06	L6810	152.98	L7272	1813.38	L8500	523.51	V2215	78.43
L6628	380.00	L6825	901.20	L7274	4556.06	L8501	116.27	V2216	81.34
L6629	116.06	L6830	1074.20	L7360	189.28	L8505	**	V2217	74.81
L6630	170.96	L6835	935.73	L7362	198.74	L8507	33.60	V2218	80.24
L6632	59.38	L6840	682.72	L7364	316.09	L8509	87.62	V2219	35.32
L6635	139.71	L6845	648.88	L7366	425.78	L8510	22.71	V2220	115.75
L6637	298.01	L6850	588.70	L7900	434.14	L8600	495.34	V2510	88.01
L6640	264.74	L6855	695.15	L8000	34.90	L8603	347.88	V2511	126.46
L6641	127.26	L6860	529.11	L8001	100.61	L8606	182.61	V2512	149.43
L6642	172.49	L6865	289.06	L8002	132.35	L8610	508.09	V2513	125.46
L6645	318.39	L6867	772.80	L8010	49.61	L8612	535.89	V2520	82.73
L6650	330.56	L6868	190.18	L8015	48.08	L8613	239.93	V2521	144.03
L6655	64.98	L6870	188.54	L8020	180.85	L8614	15186.42	V2522	140.17
L6660	72.81	L6872	747.09	L8030	261.59	L8619	6514.41	V2523	119.45
L6665	36.53	L6873	371.07	L8035	2938.86	L8630	267.25	V2530	176.92
L6670	40.39	L6875	616.55	L8041	2337.08	L8641	290.05	V2531	434.33
L6672	160.30	L6880	399.99	L8041 KM	2220.22	L8642	238.09	V2623	712.05
L6675	95.26	L6881	3279.47	L8041 KN	934.83	L8658	248.83	V2624	48.29
L6676	110.12	L6882	2487.65	L8042	2625.92	L8670	441.55	V2625	312.78
L6680	184.04	L6890	134.92	L8042 KM	2494.64	V2020	63.94	V2626	198.44
L6682	203.48	L6895	496.33	L8042 KN	1050.37	V2100	31.07	V2627	1136.13
L6684	276.50	L6900	1416.41	L8043	2941.05	V2101	32.74	V2628	259.76
L6686	624.40	L6905	1408.36	L8043 KM	2793.98	V2102	46.44	V2700	34.75
L6687	457.55	L6910	1204.30	L8043 KN	1176.42	V2103	26.98	V2710	50.86
L6688	454.80	L6915	607.18	L8044	3256.15	V2104	29.88	V2715	9.22
L6689	544.90	L6920	5293.89	L8044 KM	3093.35	V2105	36.58	V2718	22.65
L6690	593.78	L6925	7126.48	L8044 KN	1302.47	V2106	37.12	V2730	16.73
L6691	274.84	L6930	5326.72	L8045	2039.09	V2107	39.02	V2740	11.09
L6692	443.61	L6935	7237.07	L8045 KM	1937.13	V2108	37.84	V2741	8.05
L6693	2277.36	L6940	6959.70	L8045 KN	815.64	V2109	43.50	V2742	9.13
L6700	411.48	L6945	8503.93	L8046	2100.74	V2110	50.77	V2743	10.16
L6705	241.57	L6950	7910.68	L8046 KM	1995.71	V2111	44.76	V2744	17.35
L6710	273.78	L6955	9474.11	L8046 KN	840.29	V2112	44.16	V2750	20.19
L6715	271.94	L6960	10731.81	L8047	1076.63	V2113	61.02	V2755	14.59
L6720	676.72	L6965	11445.86	L8047 KM	1022.80	V2114	53.97	V2760	12.71
L6725	327.63	L6970	11926.79	L8047 KN	430.65	V2115	58.68	V2770	16.41
L6730	539.73	L6975	13044.07	L8300	77.25	V2116	52.60	V2780	13.25
L6735	236.36	L7010	2897.20	L8310	118.79	V2117	60.65		
L6740	335.88	L7015	4603.87	L8320	51.89	V2118	58.17		
L6745	294.86	L7020	2699.33	L8330	51.43	V2200	40.66		

** Pricing for this code not established at printing time.

Addresses

CLAIMS STATUS

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

APPEAL RECONSIDERATIONS

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

MEDICARE SECONDARY PAYER (MSP)

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

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

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

ELECTRONIC CLAIM FILING

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

FRAUD AND ABUSE

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

REVIEW REQUEST

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

OVERPAYMENT COLLECTIONS

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

Phone Numbers

PROVIDERS

Customer Service Representatives:
1-877-602-8816

BENEFICIARY

1-800-333-7586

ELECTRONIC MEDIA CLAIMS

EMC Start-Up:
904-791-8767, option 4

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

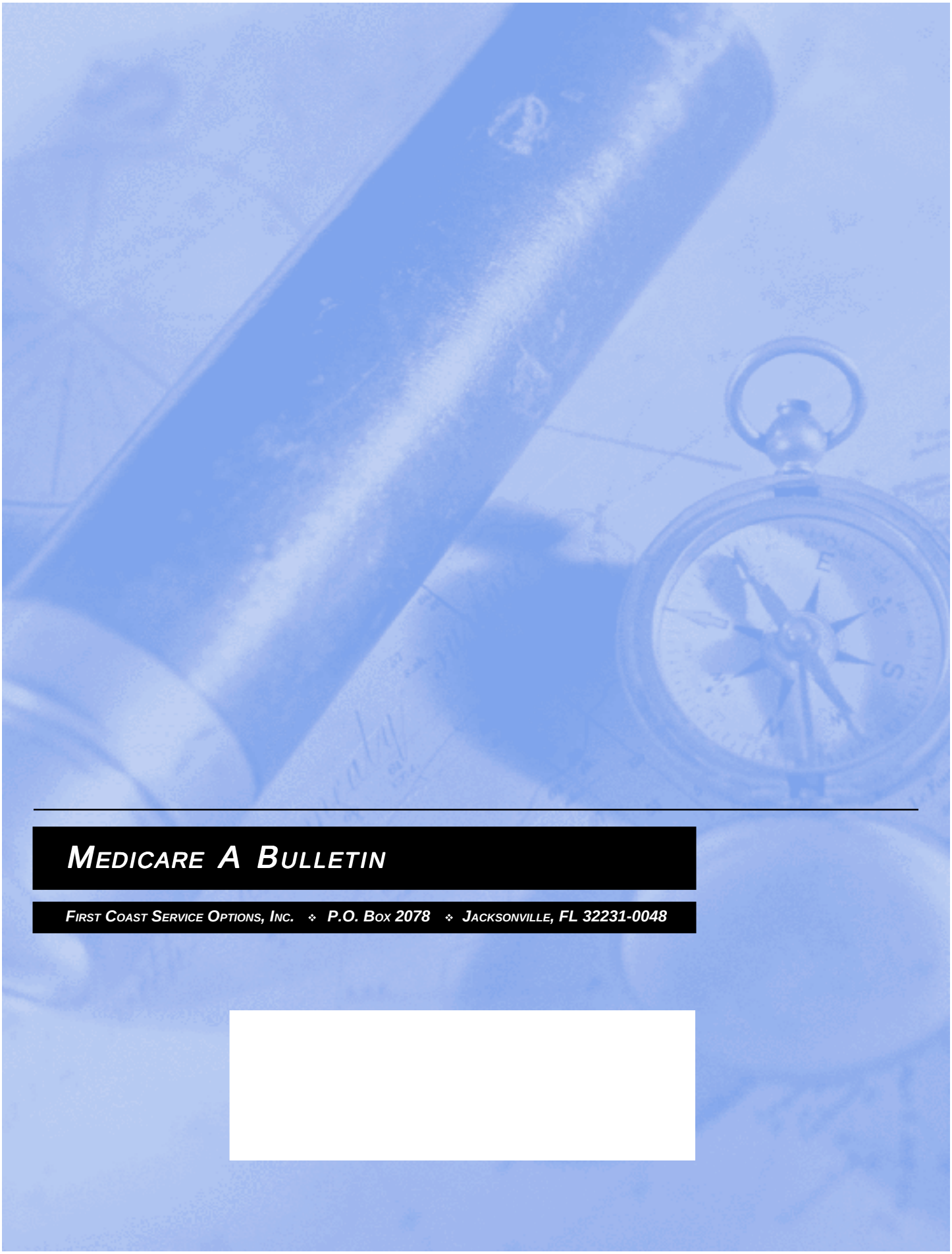
Medicare Web Sites

PROVIDERS

Florida Medicare Contractor
www.floridamedicare.com
Centers for Medicare & Medicaid Services
www.hcfa.gov

BENEFICIARIES

Florida Medicare Contractor
www.medicarefla.com
Centers for Medicare & Medicaid Services
www.medicare.gov



MEDICARE A BULLETIN

FIRST COAST SERVICE OPTIONS, INC. ❖ P.O. BOX 2078 ❖ JACKSONVILLE, FL 32231-0048