# Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

# In This Issue...



### Features



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

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

**Routing Suggestions**:

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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***Medicare A Bulletin***

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

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

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

# A PHYSICIAN'S FOCUS

## Observation Services

The implementation of the outpatient prospective payment system (OPPS) in August 2000 brought changes to the traditional Medicare payment methodology of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) is refining OPPS with periodic clarifications and updates. Despite the change in outpatient payment methodology from a generally cost based reimbursement to a prospective payment system, the Medicare definition of observation services has not changed.

For Medicare patients, observation services continue to be an outpatient hospital service and are defined as "those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the ordering physician or another individual authorized by State licensure law and hospital bylaws to admit patients to the hospital or to order outpatient tests. Most observation services do not exceed one day. Some patients, however, may require a second day of outpatient observation services. In only rare and exceptional cases do outpatient observation services span more than two calendar days" (230.6 HCFA 10, Medicare Hospital Manual).

Observation services are covered for an acute illness or injury. They are not routine services prior to or after a diagnostic or outpatient therapeutic procedure, unless there is an acute complication documented by the attending physician. Medicare defined outpatient observation services are not a substitute for an appropriate inpatient admission if inpatient services are required for the care of the patient. Observation services cannot be used for the convenience of the physician or the hospital in testing or examination of Medicare patients. Medicare beneficiaries should be informed of their outpatient observation status since it is a "Part B of A" service (hospital outpatient billed to the intermediary) as opposed to a Part A service (hospital inpatient), and may have cost implications for the beneficiary. Should the beneficiary be admitted following an initial physician order for outpatient observation services, only a single inpatient claim is submitted by the hospital.

At the time of this writing, there are Medicare proposals to allow separate payment of some observation services that are currently included in the ambulatory payment classification (APC) system groupings. Most proposals have not addressed changes in the Medicare definition of observation services. Part A providers can monitor new developments at the Web site **www.floridamedicare.com.** Providers are also encouraged to work with their physicians and allied staff in communicating the Medicare provisions regarding outpatient observation services, and to participate in the review and comment process of the draft local medical review policies that will be developed this year.

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

## About *The Medicare A Bulletin*

The *Medicare A Bulletin* is a comprehensive magazine published quarterly for Medicare Part A providers in the State of Florida. In accordance with the Centers for Medicare & Medicaid Services notification parameters, the approximate delivery dates are:

| Publication Name | Publication Date | Effective Date of Changes |
|---|---|---|
| First Quarter 2002 | Mid-November 2001 | January 1, 2002 |
| Second Quarter 2002 | Mid-February 2002 | April 1, 2002 |
| Third Quarter 2002 | Mid-May 2002 | July 1, 2002 |
| Fourth Quarter 2002 | Mid August 2002 | October 1, 2002 |

Important notifications that require communication in between these dates will be posted to the First Coast Service Option, Inc. (FCSO) Florida provider Web site **www.floridamedicare.com.** In some cases, additional unscheduled special issues will also be published.

### Who Receives the *Bulletin*?

Distribution of the Medicare Part A *Bulletin*, is limited to one copy per medical facility that is actively billing Medicare claims to the fiscal intermediary in the State of Florida. First Coast Service Options, Inc., the Medicare Part A fiscal intermediary, uses the same mailing address for **all** Medicare 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. For additional copies, providers may purchase a separate annual subscription for $75.00. A subscription order form may be found in the Education Resources section in each issue. Issues published since January 1997 may be downloaded from the provider Web site free of charge.

### 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 and Fraud and Abuse sections.

The Local Medical Review Policy section contains finalized medical policies and additions, revisions, and corrections to previously published local medical review policies. Whenever possible, the local medical review policy 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 Communication & Education
Editor, *Medicare A Bulletin*
P.O. Box 2078 – 18T
Jacksonville, FL 32231-0048

# GENERAL INFORMATION

## Reporting of Noncovered Charges on Other than Part A Inpatient Claims

Section 3604 of the Medicare Intermediary Manual (MIM), Part 3, requires all national uniform billing committee approved input data to be captured for audit trail purposes, in order to pass this data to other payers with whom coordination of benefit agreements exist. This requirement includes noncovered charges. The following initiatives are affected by the reporting of noncovered charges:

- Home health prospective payment system demand bills
- Home health prospective payment system consolidated billing (CB), last phase scheduled for January 1, 2002
- Skilled nursing facility prospective payment system CB, last phase scheduled for July 1, 2002
- Enforcement of hospital bundling requirements (inpatient and outpatient).

The initiatives stated above affect the following types of bills:

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **12x** | **14x** | **23x** | **33x** | **52x** | **72x** | **74x** | **76x** | **82x** | **85x** |
| **13x** | **22x** | **32x** | **34x** | **71x** | **73x** | **75** | **81x** | **83x** | |

### Instructions for Reporting Noncovered Charges

For demand bills, billing for denial, and other reporting of noncovered charges, this notification supersedes instructions currently in section 3604 of the MIM, Part 3, which state: "For outpatient Part B billing, only charges believed to be covered are submitted in [form locator] FL 47. Noncovered charges are omitted from the bill."

The following chart also explains how to report noncovered charge and total charges using the different claim formats:

| Claim Format | Total Charges | Non-covered Charges |
|---|---|---|
| UB-92 flat file | Use record type 61 Field No. 11 | Use record type 61 field No. 12 |
| X12 837, version 3051 implementation 3A.01 | 2 395 SV203 | 2 395 SV207 |
| X12 837, version 3051 implementation 1A.C1 | 2 375 SV203 | 2 375 SV207 |
| X12 837, version 4010 (HIPAA) | 2400 SV203 | 2400 SV207 |
| Hard copy UB-92 | FL 47 | FL 48 |

For services furnished **on or after October, 1, 2000,** in cases where there are covered and noncovered units for service that could be submitted as a single line item, providers will now have to split such submissions into two line items, one with all covered charges and the other with all noncovered charges. This implementation is effective for bills submitted **on or after April 1, 2002.**

A completely noncovered claim received without either a condition code 20 or 21, will be processed as the provider being liable for the charges unless the occurrence code is 32 and date is present signifying that an advance beneficiary notice was given to the beneficiary on that date. ❖

Source: CMS transmittal A-01-130, CR 1769

## Handling of Inpatient Claims Containing HCPCS Codes J7198, J7199, and Q2022

The Centers for Medicare & Medicaid Services has notified fiscal intermediaries that inpatient claims containing hemophilia blood clotting factor HCPCS codes J7198, J7199, and Q2022 cannot be processed to payment until a change is made in the standard system in the April 2002 release. Therefore, all inpatient claims with type of bill 11x will temporary suspend to location S/MCLOT under the reason code 70502 until the April release is installed.

Once the April 2002 release is installed, claims will be released and the interest amount will be paid if applicable. ❖

Source: CMS Transmittal A-02-003, CR 2000

## Get Paid the First Time – Reduce your RTPs

Claims that are returned to provider (RTP) cost everybody. Facilities pay the costs directly, by causing staff to have to resubmit the claim and by delaying claim payment. The taxpayer pays indirectly – the processing of RTP claims costs more than **one quarter of a million dollars** annually.

One way providers can help reduce RTPs is by reviewing the reason codes that accompany RTP claims. Below is a list of the top reason codes during the last three months. Also included are tips to avoid RTPs.

Please review your office procedures to ensure that sufficient process controls exist to avoid these problems. Failure to prevent RTPs adds to your claims submission cost, delays claims payment, and generally adds unnecessary costs to the Medicare program. Get paid faster by following the tips below.

**Reason Code 30715**

**Reason Message** The patient last name and/or first initial does not match what was found on the beneficiary record for this HIC number.

**Tips to Avoid RTPs**

- Photocopy the beneficiary's red, white, and blue Medicare card.
- Verify DDE beneficiary eligibility files to determine eligibility before filing claim.
- Submit claims to Medicare using the name **exactly** as it is printed on the beneficiary's Medicare card or as it is listed on the DDE system.
- **Do not** use nicknames. If the beneficiary's Medicare card or DDE system indicates James Smith, do not change the name to "Jim Smith."
- Include hyphens only as appropriate.
- Include any suffix of the name (e.g., Jr., Sr., III). Write the last name, leave a space, write the suffix, then write the first name (e.g., Snyder III, Harold or Adams Jr., Glen)
- Correct beneficiary information on the computerized patient information.
- For further details, please refer to the February/ March 2000 *Medicare A Bulletin*, page 7.

**Reason Code U5233**

**Reason Message** For *PPS claims* the admission date falls within a risk GHO period, but no GHO paid code or condition code '69' is indicated on the claim.

For *non-PPS inpatient and SNF claims*, the statement dates fall within, or overlap, a risk GHO period, but no GHO paid code or condition code '69' is indicated on the claim.

For *inpatient claims* that have the following criteria:

- the claim falls within a risk GHO period
- the GHO pay code equals '0' with no condition code '69' present
- the admission date and service dates are all equal
- the utilized days equals '0'
- a no-pay code is absent

**Tips to Avoid RTPs**

- Access DDE beneficiary eligibility files to determine HMO eligibility before filing claim.
- Bill claims for HMO patients to the HMO Company not the intermediary. The only exception is if you are billing for the Individual Medical Educator benefit. In this case you **must** submit condition codes 04 and 69 on the bill or you will receive this RTP reason code.

For further details, please refer to the *Medicare Part A Bulletin* H-90 dated August 6, 1998. This information is available via our provider Web site, **www.floridamedicare.com.**

**Reason Code 32000**

**Reason Message** This claim has been denied because the intermediary does not have records for the Medicare provider number.

Please verify the Medicare provider number reported on the claim. If incorrect, please submit a new claim with corrected information. If the Medicare provider number reported on the claim is correct, please contact the Medicare Part A Customer Service Department at (904) 355-8899. If the Medicare provider number reported on the claim is correct, please contact the Medicare Part A Customer Service Department at 1-877 602-8816.

**Tips to Avoid RTPs**

- Be sure that claims submitted to the fiscal intermediary are for Medicare patients. This RTP reason code is often received because providers submit non-Medicare related claims.
- Refer to your notification from the Medicare Registration Department regarding your provider entitlement date. Bills for services performed prior to your entitlement date will be returned with this RTP reason code.
- Do not include the dash in your provider number (do not key 10-XXXX, key 10XXXX).

Sight-verify your provider number before you send the claim to the Intermediary.

**Reason Code C7010**

**Reason Message** Inpatient, outpatient, or home health claim with dates of service overlapping a hospice election period and condition code 07 is not present on the bill.

**Tips to Avoid RTPs**

- Verify DDE beneficiary eligibility files to determine hospice involvement before filing claim.
- If the services are related to the terminal condition or for respite care, the claim **must** be submitted to the regional hospice intermediary. For more information contact **www.palmettogba.com.**
- Condition code **07 must** be submitted with any claim for services unrelated to the terminal condition.

**Reason Code 52238**

**Reason Message** Revenue code 634/635 or HCPCS Q0136 is on the claim, but value codes 48, 49 and 68 are not on the claim. All claims for EPO must have value code information for EPO must have value code information for services prior to September 21, 2001. After that date, all EPO claims require value information unless the patient has end stage renal disease.

**Tips to Avoid RTPs**

- Value Codes 48, 49, and 68 must be submitted when submitting claims for Epoetin Alfa (EPO) for patients who do not have ESRD.

For further details, please refer to the First Quarter 2002 *Medicare A Bulletin*, page 22. ❖

# Advance Beneficiary Notices for Services for Which Institutional Part B Claims Are Processed by Fiscal Intermediaries

*The following CMS-generated article was previously published in the August/September 2000 Medicare A Bulletin (pages 52-55) and is being republished to remind providers of the importance of this Medicare Program initiative. Implementation of these instructions became effective immediately upon receipt of the publication named above.*

The Centers for Medicare & Medicaid Services (CMS) have issued instructions regarding:

(1) The advance beneficiary notices (ABNs) that institutional providers must provide to beneficiaries in advance of furnishing what they believe to be noncovered Part B services and that any supplier or provider must provide to beneficiaries in advance of furnishing what they believe to be noncovered Part B services for which the claims will be submitted to fiscal intermediaries.

(2) The process required for submitting demand bills.

Additionally, the latest version of the Office of Management and Budget (OMB)-approved ABN for Part B services (OMB Approval No 0938-0566, Form No. HCFA-R-131) is printed in page 10 and may be used to provide notice to beneficiaries. This form satisfies the requirements for the provider's ABN and the beneficiary's agreement to pay.

Instructions in this notification supersede any conflicting current instructions in the Medicare Intermediary Manual, Part 3 (MIM) section 3722.4, 3730 and in the Hospital Manual sections 414ff.

### Instructions for the Provision of Advance Beneficiary Notices and for Mandatory Claims Submission (Demand Bills)

These instructions on the use of ABNs for the purposes of the Limitation on Liability (LOL) provision under section 1879 of the Social Security Act (the Act), apply equally to all* claims for Part B services furnished by institutional providers and/or processed by fiscal intermediaries (i.e., inclusive of claims submitted by a physician or other supplier for processing by a fiscal intermediary). Utilize ABN procedures for these Part B services; do not give inpatient notices of noncoverage (e.g., NONCs/HINNs) to beneficiaries for Part B services.

*With respect to services furnished in an emergency room, an OIG/HCFA Special Advisory Bulletin published on 11/10/99 advises that "the best practice would be for a hospital **not** to give financial responsibility forms or notices to an individual, or otherwise attempt to obtain the individual's agreement to pay for services before the individual is stabilized." This is because the circumstances surrounding the need for such services, and the individual's limited information about his/her medical condition, may not permit an individual to make a rational, informed consumer decision. The following instructions do not apply to services furnished in an emergency room before a patient is stabilized. Do not give an ABN to a beneficiary in an emergency room who has not been stabilized. ABNs given to any individual who is in a medical emergency or otherwise under great duress cannot be considered to be proper notice.

### A. Advance Beneficiary Notices (ABNs) and Liability for Claims for Part B Services

1. **Basic Requirements for ABNs.** - An ABN is a written notice you give to a Medicare beneficiary before Part B services are furnished when you believe that Medicare will not pay for some or all of the services on the basis that they are not reasonable and necessary (i.e., under section 1862(a)(1) of the Act). If you expect payment for the services to be denied by Medicare, advise the beneficiary before services are furnished that, in your opinion, the beneficiary will be personally and fully responsible for payment. To be "personally and fully responsible for payment" means that the beneficiary will be liable to make payment "out-of-pocket," through other insurance coverage (e.g., employer group health plan coverage), or through Medicaid or other federal or non-federal payment source. You must issue notices each time, and as soon as, you make the assessment that you believe Medicare payment will not be made for medical necessity reasons. You are not required to give ABNs to beneficiaries for routine screening tests, which are statutorily excluded from Medicare payment under the routine physical exclusion (i.e., under section 1862(a)(7) of the Act). If you fail to provide a proper ABN in situations where one is required, you may be held liable under the provisions on LOL, where such provisions apply.

2. **Evidence that the Beneficiary is Liable.** - In deciding whether the beneficiary or his/her authorized representative knew, or could reasonably have been expected to know, that items and services he or she received were not reasonable and necessary, the beneficiary's allegation that he or she did not know, in the absence of evidence to the contrary, will be acceptable evidence for LOL. However, there may be evidence that will rebut such an allegation. The most likely reason to find that the beneficiary knew or could reasonably have been expected to know that Medicare would not pay is where, before the item or service was furnished, you notified the beneficiary in writing, using approved ABN language, of the likelihood that Medicare would not pay for the specific service and, after being so informed, the beneficiary agreed to pay you for the service, personally or through other insurance, as evidenced by a signed agreement to pay.

3. **Approved Notice Language.** - The latest version of the OMB-approved ABN for Part B services (OMB Approval No. 0938-0566, Form No. HCFA-R-131) satisfies these requirements for your ABN and the beneficiary's agreement to pay. The approved notice language attached to Part 1 of these instructions as Exhibit 1, is the current OMB-approved ABN for Part B services. The ABN in Exhibit 1 may be appropriately modified by replacing the words "physician/supplier" with the word "provider," and by

*Advance Beneficiary Notices for Services for Which Institutional Part B... (continued)*

replacing the words "physician/supplier that he or she" with the words "provider that it," and still be acceptable for ABN purposes.

## B. Requirements for the Use of ABNs

1. **Reason for Predicting Denial.** - Statements of reasons for predicting Medicare denial of payment similar to those in Medicare Carriers Manual, Part 3 (MCM) section 7012, Item 15.0ff., "Medical Necessity" are acceptable for ABN purposes. Simply stating "medically unnecessary" or the equivalent is not an acceptable reason, insofar as it does not at all explain why you believe the services will be denied as not reasonable and necessary. To be acceptable, your ABN must give the beneficiary an idea of why you are predicting the likelihood of Medicare denial, so that the beneficiary can make an informed consumer decision, whether or not to receive the service and pay you for it personally.

2. **Prohibition of Generic and Blanket Notices**

   **a.** Generic Notice Prohibition: The requirement for an ABN is not satisfied by a signed statement by the beneficiary to the effect that, should Medicare deny payment under §1862(a)(1), the beneficiary agrees to pay for the service. Routine notices to beneficiaries, which do no more than state that Medicare denial of payment **is possible,** or that you never know whether Medicare will deny payment, are considered not to be acceptable evidence of an ABN.

   **b.** Blanket Notice Prohibition: You should not give an ABN to a beneficiary unless you have some genuine doubt regarding the likelihood of Medicare payment as evidenced by your stated reasons; your giving ABN for all claims or services is not an acceptable practice.

3. **Format.** - You must ensure that the design and readability of your ABN facilitate beneficiary understanding. No body text or heading should use a font size less than 12-point font. Italics or any typeface that is difficult to read should not be used. Put your logo (if any), name, address and telephone number at the top of the ABN form. It must be clear and obvious to the beneficiary that you, rather than the Medicare program, issued the ABN.

4. **Delivery of ABN.** - Delivery of an ABN occurs when the beneficiary (or authorized representative, i.e., the person acting on the beneficiary's behalf) both has received the notice and can comprehend its contents. All notices must include a detailed explanation written in lay language as to why you believe the services will be denied payment. An incomprehensible notice, or a notice, which the individual beneficiary or his/her authorized representative is incapable of understanding due to the particular circumstances (even if others may understand), is not sufficient notice.

   **a.** You should hand-deliver the ABN to the beneficiary or authorized representative. Delivery is your responsibility and nonreceipt of notice probably will protect the beneficiary from liability and may result in your being held liable under the LOL provisions. For this reason, it is in your own best interest (as well as being in the beneficiary's best interest) for you to hand-deliver ABNs to beneficiaries.

   **b.** A telephone notice to a beneficiary, or authorized representative, will not constitute sufficient evidence of proper notice for purposes of limiting any potential liability because the content of the telephone contact usually cannot be verified. A telephone notice must be followed up immediately with a mailed notice or a personal visit at which written notice is delivered in person.

   **c.** A requirement for delivery of a notice is that the beneficiary, or authorized representative, must be able to comprehend the notice (i.e., they must be capable of receiving notice). A comatose person, a confused person (e.g., someone who is experiencing confusion due to senility, dementia, Alzheimer's disease), a legally incompetent person, a person under great duress (for example, in a medical emergency) is not able to understand and act on his/her rights, therefore necessitating the presence of an authorized representative for purposes of notice. A person who does not read the language in which the notice is written, a person who is not able to read at all or who is functionally illiterate to read any notice, a blind person or otherwise visually impaired person who cannot see the words on the printed page, or a deaf person who cannot hear an oral notice being given by phone, or could not ask questions about the printed word without aid of a translator, is a person for whom receipt of the usual written notice in English may not constitute having received notice at all (*this is not an exclusive list*). This may be remedied when an authorized representative has no such barrier to receiving notice. However, in the absence of an authorized representative, other steps must be taken to overcome the difficulty of notification. These may include providing notice in the language of the beneficiary (or authorized representative), in Braille, in extra large print, or by getting an interpreter to translate the notice, in accordance with the needs of the beneficiary or authorized representative to act in an informed manner. If the beneficiary is not capable of receiving the notice, then the beneficiary has not received proper notice and cannot be held liable where the LOL provisions apply and you may be held liable.

   **d.** You must timely answer inquiries from a beneficiary, or authorized representative, who requests further information and/or assistance in understanding and responding to the notice. You must answer inquiries from a beneficiary, or authorized representative, regarding the basis for your assessment that services may not be covered. You must respond timely, accurately, and completely to a beneficiary, or authorized representative, who requests information about the extent of the beneficiary's personal financial liability for services for which you expect that Medicare may not pay.

*Advance Beneficiary Notices for Services for Which Institutional Part B... (continued)*

**e.** A patient must be notified well enough in advance of receiving a medical service so that the patient can make a rational, informed consumer decision. For example, do not give an ABN to a patient as he or she is connected to a test device or after he or she is already on the table for a MRI. Such last moment delivery of notice can be considered to be coercive, regardless of the provider's intentions. In such a case, the delivery of the ABN may not be considered timely and the beneficiary may not be held liable.

### C. Signature of Beneficiary

**1.** The applicable rules of the Medicare program with respect to who may sign for a beneficiary apply to signing notices, including ABNs. Whenever you furnish services to a beneficiary who is incapable of signing a notice, his or her representative who signs for other matters in accordance with Medicare rules also may sign a notice.

**2.** You must obtain the signed ABN from the beneficiary, either in person, or where this is not possible, via return mail from the beneficiary or person acting on the beneficiary's behalf, as soon as possible after it is signed. The ABN should be annotated with the date of your receipt from the beneficiary. Return a copy of the ABN, including the date of your receipt, within 30 calendar days to the beneficiary for his or her records. You must also retain a copy of the ABN. These copies will be relevant in the case of any future appeal.

**3.** If the beneficiary or the person acting on the beneficiary's behalf refuses to sign the ABN, annotate your copy of the ABN, indicating the circumstances and persons involved. If this occurs, you may decide not to furnish services to the beneficiary because the beneficiary has not agreed to be personally responsible for payment for services that are not covered by Medicare.

### D. Collection from Beneficiary

When you properly execute an ABN and give it timely to a beneficiary who agrees to pay in the event of denial by Medicare and, in fact, Medicare denies payment on the related claim, you may bill and collect from the beneficiary for that service. Medicare does not limit the amount, which you may collect from the beneficiary in such a situation.

### E. Demand Bills

You always must submit a claim for an initial determination when you gave an ABN on the basis of the likelihood of denial of payment for a service as "not reasonable and necessary" under Medicare program standards. On such a claim, enter "occurrence" code 32 on the UB-92 in one of the fields numbered 32 through 35. This code indicates the date you gave the ABN to the beneficiary. It is the "occurrence" code, and not the "condition" code that indicates to the fiscal intermediary that an ABN has been issued. In addition to placing the "occurrence" code on the claim, you must also enter "condition" code 20 in one of the fields numbered 24 through 30 to indicate that you realize the services on the claim probably or certainly are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary wants an initial determination. You may submit claims, for initial determination, for statutorily excluded services (e.g., routine physicals and screening tests, cosmetic surgery, personal comfort items), if the beneficiary requests it. On claims for statutorily excluded services, enter a "condition" code 21 on the UB-92 in one of the fields numbered 24 through 30 to indicate that you realize that the furnished services are excluded, but that you are requesting a denial notice from Medicare in order to bill Medicaid or other insurers. This is also known as a "no-pay" claim. ❖

Source CMS transmittal A-00-43, CR 1192

## Overpayment Interest Rate

Medicare assesses interest on overpaid amounts that are not refunded timely. Interest will be assessed if the overpaid amount is not refunded within 30 days from the date of the overpayment demand letter. The interest rate on overpayments is based on the higher of the private consumer rate (PCR) or the current value of funds rate.

**Effective October 31, 2001,** the interest rate applied to Medicare overpayments remains the same as **13.25 percent**, based on the revised PCR. The following table lists previous interest rates.

| Period | Interest Rate |
|---|---|
| August 7, 2001 – October 30, 2001 | 13.25% |
| April 26, 2001 – August 6, 2001 | 13.75% |
| February 7, 2001 – April 25, 2001 | 14.125% |
| August 1, 2000 – February 6, 2001 | 13.875% |
| May 3, 2000 – July 31, 2000 | 13.75% |
| February 2, 2000 – May 2, 2000 | 13.50% |
| October 28, 1999 – February 1, 2000 | 13.375% |
| August 4, 1999 – October 27, 1999 | 13.25% |
| May 5, 1999 – August 3, 1999 | 13.375% |
| February 1, 1999 – May 4, 1999 | 13.75% |
| October 23, 1998 –- January 31, 1999 | 13.50% |
| July 31, 1998 – October 22, 1998 | 13.75% |
| May 13, 1998 – July 30, 1998 | 14.00 % |
| January 28, 1998 – May 12, 1998 | 14.50% |
| October 24, 1997 – January 27, 1998 | 13.875% ❖ |

Source: Transmittal AB-01-161; CR 1896; PCM #0131208

# Advance Beneficiary Notice (ABN)

## Provider Notice:

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for *(specify particular services(s))* for the following reasons: *(give the reason(s) for predicting that Medicare will deny payment)*

## Beneficiary agreement:

I have been notified by my provider that it believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signed,

_____
(Beneficiary Signature)

OMB Approval No. 0938-0566. Expiration Date: 8/31/02. Form No. HCFA-R-131

# GENERAL COVERAGE

## Ambulatory Blood Pressure Monitoring

Ambulatory blood pressure monitoring (ABPM) involves use of a noninvasive device to measure blood pressure in 24-hour cycles. These 24-hour measurements are stored in the device and later interpreted at the physician's office. ABPM must be performed for at least 24 hours to meet coverage criteria.

ABPM is only covered for those patients with suspected white coat hypertension. Suspected white coat hypertension is defined as:

1) office blood pressure greater than 140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit;
2) at least two documented blood pressure measurements taken outside the office which are less than 140/90 mm Hg; and
3) no evidence of end-organ damage.

ABPM is not covered for any other uses. In the rare circumstance that ABPM needs to be performed more than once in a beneficiary, the qualifying criteria described above must be met for each subsequent ABPM test.

### Applicable HCPCS Codes

*93784* *ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report*

*93786* *ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only*

*93790* *ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report.*

*CPT* code 93788 (ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report) is not approved for Medicare payment.

### Payment Requirements

Intermediary payment is allowed for noninstitutionalized beneficiaries in the following provider settings. Payment is as follows:

- Hospital outpatient department – outpatient prospective payment system, based on the ambulatory payment classification
- Comprehensive outpatient rehabilitation facility – Medicare physician fee schedule (MPFS)
- Critical access hospital (CAH) – Reasonable cost or for those who have selected combined billing (option method II) they will receive 115 percent of MPFS.
- Rural health clinics/federally qualified health centers (RHCs/FQHCs) – All inclusive rate, professional component only, based on the visit furnished to the RHC/FQHC beneficiary. The technical component is outside the scope of the RHC/FQHC benefit. Therefore, the provider of the technical service bills the carrier on claim Form HCFA-1500 or its electronic equivalent and payment is made under MPFS. For provider based RHCs/FQHCs, payment for the technical component is made as indicated above based on the type of provider the RHC/FQHC is based with. For skilled nursing facility (SNF) based RHCs/FQHCs, payment for the technical component is made based on the MPFS.

  Deductible and coinsurance apply.

### Applicable Bill Types

The applicable types of bill are:
13x, 14x, 23x, 71x, 73x, 75x and 85x.

### Special Billing Instructions for RHCs, and FQHCs

Independent RHCs and free-standing FQHCs bill under the types of bill 71x and 73x for the professional component. The technical component is outside the scope of the RHC/FQHC benefit. The provider of the technical service bills the carrier on claim Form HCFA-1500 or its electronic equivalent.

The technical component for a provider based RHC/FQHC is typically furnished by the provider. The provider of that service bills under type of bill 13x, 14x, 23x or 85x as appropriate using the outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services.)

### Applicable Revenue Codes

The applicable revenue code for the test procedure is 920 except for CAHs, independent RHCs and free-standing FQHCs. CAHs report these procedures under revenue codes 96x, 97x or 98x. Independent RHCs and free-standing FQHCs report these procedures under revenue codes 521 and 520 respectively. ❖

Source: CMS transmittal 149, CR1985 (CIM section 50-42)
CMS transmittal AB-01-188, CR 1985

## Diagnosis Coding for the UB-92 Form

*An article to clarify reporting of the International Classification of Diseases Ninth Revision, Clinical Modification (ICD-9-CM) codes for diagnostic test was published in the First Quarter 2002 Medicare A Bulletin (pages 5-8). Since the release of that publication, the Centers for Medicare & Medicaid Services regional office has issued a clarification regarding how hospitals are to report "secondary" diagnosis codes on the Form HCFA-1450 (UB-92) or its electronic equivalent.*

Program Memorandum (PM) AB-01-144 provides guidance on the proper use of diagnosis codes that best represent the reason a diagnostic test was ordered. It provides instructions regarding coding for signs and symptoms as well as coding for the patient's final diagnosis. A copy of the PM may be obtained at **www.hcfa.gov** or from the fiscal intermediary.

Since the release of this PM, there has been some confusion regarding proper placement of these diagnosis codes on Form HCFA-1450 (UB-92). Some hospitals have had claims denied for diagnostic testing because of inaccurate or incomplete diagnosis coding on the claim forms. This occurs frequently when the intermediary has a local medical review policy in place for a particular test or service.

Form HCFA-1450 (UB-92) has 11 fields (67-77) that a facility may use for diagnosis coding.

- Field 67 is for the principal diagnosis code
- Fields 68-75 for other diagnosis codes that relate to the facility's treatment of the patient
- Fields 76 and 77 are reserved for admitting and discharge diagnosis codes

Diagnosis codes relating to a sign or symptom (e.g., chest pain) may be reported in fields 68-75. Intermediary claim processing systems will scan all diagnosis fields looking for a diagnosis code that will allow the claim to be paid. Therefore, it is important that a facility make full use of these fields to prevent unnecessary claim denials.

Additional information regarding ICD-9-CM coding and Form HCFA-1450 (UB-92) claim forms may be obtained on the Medicare Learning Network at www.hcfa.gov/medlearn/cbts.htm.

Questions related to the proper use of Form HCFA-1450 (UB-92) may be addressed to the Medicare Part A Customer Service Department at 1-877-602-8816. ❖

Source: Regional Office notification

## Treatment of Actinic Keratosis

Treatment of actinic keratosis (AK) permits coverage for the destruction of actinic keratoses. Coverage is extended for surgical or medical treatment methods, including but not limited to cryosurgery with liquid nitrogen, curettage, excision, and photodynamic therapy (PDT), without restrictions based on patient or lesion characteristics.

Actinic keratoses, also known as solar keratoses, are common, sun-induced skin lesions that are confined to the epidermis and have potential to become a skin cancer. Various options exist for treating AKs. Clinicians should select an appropriate treatment based on the patient's medical history, lesion's characteristics, and patient's preference for a specific treatment. Commonly performed treatments for AKs include cryosurgery with liquid nitrogen, topical drug therapy, and curettage. Less commonly performed treatments for AK include dermabrasion, excision, chemical peels, laser therapy, and PDT. An alternative approach to treating AKs is to observe the lesions over time and remove them only if they exhibit specific clinical features suggesting possible transformation to invasive squamous cell carcinoma.

Coverage for the treatment of AK is effective for services furnished **on and after November 26, 2001.** ❖

Source: CMS Transmittal 145, CR 1892 (CIM 35-101)

## New CLIA Waived Tests

Listed below is a test that will have a new *Current Procedural Terminology* (*CPT*) code in 2002. This test was previously approved by the Food and Drug Administration as a waived test under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The *CPT* code for this test must have the modifier QW to be recognized as a waived test.

*CPT* code 87804 is a new code for 2002 that was developed for infectious agent antigen detection byimmunoassay with direct optical observation; influenza. Hence, effective for services rendered on or after January 1, 2002, *CPT* code 87804QW replaces *CPT* code 87899QW for the Quidell QuickVue® influenza test. ❖

Source: CMS Transmittal AB-01-187; CR 1976

# HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

## Clarification of Payments Made to Hospital Outpatient Departments under the Outpatient Prospective Payment System

Under the outpatient prospective payment system (OPPS), packaged services are items and services considered to be an integral part of another service paid under the OPPS. No separate payment is made for packaged services, because the cost of these items is included in the ambulatory payment classification (APC) for the service of which they are an integral part. For example, routine supplies, anesthesia, recovery room and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure.

### Claims Resulting in APC Payments

If a claim contains services that result in an APC payment but also contains packaged services, separate payment for the packaged services is not made since payment is included in the APC. However, charges related to the packaged services are used for outlier and transitional corridor payments, as well as for future rate setting.

### Claims Resulting in No APC Payments

Packaged services are not separately payable if the claim contains services that would be packaged services if an APC were payable, and:

- the claim contains only services payable under cost reimbursement, such as ambulance
- the claim contains only services payable under a fee schedule, such as clinical diagnostic laboratory
- the claim contains services payable under cost reimbursement and services payable under a fee schedule.

In addition, the charges are not used to calculate transitional outpatient payments.

### Reminder

During claims processing of types of bill 12x, 13x, and 14x, cost reimbursement payments may not be made to hospital outpatient departments for any items or services except for:

- corneal tissue; and
- ambulance services

Payment on a cost reimbursement basis no longer applies under the OPPS with the exception of those items previously listed. ❖

Source: CMS transmittal A-01-133, CR 1940

# FRAUD AND ABUSE

## Ordering Diagnostic Services

Medicare coverage requirements for diagnostic services (e.g., laboratory tests and radiology procedures) indicate these must be medically necessary for the treatment and/or diagnosis of the patient. In addition, any diagnostic service may be covered only when furnished on the order of a physician. An exception to this requirement is when the treating physician performs a diagnostic service. It is expected the physician's order for diagnostic services is documented and maintained in the patient's medical record by both the ordering physician and the provider who performs the service. To help ensure payment is made only for medically necessary services, any diagnostic service furnished on the referral or order of a physician must include in the physician order the reason why the diagnostic service is medically necessary—this may be in the form of an ICD-9-CM code.

A physician's order for diagnostic services may list one or more tests/procedures. For the most part, the services are furnished as ordered by the physician. However, there are instances when tests/procedures are furnished other than or in addition to those ordered by the physician. These services should not be covered by Medicare because they are not ordered by a physician. Physicians who order diagnostic services can assist the Medicare program in ensuring only those services actually ordered are paid by Medicare, by considering the following process:

- Maintain copies of the physician orders annotate the specific diagnostic services ordered in the patient's medical records.
- When the results of the diagnostic services are received by the physician, compare the report of the services furnished against the physician orders.
- If it is noted that services were furnished other than or in addition to the diagnostic services on the physician order, the physician should contact the provider of services to determine why the services furnished were not the same as those ordered.
- If the physician cannot resolve the issue, then the Medicare contractor may be contacted for assistance.

By implementing this process, physicians who order diagnostic services can help ensure that only those services which are medically necessary, and ordered, are paid by the Medicare program. The result would be a savings in tax dollars that may be used to pay for noncovered and/or inappropriate services. ❖

# ELECTRONIC DATA INTERCHANGE

## Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA-AS) require that Medicare, and all other health insurance payers in the United States; comply with the EDI standards established by the Secretary of Health and Human Services for specified health care transactions. The ANSI X12N 837 implementation guides have been established as the standards of compliance for claim transactions. The implementation guides for each transaction are available electronically at **www.wpc-edi.com.**

The following information is intended to serve only as a companion document to the HIPAA-AS ANSI X12N 837, version 004010X096 Implementation Guide. The use of this document is solely for the purpose of clarification and is not a substitute for review of the relevant implementation guides.

The information in this document is subject to change. Changes will be communicated in Medicare EDI notifications and will be available on the Medicare Web site at **www.floridamedicare.com.** This companion document supplements, but does not contradict any requirements in the X12N 837 Institutional Implementation Guide.

### Medicare Specific Guidelines Related To The HIPAA-AS 4010 837

- First Coast Service Options will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare Processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.
- You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the ANSI X12 837 Institutional Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set may cause the interchange (transmission) to be rejected at the translator. The characters ~ (tilde), * (asterisk), and > (greater than), which are part of the extended character set, may be used only as segment, element and sub-element delimiters. Use of these characters other than as specified will cause the interchange (transmission) to be rejected at the translator.
- Only loops, segment, and data elements valid for the HIPAA-AS Institutional Guide will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.
- All dates that are submitted on an incoming 837 claim transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date or submission of a future date will result in rejection of the claim or the applicable interchange.
- First Coast Service Options will reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code).
- First Coast Service Options will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.
- First Coast Service Options will only accept claims for one line of business per Functional Group (GS – GE).
- Compression of files using PKZIP is supported for transmissions between the submitter and First Coast Service Options.
- The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.
- If used, currency code (CUR02) must equal 'USA'.
- Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102).
- The last revenue code (SV2) submitted for a claim must be '0001' indicating a total line for all proceeding revenue codes.
- Do not use Credit/Debit card information to bill Medicare.
- For Medicare, the subscriber is always the same as the patient (SBR02 = 18, SBR09 = MA) The Patient Hierarchical Level (2000C loop) is not used.
- Any data submitted in the PWK (paperwork) segment will not be considered for processing.
- Transaction Set Purpose Code (BHT02) must be equal '00' (Original).
- Claim or Encounter Indicator (BHT06) must equal 'CH' (Chargeable).
- First Coast Service Options will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Institutional Implementation Guides. Requirements listed under "enveloping."
- First Coast Service Options will reject an interchange (transmission) that is submitted with a sender number that is not authorized for electronic claim submission.
- For any claim that contains over 450 revenue codes, only the first 450 will be passed to the standard system. This claim will then be returned to provider (RTP) in the standard system.
- Only valid qualifiers for Medicare should be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicare processing not defined for use in Medicare billing may cause the claim or the transaction to be rejected.

***Administrative Simplification Provisions of HIPAA (continued)***

- You may send up to four modifiers; however, the last two modifiers will not be considered. The Fiscal Intermediary Standard System (FISS) processing system will only use the first two modifiers for adjudication and payment determination of claims.
- You may send up to twelve diagnosis codes per claim; however, the last three diagnosis codes will not be considered in processing.
- First Coast Service Options will return the version of the 837 inbound transaction in GS08 (Version / Release/Industry Identifier Code) of the 997.
- We suggest retrieval of the ANSI 997 functional acknowledgment files on or before the first business day after the claim file is submitted, but no later than five days after the file submission.
- Any file resubmitted within 30 days will reject as a duplicate file if the two files are an exact byte for byte match.
- The HIPAA 837 transaction only allows for 1 Investigational Device Exemption (IDE) per electronic claim. Claims containing multiple IDEs must be submitted via paper. Any claims submitted via Direct Data Entry (DDE) containing multiple IDEs will be RTP'd by the standard system.
- Claims containing a nonnumeric revenue code will have the revenue code replaced with 9's by the standard system, and the claims will RTP.
- Notice of Election (NOE) is not established under HIPAA. These claims should be submitted via paper or DDE.

## Schedule Your Testing Appointment - Don't Delay

EDI submitters should request a testing appointment as soon as possible to facilitate completing testing and correcting any detected system problems prior to October 2002. Appointment slots will be assigned on a first come basis. To schedule an appointment, call (904) 791-6865. This fiscal intermediary will not be able to guarantee testing by the end of September 2002 for any entities that delay scheduling testing until late in the transition period. If a test transmission is received from a vendor, clearinghouse or billing service that does not have an appointment, the fiscal intermediary may not be able to review the file.

If an EDI submitter is using a vendor, clearinghouse, or billing service to generate a certain transaction and that entity has passed testing requirements for a specific transaction and is using the same program to generate the translation for all of their clients, then all clients of the vendor, clearing house, or billing service will not be required to test prior to intermediary acceptance of production. It is the responsibility of the vendor, clearinghouse, or billing service to provide Medicare with their client information.

Please refer to the "Medicare HIPAA-AS Related News" dated November 26, 2001, for additional information on testing levels.

## Specifications Necessary For Creating And Transmitting Your Test File

**Test File**

Please limit your version 4010 test file to 10 - 25 claims each, representative of all types of bills you currently send to Medicare Part A. We ask that you only send us positive test files, which contain claims you believe should process and pay. **Note:** this file will only be processed as a test, no claims will be paid.

**Delimiters**

The Functional Acknowledgment report (997) will be returned to you using the delimiters specified within the 837.

**Note:** If you use the tilde (~) as a segment delimiter, your 997 will be returned to you as one string, 'unwrapped'.

**Enveloping**

Enveloping information must be as follows:

| ELEMENT | CONTENT |
|---|---|
| ISA 05 & 07 | ZZ |
| ISA 06 | Your Mailbox number |
| ISA 08 | 592015694 |
| ISA 15 | T |
| GS 02 | Your Sender Number |
| GS 03 | MEDA00090EMC |
| GS 08 | 004010X096 |
| REF 02 | 004010X096D |

When transmitting your test file, please use the "T" indicator in ISA 15 and "004010X096D in REF 02. When you are accepted to "Production," change ISA 15 to "P"" and remove the "D" from REF 02.

**Commands**

Please review your SUBMIT and OBTAIN commands. The commands used to submit the ANSI X12 files and obtain the acknowledgments are slightly different than those that are used to submit and obtain acknowledgments for National Standard Format. The appropriate command instructions can be found in our publication "Guide To Gateway" which is available on our Web site at **www.floridamedicare.com.**

**Phone Number**

For asynchronous transmissions, you will need to dial (904) 356-0237.

For Bisynchronous 2780 & 3780

CCITT V.32 (904) 350-1150
BELL 201C/208B (904) 356-0534

**NOTE:** If you are having trouble transmitting please contact the corporate Help Desk at (904) 905-8880.

## Fiscal Intermediary Standard System EDITS

Claim transactions will subsequently be edited for submission of valid Medicare data by FISS. There are a number of elements where the 837 version 4010 Implementation Guide accommodates data in excess of that which would be result in valid data for adjudication of your Medicare claims. In these instances, if a numeric field is

***Administrative Simplification Provisions of HIPAA (continued)***

received longer than the FISS processing system edits allow, that field will be converted to all nines. If an alphanumeric field is received longer than FISS edits allow, that field will be converted to all ampersands. Claims containing fields converted to nines or ampersands will reject (RTP) at the processing system. For example: The billing provider number (NM109) accommodates up to a maximum of 80 characters, however, for Medicare processing the FISS would not expect to receive a provider number in excess of 13 characters as a valid entry. If Medicare receives a claim with a provider number of 15 characters, the file will be accepted at mailbox, the provider number will be converted to 9999999999999 to reflect that data provided exceeds that expected by Medicare for processing and the claim will reject (RTP) at the FISS processing system. These abbreviated field lengths are in line with current Medicare claim billing and processing.

For a complete listing of those fields where due to Medicare billing guidelines, the FISS would expect to receive fewer characters than the IG supports, you may refer to the file, 4010837i.XLS. This file can be the found on the CMS Web site at **http://www.hcfa.gov/medicare/edi/hipaadoc.htm** under the heading "Intermediaries."

**Reports**

If your test file contains incorrect enveloping information (ISA, GS, ST, SE, GE, IEA segments), a TA1 will be returned to you. If you need assistance reading your TA1 please contact Medicare EDI at the number below.

As in current ANSI business, your ANSI X12 4010 837 file will create a Functional Acknowledgment (997) report. This report, sent to your mailbox for retrieval, will tell you if your file has been accepted under X12 Standard. Standard requirements can be found in the 4010 Implementation Guide (IG) under the "STANDARD" heading for each segment.

Subsequent to files passing the Standard, they are then reviewed for X12 Implementation Guide requirements. X12 Implementation Guide requirements can be found in the 4010 Implementation Guide under the "IMPLEMENTATION" heading for each segment and in the body of the segment information. If your file fails any IG edit(s), a 4010 Transmission Acknowledgment report will be created. This report, based on the existing National Standard Format Acknowledgment layout, will list the details of your errors, including line number and segments. Only the first 100 errors will be listed. The ISA, GS and ST Control numbers will also be included so you can relate the 4010 Transmission Acknowledgment report back to the correct inbound file. **Note:** If you receive a 997 indicating your file rejected, the file will not be subjected to the implementation guide requirements and therefore, no 4010 Transmission Acknowledgment report will be created.

If your file rejects at 997, all errors must be corrected and the file resent. We will not contact you in regards to a rejected file. If your file passes both Standard and IG requirements, Medicare will contact you with your test results within ten business days.

If you have additional questions please contact Audrey Lipinski at (904) 791-6865 or email at *Audrey.Lipinski@fcso.com*.

X12 Implementation Guides can be downloaded from **www.wpc-edi.com**.

## Testing the Medicare A 4010 835 Remittance Advice Transaction

Version 4010 of the 835 remittance advice transaction contains some significant changes from earlier versions of Medicare-supported electronic remittance advice formats. Therefore, testing of the new 4010 version of the 835 remittance advice transaction is important to ensure that you are able to successfully retrieve and understand the remittance advice.

Please read this notice carefully as it contains information for successful testing of the ANSI 4010 835 remittance advice transaction.

**General 835 Remittance Advice Testing Information**

To test the 835 remittance advice transaction, you will need to contact the Medicare EDI Department of First Coast Service Options at (904) 791-8254. At that time, Medicare EDI will configure you to receive a test ANSI 835 version 4010 remittance advice in addition to any version of electronic remittance advice you currently receive.

**Parameters**

Medicare will generate both the basic character set and the extended character set with the exception of the * (asterisk) and the > (greater than) signs. All characters will be in upper case.

**Delimiters**

Characters currently used as file delimiters for the 835 remittance advice transaction are: Segment 0A (line feed), Element 2A (*), Sub-element 3E (>). If you want your 835 remittance advice to contain different delimiters, you must notify Medicare EDI before testing.

**Retrieving The 4010 835 Remittance Advice**

The phone number to dial for the retrieval of the 835 4010 is:

| BISYNCHRONOUS | MODEM TYPE |
|---|---|
| (904) 356-0534 | Sync 201/208 |
| (904) 355-2670 | Sync 201 |
| (904) 350-1150 | CCITT V.32 |
| ASYNCHRONOUS | |
| (904) 356-0237 | |

When you connect to the phone number, you should submit a set of "logon" and "obtain" script commands to retrieve the 4010 835 remittance advice. **Note:** If you experience difficulties connecting to this environment, please contact us so we can confirm your mailbox information.

**Examples of the script commands are:**
$BCBSF$ LOGON MAILBOX ID PASSWORD
$BCBSF$
$BCBSF$ OBTAIN EDI $BCBSF$

In the examples above, "MAILBOX ID" would be replaced by your mailbox number and "PASSWORD"

***Administrative Simplification Provisions of HIPAA (continued)***

would be replaced by your password. Your mailbox and password will be the same as they are in the production environment.

Instructions on creating and submitting script commands are available in the "Guide to Gateway," which can be found at **www.floridamedicare.com**, in the EDI section under "specs" by selecting gtg.pdf.

**Medicare A 4010 835 Remittance Advice Enveloping Information**

| ELEMENT | DESCRIPTION | VALUE |
|---|---|---|
| ISA05 | Interchange Control Qualifier | ZZ |
| ISA 06 | Interchange Sender ID | 00090 |
| ISA07 | Interchange Control Qualifier | ZZ |
| ISA 08 | Interchange Receiver ID | Your sender code |
| GS 02 | Application Sender's Code | 00090 |
| GS 03 | Application Receiver's Code | Your sender code |

Be sure to also obtain a copy of the Implementation Guide before you begin testing. A copy can be downloaded at no charge from **www.wpc-edi.com.**

**For Additional Information**

If you have additional questions about the 4010 837 inbound claims transaction, please contact Audrey Lipinski at (904) 791-6865, or via email at *Audrey.Lipinski@fcso.com.*

If you have additional questions about the 4010 835 remittance advice transaction, please contact Cynthia Moore at (904) 791-8254, or via email at *Cynthia.Moore@fcso.com*.

# CRITICAL ACCESS HOSPITAL SERVICES

## Critical Access Hospitals Exempt from the Ambulance Fee Schedule

Section 205 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, exempts certain critical access hospitals (CAHs) from the current ambulance cost per trip payment limit as well as from the ambulance fee schedule. Section 205(a) of BIPA states:

> The Secretary shall pay the reasonable costs incurred in furnishing ambulance services if such services are furnished (A) by a CAH (as defined in section 1861 (mm)(1)), or (B) by an entity that is owned and operated by a CAH, but only if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of such CAH.

This provision is effective for ambulance services furnished **on or after December 21, 2000.**

### Payment Requirements

Ambulance services furnished **on or after December 21, 2000,** by eligible CAHs will be paid on a reasonable cost basis. Eligible CAHs will continue to be paid based on reasonable cost after implementation of the ambulance fee schedule.

**Note:** CAHs that are not exempt will be paid based on the ambulance fee schedule.

Part B deductible and coinsurance apply.

### Billing Requirements

Providers must bill by following the general bill review instructions in section 3604 of the Medicare Intermediary Manual, Part 3, using Form HCFA-1450 (UB-92) or its electronic equivalent.

### Applicable Type of Bill

The appropriate type of bill is 85x.

### Coding Requirements

For claims with dates of service **on or after December 21, 2000,** *CAHs that meet these criteria and are exempt* must report, using existing billing instructions for ambulance services condition code B2 (Critical Access Hospital Ambulance Attestation) in form locators 24-30, "Condition Codes."

CAHs that are **not** exempt may not report condition code B2. ❖

Source: CMS Transmittal A-02-004, CR 1951

# MEDICAL POLICIES

The Centers for Medicare & Medicaid Services (CMS) instructions regarding development of local medical review policies (LMRPs) are addressed in the Medicare Intermediary Manual (CMS 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 CMS 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 **March 28, 2002**, and after, unless otherwise noted.

### Medicare Part A Medical Policy Procedures

Medical policies may be applied to Medicare claims on a pre-payment or postpayment basis. Medicare providers are accountable for complying with Medicare coverage/policy information published via national CMS 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**



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



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

The Centers for Medicare & Medicaid Services (CMS) and the AMA recently signed an amendment to the original 1983 Agreement on CMS'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 Web site (**www.floridamedicare.com**).*

# 20974: Osteogenic Stimulation

## Policy Number
20974

## Contractor Name
First Coast Service Options, Inc.

## Contractor Number
090

## Contractor Type
Intermediary

## LMRP Title
Osteogenic Stimulation

## AMA CPT Copyright Statement


## CMS National Coverage Policy
Coverage Issues Manual, Section 35-48

## Primary Geographic Jurisdiction
Florida

## Secondary Geographic Jurisdiction
N/A

## CMS Region
Region IV

## CMS Consortium
Southern

## Original Policy Effective Date
03/28/2002

## Original Policy Ending Date
N/A

## Revision Effective Date
N/A

## Revision Ending Date
N/A

## LMRP Description
Electrical stimulation to augment bone repair can be attained either invasively or noninvasively. Invasive devices provide electrical stimulation directly at the fracture site either through percutaneously placed cathodes or by implantation of a coiled cathode wire into the fracture site. The power pack for the latter device is implanted into soft tissue near the fracture site and subcutaneously connected to the cathode, creating a self-contained system with no external components. The power supply for the former device is externally placed and the leads are connected to the inserted cathodes. With the noninvasive device, opposing pads, wired to an external power supply, are placed over the cast. An electromagnetic field is created between the pads at the fracture site.

An ultrasonic osteogenic stimulator is a non-invasive device that emits low intensity, pulsed ultrasound. The ultrasound signal is applied to the skin surface at the fracture location via ultrasound using conductive gel in order to stimulate fracture healing.

## Indications and Limitations of Coverage and/or Medical Necessity

**Noninvasive Stimulator (procedure code 20974):**

The noninvasive stimulator device is covered only for the following indications:

- Nonunion of long bone fractures;
- Failed fusion, where a minimum of nine months has elapsed since the last surgery;
- Congenital pseudarthroses; and
- As an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis due to previously failed spinal fusion at the same site or for those undergoing multiple level fusion. A multiple level fusion involves 3 or more vertebrae (e.g., L3-L5, L4-S1, etc.).

**Invasive (Implantable) Stimulator (procedure code 20975):**

The invasive stimulator device is covered only for the following indications:

- Nonunion of long bone fractures; and
- As an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis due to previously failed spinal fusion at the same site or for those undergoing multiple level fusion. A multiple level fusion involves 3 or more vertebrae (e.g., L3-L5, L4-S1, etc.).

Effective for services performed on or after September 15, 1980, nonunion of long bone fractures, for both noninvasive and invasive devices, is considered to exist only after six or more months have elapsed without healing of the fracture.

Effective for services performed on or after April 1, 2000, nonunion of long bone fractures, for both noninvasive and invasive devices, is considered to exist only when serial radiographs have confirmed that fracture healing has ceased for three or more months prior to starting treatment with the electrical osteogenic stimulator. Serial radiographs must include a minimum of two sets of radiographs, each including multiple views of the fracture site, separated by a minimum of 90 days.

**Ultrasonic Osteogenic Stimulators (procedure code 20979):**

Effective for services performed on or after January 1, 2001, ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of non-union fractures. In demonstrating non-union of fractures, we would expect:

- A minimum of two sets of radiographs obtained prior to starting treatment with the osteogenic stimulator, separated by a minimum of 90 days. Each radiograph must include views of the fracture site accompanied with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.
- Indications that the patient failed at least one surgical intervention for the treatment of the fracture.

***20974: Osteogenic Stimulation (continued)***

Non-union fractures of the skull, vertebrae, and those that are tumor-related are excluded from coverage. The ultrasonic stimulator may not be used concurrently with other non-invasive osteogenic devices. The national non-coverage policy related to ultrasonic osteogenic stimulators for fresh fractures and delayed unions remains in place.

## CPT/HCPCS Section & Benefit Category

Musculoskeletal System/Surgery

## Type of Bill Code

Hospital – 13x
Critical Access Hospital – 85x

## Revenue Codes

278 Medical/Surgical Supplies and Devices, Other Implants
360 Operating Room Services, General Classification

## CPT/HCPCS Codes

*20974* *Electrical stimulation to aid bone healing; noninvasive (nonoperative)*
*20975* *Electrical stimulation to aid bone healing; invasive (operative)*
*20979* *Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)*

## Not Otherwise Classified Codes (NOC)

N/A

## ICD-9-CM Codes that Support Medical Necessity

**For procedure code 20974, the following ICD-9-CM codes apply:**

| | |
|---|---|
| 733.81 | Malunion of fracture |
| 733.82 | Nonunion of fracture |
| 996.4 | Mechanical complication of internal orthopedic device, implant, and graft |
| V45.4 | Arthrodesis status |

**For procedure code 20975, the following ICD-9-CM codes apply:**

| | |
|---|---|
| 733.81 | Malunion of fracture |
| 733.82 | Nonunion of fracture |

**For procedure code 20979, the following ICD-9-CM code applies:**

| | |
|---|---|
| 733.82 | Nonunion of fracture |

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

Ultrasonic osteogenic stimulators used for non-union fractures of the skull, vertebrae, and those that are tumor-related are excluded from coverage. In addition, national non-coverage related to ultrasonic osteogenic stimulators for fresh fractures and delayed unions remains in place.

## 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

When billing for the Osteogenesis Stimulator, electrical, (surgically implanted), the device should be coded as E0749. For services performed on or after August 1, 2000, the device will be reimbursed under the hospital outpatient prospective payment system. Hospital providers will no longer submit claims to the carrier for the implanted device. The implantable device itself should be coded with revenue code 278.

The ultrasonic method of osteogenic stimulation is generally performed in the residence of the beneficiary. Therefore, it would generally be expected to see only one ultrasonic stimulator service billed per beneficiary per episode of injury.

## Documentation Requirements

Documentation must support that this service meets the requirements as listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy. This information is normally found in the office/progress notes and/or operative report.

## Utilization Guidelines

N/A

## Other Comments

N/A

## Sources of Information and Basis for Decision

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 advisory groups, which includes representatives from the Orthopedic and Surgical Societies.

## Start Date of Comment Period

02/28/2001

## End Date of Comment Period

04/14/2001

## Start Date of Notice Period

02/01/2002

## Revision History

| | |
|---|---|
| Revision Number: | Original |
| Start Date of Comment Period: | 02/28/2001 |
| Start Date of Notice Period: | 02/01/2002 |
| | 2nd Qtr 2002 *Bulletin* |
| Original Effective Date | 03/28/2002 ❖ |

# 53850: Prostate Treatments

*Revision Overview: Several sections of this policy have been revised to incorporate coverage for water-induced thermotherapy and changes due to the annual 2002 HCPCS update.*

### Policy Number
53850

### Contractor Name
First Coast Service Options, Inc.

### Contractor Number
090

### Contractor Type
Intermediary

### LMRP Title
Prostate Treatments

### AMA CPT Copyright Statement


### CMS National Coverage Policy
N/A

### Primary Geographic Jurisdiction
Florida

### Secondary Geographic Jurisdiction
N/A

### CMS Region
Region IV

### CMS Consortium
Southern

### Original Policy Effective Date
01/21/1999

### Original Policy Ending Date
N/A

### Revision Effective Date
03/28/2002

### Revision Ending Date
03/27/2002

### LMRP Description
The prostate gland is located below the internal urethral orifice, behind the symphysis pubis and close to the rectal wall. The gland averages 4 cm in width at its base, 3 cm from top to bottom, 2 cm from front to back, and 20 g in weight. Clinically, the prostate gland is important because of its affinity for congestive, inflammatory, hyperplastic, and malignant diseases. Since the prostate gland is close to the rectal wall, it is easily palpable by rectal examination, and this makes diagnosis of problems at an early stage possible. Because of the anatomic relationship of the prostate gland to the urethra, most prostatic diseases present as urinary tract symptoms.

Benign prostatic hyperplasia (BPH), the most common benign neoplasm in the aging human male, has a high prevalence that increases progressively with age. The prevalence of histologically identifiable BPH for 60 year old males is greater than 50 percent. By age 85, the prevalence is approximately 90 percent. BPH is fundamentally a disease that causes morbidity through the urinary symptoms with which it is associated. While a minority of men undergo prostatectomy for absolute indications such as recurrent or refractory urinary retention, urinary tract infections, obstructive uropathy or severe hematuria, the majority of men undergo an operation to relieve bothersome urinary symptoms such as frequency, urgency and sensation of incomplete emptying and to improve their quality of life.

For many years prostatectomy, particularly transurethral prostatectomy, has been the standard treatment for symptomatic BPH. More recently, however, a plethora of competing therapies is being used to treat patients with symptomatic BPH. These treatments include transurethral incision of the prostate, laser prostatotomy, balloon dilation, hyperthermia, insertion of prostatic stents, a-adrenergic blocking drugs and hormonal therapy. In addition, a "watchful waiting" approach can be followed.

This policy addresses three treatment options for BPH: Transurethral Microwave Thermotherapy (TUMT), Transurethral Radiofrequency Thermotherapy, and Water-induced Thermotherapy (WIT). Thermotherapy for BPH is based on the principle that heating the adenoma (greater than 45°) causes necrosis of obstructing tissue and leads to relief of prostatic obstruction. Transurethral Microwave Thermotherapy provides simultaneous microwave heating of the prostate with temperatures of 45-55 degrees Celsius with some devices also providing concurrent conductive cooling of the urethra. This treatment results in high-power microwave application deep in the lateral lobes, leading to irreversible cell damage of prostatic tissue without damaging the urethra. TUMT effectively maintains temperatures in the urethra sphincter and rectum at physiologically safe temperatures while targeting heat deep within the prostate transition zone.

Transurethral Radiofrequency Thermotherapy uses radiofrequency (RF) energy (460-490kHz) for prostatic heating. Normally, the RF signal that is generated is carried into the prostate via needles. Thermal energy is generated through inductive heating of water molecules and by friction. The amount of heat energy produced and the subsequent thermal effect are determined by the amount of the tissue contact (length of the needle) and by the wattage energy. These physical properties allow RF energy to achieve: target tissue ablation; precision tissue ablation allowing for the preservation of adjacent tissues and organs; and customized tissue ablation.

Water-induced Thermotherapy (WIT) for BPH is performed in a single outpatient session without anesthesia and delivers heat conductively, thus sparing the need for rectal or urethral temperature monitoring. This type of thermotherapy uses a closed-loop catheter set which heats and maintains circulating hot water at 60 degrees Celsius. The thermally transmissive treatment balloon is inflated within the prostatic urethra. The remaining portion of the catheter shaft is insulated and remains at temperatures below 40 degrees Celsius. This single 45-minute procedure produces deep necrosis within the prostate tissue. The necrosed tissue either sloughs off or is reabsorbed, providing an adequate pathway for the passage of urine.

*53850: Prostate Treatments (continued)*

## Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider the thermotherapy procedures addressed in this policy medically reasonable and necessary when performed with a FDA approved device approved for this specific indication and the patient meets the following criteria:

- Clinical diagnosis of benign prostatic hyperplasia (BPH); and
- American Urological Association Symptom Score of 11 or greater.

**Relative Contraindications**

The following conditions are considered relative contraindications to thermotherapy procedures:

- Active/untreated cystolithiasis, gross hematuria, urethral stricture, bladder neck contracture, active prostatitis, or diabetes mellitus affecting bladder function
- Active urinary tract infection
- Neurogenic bladder without obstruction
- Prostate cancer
- Prostate gland with an obstructive median lobe

## CPT/HCPCS Section & Benefit Category

Surgery/Urinary System

## Type of Bill Code

Hospital – 13x
Critical Access Hospital – 85x

## Revenue Code

360 Operating Room Services, General Classification

## CPT/HCPCS Codes

*53850 Transurethral destruction of prostate tissue; by microwave thermotherapy*
*53852 by radiofrequency thermotherapy*
*53853 by water-induced thermotherapy*

## Not Otherwise Classified Codes (NOC)

N/A

## ICD-9-CM Codes that Support Medical Necessity

600.0 Hypertrophy (benign) of prostate

## 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 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 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

N/A

## Documentation Requirements

Medical record documentation maintained in the patient's file must document that the patient has a clinical diagnosis of BPH and a AUA symptom score of 11 or greater. In addition, a description of the thermotherapy procedure must be documented. This information is usually found in the office/progress notes, history and physical, and/or procedure note.

## Utilization Guidelines

N/A

## Other Comments

N/A

## Sources of Information and Basis for Decision

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

## Advisory Committee Notes

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

## Start Date of Comment Period

05/18/2001

## End Date of Comment Period

07/02/2001

## Start Date of Notice Period

02/01/2002

## Revision History

| | |
|---|---|
| Revision Number: | 5 |
| Start Date of Comment Period | 05/18/2001 |
| Start Date of Notice Period | 02/01/2002 |
| | 2nd Qtr 2002 *Bulletin* |
| Revised Effective Date: | 03/28/2002 |

Explanation of Revision: 2002 HCPCS deleted code C9700, therefore all references regarding this code were deleted. Procedure code 53853 was added to the policy.

| | |
|---|---|
| Revision Number: | 4 |
| Start Date of Comment Period | 05/18/2001 |
| Start Date of Notice Period | 02/01/2002 |
| | 2nd Qtr 2002 *Bulletin* |
| Revised Effective Date: | 03/28/2002 |

Explanation of Revision: A recent evaluation of water-induced thermotherapy was completed resulting in a coverage decision. The information regarding this thermotherapy was added to the policy. ❖

# 77300: Basic Radiation Dosimetry Calculation

*Revision Overview: Policy has been revised as a result of the annual 2002 HCPCS update. "Type of Bill Code" section of the policy has been revised.*

### Policy Number
77300

### Contractor Name
First Coast Service Options, Inc.

### Contractor Number
090

### Contractor Type
Intermediary

### LMRP Title
Basic Radiation Dosimetry Calculation

### AMA CPT Copyright Statement


### CMS National Coverage Policy
N/A

### Primary Geographic Jurisdiction
Florida

### Secondary Geographic Jurisdiction
N/A

### CMS Region
Region IV

### CMS Consortium
Southern

### Original Policy Effective Date
02/24/1997

### Original Policy Ending Date
N/A

### Revision Effective Date
01/01/2002

### Revision Ending Date
12/31/2001

### LMRP Description
Basic dosimetry is a calculation of the amount of radiation being received at a tumor site and is only performed when requested by the radiation oncologist. This is done either by the radiation oncologist, the medical radiological physicist, or the medical treatment planning dosimetrist under the technical supervision of the radiation oncologist.

### Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider basic radiation dosimetry to be medically necessary for each treatment field (area) if the patient has off-axis calculations, if there are calculations for different depth doses, different target areas, secondary film dosimetry, abutting fields, or any other situation requiring individual point calculations of radiation dosage. Changes in a patient's weight during the course of radiation treatment may necessitate dosimetry recalculation.

This procedure is not to be routinely performed each time the patient is treated. It would be expected that utilization of this procedure would correspond with the level of complexity of the clinical treatment planning services provided for the patient.

### CPT/HCPCS Section & Benefit Category
Radiology/Radiation Oncology

### Type of Bill Code
Hospital – 12x, 13x
Critical Access Hospital – 85x

### Revenue Code
333 Radiation Therapy

### CPT/HCPCS Codes
*77300* *Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician*

### Not Otherwise Classified Codes (NOC)
N/A

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

### 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 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 Codes
N/A

### Noncovered Diagnosis
N/A

### Coding Guidelines
Basic dosimetry calculations may be reported as many times as the calculations are performed; however, the calculation of different projections for the same site are considered to be included as one (1) calculation. Example: if the site of treatment will be the prostate but calculations will be done from different directions such as AP, PA and lateral, this is considered one (1) calculation for billing purposes. If different organ sites will be treated such as a primary and metastatic site, additional calculations may then be allowed.

***77300: Basic Radiation Dosimetry Calculation (continued)***

## Documentation Requirements

Medical record documentation maintained in the patient's medical record must include the following:

- identification of all body area(s) being treated and requiring dosimetry calculations,
- an explanation for the need for additional calculations,
- the calculation of the radiation dose distribution (i.e., the radiation dosage and length of time to deliver the dose) either by hand calculation or computer, and
- the signature of both the medical radiological physicist and the radiation oncologist on the approved calculations.

## Utilization Guidelines

N/A

## Other Comments

N/A

## Sources of Information and Basis for Decision

User's Guide for the Radiation Oncology Related CPT Codes; 4th Edition; American College of Radiology

## 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 Radiology and Radiation Oncology Societies.

## Start Date of Comment Period

N/A

## End Date of Comment Period

N/A

## Start Date of Notice Period

02/01/2002

## Revision History

| | |
|---|---|
| Revision Number: | 2 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 02/01/2002<br>2nd Qtr 2002 *Bulletin* |
| Revised Effective Date: | 01/01/2002 |
| Explanation of Revision: | Annual 2002 HCPCS Update. |

| | |
|---|---|
| Revision Number: | 1 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 02/25/2002<br>Feb. 25, 2000 *Bulletin* |
| Revised Effective Date: | 08/01/2000 |
| Explanation of Revision: | Outpatient PPS implementation. |

| | |
|---|---|
| Revision Number: | Original |
| Start Date of Comment Period | None needed |
| Start Date of Notice Period | 01/22/1997 |
| Original Effective Date: | 02/24/1997 ❖ |

# 78267: Breath Test for Helicobacter Pylori (H. PYLORI)

*Revision Overview: Policy has been revised as a result of the annual 2002 HCPCS update. "Type of Bill Code" section of the policy has been revised.*

### Policy Number
78267

### Contractor Name
First Coast Service Options, Inc.

### Contractor Number
090

### Contractor Type
Intermediary

### LMRP Title
Breath Test For Helicobacter Pylori (H. PYLORI)

### AMA CPT Copyright Statement


### CMS National Coverage Policy
N/A

### Primary Geographic Jurisdiction
Florida

### Secondary Geographic Jurisdiction
N/A

### CMS Region
Region IV

### CMS Consortium
Southern

### Original Policy Effective Date
02/25/2000

### Original Policy Ending Date
N/A

### Revision Effective Date
01/01/2002

### Revision Ending Date
12/31/2001

### LMRP Description
Helicobacter pylori is a gram-negative rod that is adapted to survive in the highly acid gastric environment. It plays a major role in the pathogenesis of peptic ulcer disease and to the development of chronic active gastritis. H. pylori infection is an independent risk factor for gastric cancer and primary gastric malignant lymphoma.

The breath test for H. pylori is a non-invasive diagnostic procedure utilizing analysis of breath samples to determine the presence of H. pylori. The test is positive when an active H. pylori infection is present, and is negative with eradication of the infection. The breath test can detect H. pylori colonization with reported 95% accuracy. There are several different types of breath tests available, depending on the use of C-13 or C-14 isotope.

The carbon-13 breath test (not radioactive) consists of analysis of breath samples before and after ingestion of 13C-urea. 13C-urea will decompose to form 13CO2 and NH4 in the presence of urease, which is produced by H. pylori in the stomach. The 13CO2 is absorbed in the blood, then exhaled in the breath. The exhaled breath sample is then analyzed and compared with the baseline breath sample which was obtained before the ingestion of the 13C-urea.

The 14C-urea breath test (radioactive) is performed by having the patient swallow a capsule containing C-14 urea. A breath sample is collected in a balloon or vial 10 minutes later. The sample is then mixed with scintillation fluid and analyzed by a scintillation counter.

There are other tests that can aid in the detection of peptic ulcer disease. These include EGD (Esophagogastroduodenoscopy) with tissue examination, serum antibody test, and radiological examination.

### Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider the breath test for H. pylori to be medically reasonable and necessary for the following conditions:

- A patient has uncomplicated symptoms of peptic ulcer disease (e.g., epigastric pain, dyspepsia, nausea, and anorexia) and antibiotic therapy is planned if the H. pylori breath test is positive, and no gastrointestinal endoscopy has been done within the preceding six weeks or is planned;
- An upper gastrointestinal contrast series has been done which shows duodenal ulcer or significant gastritis and/or duodenitis, and no endoscopy has been done within the preceding six weeks or is planned; and/or
- There are persistent or recurrent symptoms six weeks after appropriate antibiotic and H3 antagonist treatment for a documented H. pylori infection and no endoscopy has been planned.

Florida Medicare will consider the breath test for H. pylori **not** medically necessary in the following situations:

- Patients who are being screened for H. Pylori infection in the absence of documented upper gastrointestinal tract symptoms and/or pathology;
- Patients who have had an upper gastrointestinal endoscopy within the preceding six weeks or for whom an upper gastrointestinal endoscopy is planned;
- Patients who have new onset dyspepsia responsive to conservative treatment (withdrawal of nonsteroidal antiinflammatory drugs and/or use of antisecretory agents);
- Patients who have non-specific dyspeptic symptoms with a negative H. pylori serum antibody test, and/or
- Patients who are asymptomatic after treatment of an H. pylori infection (either proven or suspected). Therefore, repeating the breath test for mere confirmation of treatment success will not be covered.

### CPT/HCPCS Section & Benefit Category
Pathology and Laboratory/Chemistry
Radiology/Nuclear Medicine

### Type of Bill Code
Hospital – 12x, 13x, 14x
Skilled Nursing Facility – 21x, 22x, 23x
Critical Access Hospital – 85x

***78267: Breath Test for Helicobacter Pylori (H. PYLORI) (continued)***

## Revenue Code

301 Chemistry
34x Nuclear Medicine

## CPT/HCPCS Codes

*78267* *Urea breath test, C-14; acquisition for analysis;* (**Note:** use this code for C-14 Breath Test only)
*78268* *analysis* (**Note:** use this code for C-14 Breath Test only)
*83013* *Helicobacter pylori; analysis for urease activity, non-radioactive isotope* (**Note:** use this code for C-13 Breath Test only)
*83014* *drug administration and sample collection* (**Note:** use this code for C-13 Breath Test only)

## Not Otherwise Classified Codes (NOC)

N/A

## ICD-9-CM Codes that Support Medical Necessity

| | |
|---|---|
| 151.0-151.9 | Malignant neoplasm of stomach (MALT lymphoma) |
| 531.30-531.31 | Gastric ulcer, acute without mention of hemorrhage or perforation |
| 531.70-531.71 | Gastric ulcer, chronic without mention of hemorrhage or perforation |
| 532.30-532.31 | Duodenal ulcer, acute without mention of hemorrhage or perforation |
| 532.70-532.71 | Duodenal ulcer, chronic without mention of hemorrhage or perforation |
| 534.30-534.31 | Gastrojejunal ulcer, acute without mention of hemorrhage or perforation |
| 534.70-534.71 | Gastrojejunal ulcer, chronic without mention of hemorrhage or perforation |
| 535.00 | Acute gastritis without mention of hemorrhage |
| 535.10 | Atrophic gastritis without mention of hemorrhage |
| 789.01 | Abdominal pain, right upper quadrant |
| 789.02 | Abdominal pain, left upper quadrant |
| 789.06 | Abdominal pain, epigastric |

## 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 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 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

Use code 78267 (C-14) or 83013 (C-13) for isotope administration and sample collection only.

Use code 78268 (C-14) or 83013 (C-13) for the actual analysis. If the physician performs the drug administration, specimen collection and analysis, then both codes (78267 and 78268 or 83013 and 83014) should be reported.

Currently, the kit used by the practitioner performing the acquisition includes the isotope. Therefore, separate reporting for the provision of the radiopharmaceutical (HCPCS A4641 or code 78990) is unnecessary. Also included is a "mailer," which precludes the reporting of code 99000.

## Documentation Requirements

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

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

## Utilization Guidelines

N/A

## Other Comments

N/A

## Sources of Information and Basis for Decision

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

## Advisory Committee Notes

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

## Start Date of Comment Period

N/A

## End Date of Comment Period

N/A

## Start Date of Notice Period

02/01/2002

## Revision History

| | |
|---|---|
| Revision Number: | 4 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 02/01/2002 2nd Qtr 2002 *Bulletin* |
| Revised Effective Date: | 01/01/2002 |
| Explanation of Revision: | Annual 2002 HCPCS Update |
| Revision Number: | 3 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 12/22/2000 Special Issue 2000 *Bulletin* |
| Revised Effective Date: | 01/01/2001 |
| Explanation of Revision: | Annual 2001 HCPCS Update ❖ |

# 93975: Duplex Scanning

*Revision Overview: "Additional diagnoses have been added to the policy. "Type of Bill Code" section of the policy has been revised.*

### Policy Number
93975

### Contractor Name
First Coast Service Options, Inc.

### Contractor Number
090

### Contractor Type
Intermediary

### LMRP Title
Duplex Scanning

### AMA CPT Copyright Statement


### CMS National Coverage Policy
Coverage Issues Manual, Section 50-7
Hospital Manual, Section 443
Intermediary Manual, Section 3631

### Primary Geographic Jurisdiction
Florida

### Secondary Geographic Jurisdiction
N/A

### CMS Region
Region IV

### CMS Consortium
Southern

### Original Policy Effective Date
05/27/1999

### Original Policy Ending Date
N/A

### Revision Effective Date
01/14/2002

### Revision Ending Date
01/13/2002

### LMRP Description
Duplex scanning describes an ultrasonic scanning procedure with display of both two-dimensional structure and motion with time and Doppler ultrasonic signal documentation with spectral analysis and/or color flow velocity mapping or imaging.

### Indications and Limitations of Coverage and/ or Medical Necessity

**Arterial inflow and venous outflow of abdominal, pelvic, and/or retroperitoneal organs (procedure codes 93975 and 93976)**

Florida Medicare may provide coverage for duplex scanning of arterial inflow and venous outflow of abdominal, pelvic, and/or retroperitoneal organs (procedure codes 93975 and 93976) ]when performed for the following indications:

- To evaluate patients presenting with signs or symptoms such as epigastric or periumbilical postprandial pains that last for 1-3 hours and/or with associated weight loss resulting from decreased oral intake which may indicate chronic intestinal ischemia.
- To evaluate patients presenting with an acute onset of crampy or steady epigastric and periumbilical abdominal pain combined with minimal or no findings on abdominal examination and a high leukocyte count to rule out acute intestinal ischemia.
- To evaluate a patient who has sustained trauma to the abdominal, pelvic and/or retroperitoneal area resulting in a possible injury to the arterial inflow and/or venous outflow of the abdominal, pelvic and/or retroperitoneal organs.
- To evaluate a suspicion of an aneurysm of the renal artery or other visceral artery based on a patient's signs and symptoms of abdominal pain or noted as an incidental finding on another radiological examination.
- To evaluate a hypertensive patient who has failed first line antihypertensive drug therapy in order to rule out renovascular disease such as renal artery stenosis, renal arteriovenous fistula, or renal aneurysm as a cause for the uncontrolled hypertension.
- To evaluate a patient with signs and symptoms of portal hypertension. These may include abdominal discomfort and distention, abdominal collaterals (caput medusae), abdominal bruit, ascites, encephalopathy, esophageal varices, splenomegaly, etc.
- To evaluate patients suspected of an embolism, thrombosis, hemorrhage or infarction of the portal vein, renal vein and/or renal artery. These patients may present with many different symptoms such as abdominal discomfort, hematuria, cardiac failure, diastolic hypertension, jaundice, fatigue, weakness, malaise, etc.

**Aorta, inferior vena cava, iliac vasculature, or bypass grafts ( procedure codes 93978 and 93979):**

Florida Medicare may provide coverage for duplex scanning of aorta, inferior vena cava, iliac vasculature, or bypass grafts when performed for the following indications:

- To confirm a suspicion of an abdominal or iliac aneurysm raised by a physical examination or noted as an incidental finding on another radiological examination. The physical examination usually reveals a palpable, pulsatile and nontender abdominal mass.
- To monitor the progression of an abdominal aortic aneurysm. It is usually expected that monitoring occurs approximately every six (6) months.
- To evaluate patients presenting with signs and symptoms of a thoracic aneurysm. The symptoms usually associated with a thoracic aneurysm are substernal chest pain, back or neck pain described as deep and aching or throbbing as well as symptoms due to pressure on the trachea (dyspnea, stridor, a brassy cough), the esophagus (dysphagia), the laryngeal nerve (hoarseness), or superior vena cava (edema in necks and arms, distended neck veins).

***93975: Duplex Scanning (continued)***

- To evaluate patients presenting with signs and symptoms of an abdominal aneurysm. The symptoms usually associated with an abdominal aneurysm are constant pain located in the midabdomen, lumbar region or pelvis which can be severe and may be described as having a boring quality. A leaking aneurysm is characterized by lower back pain, whereas, acute pain and hypotension usually occur with rupture.
- To evaluate a patient presenting with signs and symptoms suggestive of an aortic dissection. A patient with an aortic dissection has symptoms such as a sudden onset of severe, continuous tearing or crushing pain in the chest that radiates to the back and is generally unaccompanied by EKG evidence of a myocardial infarction. On physical examination, the patient is agitated, has a murmur of aortic regurgitation, asymmetric diminution of arterial pulses and systolic bruits over the areas where the aortic lumen is narrowed.
- Initial evaluation of a patient presenting with signs and symptoms such as intermittent claudication in the calf muscles, thighs and/or buttocks, rest pain, weakness in legs or feeling of tiredness in the buttocks, etc. which may suggest occlusive disease of the aorta and iliac arteries. The physical examination usually reveals decreased or absent femoral pulses, a bruit over the narrowed artery, and possibly muscle atrophy. If severe occlusive disease exists, the patient will have atrophic changes of the skin, thick nails, coolness of the skin with pallor and cyanosis.
- To evaluate patients suspected of an abdominal or thoracic arterial embolism or thrombosis. These patients usually present with severe pain in one or both lower extremities, numbness, and symmetric weakness of the legs, with absent or severely reduced pulses below the embolism site.
- To evaluate patients presenting with complaints of pain in the calf or thigh, slight swelling in the involved leg, tenderness of the iliac vein, etc. which may suggest phlebitis or thrombophlebitis of the iliac vein or inferior vena cava.
- To evaluate a patient who has sustained trauma to the chest wall and/or abdomen resulting in a possible injury to the aorta, inferior vena cava and/or iliac vasculature.
- To assess the continued patency of both native venous and prosthetic arterial grafts following surgical intervention. Usually this is performed at 6 weeks, 3 months, then every six (6) months.
- To monitor the sites of various percutaneous interventions, including, but not limited to angioplasty, thrombolysis/thrombectomy, atherectomy, or stent placement. Usually this is performed at 6 weeks, 3 months, then every six (6) months.

**Note:** Duplex testing should be reserved for specific indications for which the precise anatomic information obtained by this technique is likely to be useful. Therefore, it would be rare to see duplex scanning being performed for conditions in which another diagnostic test is recommended (e.g., an aortic dissection is better diagnosed with a chest X-ray, transesophageal echocardiogram or aortography).

## CPT/HCPCS Section & Benefit Category

Non-invasive Vascular Diagnostic Studies/Medicine

## Type of Bill Code

Hospital – 12x, 13x, 14x
Skilled Nursing Facility – 21x, 22x, 23x
Critical Access Hospital – 85x

## Revenue Code

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

## CPT/HCPCS Codes

| | |
|---|---|
| *93975* | *Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study* |
| *93976* | *limited study* |
| *93978* | *Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study* |
| *93979* | *unilateral or limited study* |

## Not Otherwise Classified Codes (NOC)

N/A

## ICD-9-CM Codes that Support Medical Necessity

**Arterial inflow and venous outflow of abdominal, pelvic, and/or retroperitoneal organs (procedure codes 93975 and 93976)**

| | |
|---|---|
| 288.8 | Other specified disease of white blood cells |
| 401.9 | Unspecified essential hypertension |
| 440.1 | Atherosclerosis of renal artery (renal artery stenosis) |
| 442.1 | Other aneurysm of renal artery |
| 442.84 | Other aneurysm of other visceral artery (e.g., celiac, superior mesenteric) |
| 452 | Portal vein thrombosis |
| 453.3 | Other venous embolism and thrombosis of renal vein |
| 456.0-456.21 | Esophageal varices |
| 557.0 | Acute vascular insufficiency of intestine |
| 557.1 | Chronic vascular insufficiency of intestine |
| 572.3 | Portal hypertension |
| 593.81 | Vascular disorders of kidney (e.g., renal artery thrombosis) |
| 593.89 | Other specified disorders of kidney and ureter (renal artery fistula) |
| 599.7 | Hematuria |
| 780.79 | Other malaise and fatigue |
| 782.4 | Jaundice, unspecified, not of newborn |
| 783.21 | Loss of weight |
| 785.9 | Other symptoms involving cardiovascular system (bruit) |
| 789.00-789.09 | Abdominal pain |
| 789.1 | Hepatomegaly |
| 789.2 | Splenomegaly |
| 789.30-789.39 | Abdominal or pelvic swelling, mass, or lump |
| 789.5 | Ascites |
| 793.6 | Nonspecific abnormal findings on radiological and other examination of abdominal area, including retroperitoneum |

***93975: Duplex Scanning (continued)***

| | |
|---|---|
| 902.20-902.27 | Injury to celiac and mesenteric arteries |
| 902.31-902.39 | Injury to portal and splenic veins |
| 902.41 | Injury to blood vessels of renal artery |
| 902.42 | Injury to blood vessels of renal vein |
| 902.87 | Injury multiple vessels of abdomen and pelvis |
| 902.9 | Injury to unspecified blood vessel of abdomen and pelvis |

**Aorta, inferior vena cava, iliac vasculature, or bypass grafts (procedure codes 93978 and 93979)**

| | |
|---|---|
| 424.1 | Aortic valve disorders (aortic regurgitation) |
| 440.21-440.24 | Atherosclerosis of native arteries of the extremities |
| 441.00-441.03 | Dissection of aorta |
| 441.2 | Thoracic aneurysm without mention of rupture |
| 441.4 | Abdominal aneurysm without mention of rupture |
| 441.7 | Thoracoabdominal aneurysm, without mention or rupture |
| 441.9 | Aortic aneurysm of unspecified site without mention of rupture |
| 442.2 | Other aneurysm of iliac artery |
| 443.9 | Peripheral vascular disease, unspecified (intermittent claudication) |
| 444.0 | Arterial embolism and thrombosis of abdominal aorta |
| 444.1 | Arterial embolism and thrombosis of thoracic aorta |
| 444.81 | Arterial embolism and thrombosis of iliac artery |
| 451.81 | Phlebitis and thrombophlebitis of iliac vein |
| 453.2 | Other venous embolism and thrombosis of vena cava |
| 458.9 | Hypotension, unspecified |
| 723.1 | Cervicalgia |
| 724.1 | Pain in thoracic spine |
| 724.2 | Lumbago |
| 729.5 | Pain in limb |
| 782.0 | Disturbance of skin sensation |
| 782.3 | Edema |
| 782.5 | Cyanosis |
| 782.61 | Pallor |
| 782.8 | Changes in skin texture |
| 784.49 | Other voice disturbance (hoarseness) |
| 784.5 | Other speech disturbance (dysphagia) |
| 785.9 | Other symptoms involving cardiovascular system (arterial bruits, weak pulses) |
| 786.05 | Shortness of breath (dyspnea) |
| 786.1 | Stridor |
| 786.2 | Cough |
| 786.50 | Chest pain, unspecified |
| 789.00-789.09 | Abdominal pain |
| 789.30-789.39 | Abdominal or pelvic swelling, mass, or lump |
| 793.6 | Nonspecific abnormal findings on radiological and other examination of abdominal area, including retroperitoneum |
| 902.0 | Injury to blood vessels of abdominal aorta |
| 902.10 | Injury to blood vessels of inferior vena cava, unspecified |
| 902.53 | Injury to blood vessels of iliac artery |
| 902.54 | Injury to blood vessels of iliac vein |
| V67.00 | Follow-up examination following surgery, unspecified |
| V67.09 | Follow-up examination following other surgery |
| V67.59 | Follow-up examination, following other treatment |

## 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 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 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

Reimbursement for non-invasive vascular diagnostic studies include the following:

- patient care required to perform the studies,
- supervision of the studies,
- interpretation of study results with hard copy output for patient records, and
- bidirectional vascular flow or imaging when provided.

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 part of the physical examination of the vascular system and is not separately reported.

## Documentation Requirements

Medical record documentation maintained by the ordering physician must clearly indicate the medical necessity of the services being billed. The results of the study must also 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 duplex scan study(ies) 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.

***93975: Duplex Scanning (continued)***

## Utilization Guidelines

N/A

## Other Comments

**Terms defined:**

*Aneurysm* – localized abnormal dilatation of a blood vessel, usually an artery.

*Arteriosclerosis* – generic term for processes causing hardening and thickening of arteries. Arteriosclerosis is the thickening and narrowing of small arteries and arterioles that develops in hypertension, diabetes, and amyloidosis.

*Atherosclerosis* – is a disease of the elastic arteries, including the aorta and iliac arteries, and large and medium-sized muscular arteries, including the coronary, carotid, intracerebral and femoropopliteal arteries.

*Aortic dissection* – caused by a forceful penetration of blood between the layers of the vessel, characteristically separating the outer third from the inner two-thirds of the media.

*Embolism* – obstruction of a blood vessel by foreign substances or a blood clot.

*Fusiform aneurysm* – affects the entire circumference of a segment of the vessel, resulting in a diffusely dilated lesion.

*Intermittent claudication* – an aching sensation that occurs reproducibly on walking and then resolves promptly (within 10 minutes) of rest.

*Peripheral vascular disease (PVD )*– an imprecise term indicating diseases of the arteries and veins of the extremities, especially those conditions that interfere with adequate flow of blood to or from the extremities, such as atherosclerosis with narrowing of the arterial lumen.

*Phlebitis* – inflammation of a vein.

*Portal hypertension* – increases pressure in the portal vein as a result of obstruction of the flow of blood through the liver.

*Saccular aneurysm* – involves only a portion of the circumference, resulting in an outpouching of the vessel wall.

*Thrombophlebitis* – inflammation of a vein in conjunction with the formation of a thrombus.

*Thrombosis* – the formation, development, or existence of a blood clot that obstructs a blood vessel or a cavity of the heart.

## Sources of Information and Basis for Decision

American Heart Association. (1994). *Nomenclature and criteria for diagnosis of diseases of the heart and great vessels* (9th ed.). Boston: Little, Brown, and Company.

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## Advisory Committee Notes

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

## Start Date of Comment Period

N/A

## End Date of Comment Period

N/A

## Start Date of Notice Period

02/01/2002

## Revision History

| | |
|---|---|
| Revision Number: | 4 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 02/01/2002<br>2nd Qtr 2002 *Bulletin* |
| Revised Effective Date: | 01/14/2002 |
| Explanation of Revision: | Additional diagnoses were added to reflect the signs/symptoms associated with the covered indications. |

| | |
|---|---|
| Revision Number: | 3 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 10/01/2000<br>Oct/Nov 2000 *Bulletin* |
| Revised Effective Date: | 10/01/2000 |
| Explanation of Revision: | Annual ICD-9-CM Update |

| | |
|---|---|
| Revision Number: | 2 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 02/25/2000<br>Special Issue 2000 *Bulletin* |
| Revised Effective Date: | 08/01/2000 |
| Explanation of Revision: | Outpatient PPS Implementation |

| | |
|---|---|
| Revision Number: | 1 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 06/07/1999 |
| Revised Effective Date: | 07/22/1999 |
| Explanation of Revision: | Based on the information in the Hospital and Intermediary Manual revenue code 921 was identified as the appropriate revenue code to bill with the HCPCS code listed in this policy. |

| | |
|---|---|
| Revision Number: | Original |
| Start Date of Comment Period | 12/07/1998 |
| Start Date of Notice Period | 03/18/1998 |
| Original Effective Date: | 05/27/1999 ❖ |

# 93990: Duplex Scan of Hemodialysis Access

*Revision Overview: Policy was revised to include clarification of the clinical indicators, documentation requirements and utilization guidelines. "Type of Bill Code" section of the policy has also been revised.*

## 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


## CMS National Coverage Policy
Intermediary Manual 3, Addendum K
Provider Reimbursement Manual, Section 2710
Transmittals AB-00-44 and AB-00-55
Program Memorandum AB-01-189 (Change Request 1855, dated December 20, 2001)

## Primary Geographic Jurisdiction
Florida

## Secondary Geographic Jurisdiction
N/A

## CMS Region
Region IV

## CMS Consortium
Southern

## Original Policy Effective Date
03/15/2001

## Original Policy Ending Date
N/A

## Revision Effective Date
01/01/2002

## Revision Ending Date
12/31/2001

## 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 canulation by multiple personnel;
- thrombus aspiration by multiple personnel;
- prolonged bleeding after needle withdrawal;
- pain in graft arm;
- persistent swelling in graft arm;
- elevated dynamic venous pressure greater than 200 mm Hg when measured during dialysis with the blood pump seton a 200 cc/min;
- access recirculation time of 12% or greater;
- an otherwise unexplained urea reduction ratio 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
- an access with a palpable "water hammer" pulse on examination, (which implies venous outflow obstruction)].

## CPT/HCPCS Section & Benefit Category
Medicine/Noninvasive Vascular Diagnostic Studies

## Type of Bill Code
Hospital – 12x, 13x
Skilled Nursing Facility – 21x, 22x, 23x
End Stage Renal Disease – 72x
Critical Access Hospital – 85x

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

## CPT/HCPCS Codes
*93990* *Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)*

## Not Otherwise Classified Codes (NOC)
N/A

*93990: Duplex Scan of Hemodialysis Access (continued)*

## ICD-9-CM Codes that Support Medical Necessity

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

## 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 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 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

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.

## Documentation Requirements

Medical record documentation maintained by the facility and/or physician must clearly indicate the medical necessity of the services being billed. The documentation must also indicate that the service was performed. This information is normally included in the office/progress notes, facility/hospital records, and/or procedure report.

## Utilization Guidelines

Unless the documentation is provided supporting the necessity of more than one study, Medicare will limit payment to either a Doppler flow study or an arteriogram (fistulogram, or venogram), but not both.

## Other Comments

Medicare pays for outpatient maintenance dialysis services furnished by ESRD facilities based on a composite payment rate. This rate is a comprehensive payment and includes all services, equipment, supplies, and certain laboratory tests and drugs that are necessary to furnish a dialysis treatment.

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 and Basis for Decision

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

## Advisory Committee Notes

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

## Start Date of Comment Period

N/A

## End Date of Comment Period

N/A

## Start Date of Notice Period

02/01/2002

## Revision History

| | |
|---|---|
| Revision Number: | 1 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 02/01/2002<br>2nd Qtr 2002 *Bulletin* |
| Revised Effective Date: | 01/01/2002 |

Explanation of Revision: Transmittal AB-01-189 was released September 15, 2001. Policy was revised for clarification.

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

# 95900: Nerve Conduction Studies

*Revision Overview: Policy has been revised as a result of the annual 2002 HCPCS update. "Type of Bill Code" section of the policy has been revised.*

### 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


### CMS National Coverage Policy
Coverage Issues Manual, Section 50-17

### Primary Geographic Jurisdiction
Florida

### Secondary Geographic Jurisdiction
N/A

### CMS Region
Region IV

### CMS Consortium
Southern

### Original Policy Effective Date
07/13/1998

### Original Policy Ending Date
N/A

### Revision Effective Date
01/01/2002

### Revision Ending Date
12/31/2001

### 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, or motor.

- 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 bracheal 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.

## CPT/HCPCS Section & Benefit Category

Medicine/Neurology and Neuromuscular Procedures

## Type of Bill

Hospital – 12x, 13x, 14x
Skilled Nursing Facility – 21x, 22x, 23x
Comprehensive Outpatient Rehabilitation Facility – 75x
Critical Access Hospital – 85x

## Revenue Codes

92x Other Diagnostic Services

## CPT/HCPCS Codes

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

## 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 |

## 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 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 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

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 vasculities.

*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.

*Neuronopathies* 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 neuronopathies) or, less commonly, of the dorsal root ganglia (sensory neuronopathies).

*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 manifest 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 findings. Manifestations of vasomotor instablility 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 and Basis for Decision

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

## Advisory Committee Notes

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

## Start Date of Comment Period

N/A

## End Date of Comment Period

N/A

## Start Date of Notice Period

02/01/2002

## Revision History

| | |
|---|---|
| Revision Number: | 5 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 02/01/2002<br>2nd Qtr 2002 *Bulletin* |
| Revised Effective Date: | 01/01/2002 |
| Explanation of Revision: | Annual 2002 HCPCS Update. |

| | |
|---|---|
| Revision Number: | 4 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 02/25/2000 Feb. 2000 Special Issue |
| Revised Effective Date: | 08/01/2000 |
| Explanation of Revision: | Outpatient PPS implementation. Added statement regarding QST testing |

| | |
|---|---|
| Revision Number: | 3 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 12/1999 Dec. 1999 Special Issue *Bulletin* |
| Revised Effective Date: | 01/01/2000 |
| Explanation of Revision: | Annual 2000 HCPCS Update |

| | |
|---|---|
| Revision Number: | 2 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 11/02/1998 |
| Revised Effective Date: | 10/01/1998 |
| Explanation of Revision: | Annual 1999 ICD-9-CM Update |

| | |
|---|---|
| Revision Number: | 1 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 09/18/1998 |
| Revised Effective Date: | 09/03/1998 |
| Explanation of Revision: | This policy has been revised to add diagnoses 335.0-335.9 (anterior horn cell disease) to the "ICD-9-CM Codes That Support Medical Necessity" section of this policy. |

| | |
|---|---|
| Revision Number: | Original |
| Start Date of Comment Period | 02/23/1998 |
| Start Date of Notice Period | 05/29/1998 |
| Original Effective Date: | 07/13/1998 ❖ |

# 97003: Occupational Therapy Policy for Rehabilitation Services

*Revision Overview: Policy has been revised as a result of the annual 2002 HCPCS update. "Type of Bill Code" section of the policy has been revised.*

### Policy Number
97003

### Contractor Name
First Coast Service Options, Inc.

### Contractor Number
090

### Contractor Type
Intermediary

### LMRP Title
Occupational Therapy Policy for Rehabilitation Services

### AMA CPT Copyright Statement


### CMS National Coverage Policy
Coverage Issues Manual, Sections 35-72 and 45-12
Medicare Manual References:
Hospital Manual, Sections 241-242.4; 445-445.2
Skilled Nursing Manual, Section 230.3
Outpatient Rehabilitation and CORF Manual, Sections 200-205.3; 401-403.4
Medicare Intermediary Manual, Sections 3147-3149; 3903-3910; 3350
Code of Federal Register, Sections 3128 (b)(2)(3), 16,838G and 16,959

### Primary Geographic Jurisdiction
Florida

### Secondary Geographic Jurisdiction
N/A

### CMS Region
Region IV

### CMS Consortium
Southern

### Original Policy Effective Date
10/18/1998

### Original Policy Ending Date
N/A

### Revision Effective Date
01/01/2002

### Revision Ending Date
12/31/2001

### LMRP Description
Occupational therapy is a medically prescribed treatment concerned with improving or restoring functions which have been impaired, permanently lost or reduced by illness or injury. Occupational therapy facilitates learning of the skills and functions essential for adaptation and productivity to achieve one's maximum potential for independent functioning.

Occupational therapy may involve:

- the evaluation and re-evaluation when indicated, of a patient's level of functioning;
- selection and teaching of task-oriented therapeutic activities designed to restore physical functioning;
- planning, implementing and supervising an individualized therapeutic activity program for a psychiatric patient as part of an overall active treatment plan;
- planning and implementing therapeutic activities and tasks to restore sensory-integrative function;
- teaching compensatory techniques to improve the level of independence in activities of daily living; and
- designing, fabricating and fitting of orthotic and self-help devices.

### Indications and Limitations of Coverage and/or Medical Necessity
Covered occupational therapy services must relate directly and specifically to a written treatment regimen established by the physician (MD, DO, or Podiatrist legally authorized to practice by the State in which services are performed) after any needed consultations with the qualified occupational therapist, or by the occupational therapist providing the services.

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

The patient is under the care of a physician.

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 that the patient has been seen by the physician at least every 30 days.

The physician must document an adequate assessment of the patient that will provide justification for the need of an occupational therapist (the physician has evaluated the patient and has determined that a medical need and rehabilitation potential exists). The assessment must occur **prior** to the initiation of the referral process.

The therapy must be furnished under a written plan of treatment, with measurable goals and time frames, established by the physician or therapist caring for the patient and approved/signed by the physician. The plan of care must address a condition for which occupational therapy is an acceptable method of treatment as defined by standards of medical practice. The written plan of treatment must be approved and signed by the physician.

The services must be of such a level of complexity and sophistication they can only be performed by a qualified occupational therapist or under his/her supervision.

There is a reasonable expectation that the patient's condition will improve significantly within a reasonable and predictable period of time.

The type, amount, frequency, and duration of the services are considered reasonable.

The occupational therapy services are not duplicative of other rehabilitation services concurrently being performed.

A qualified occupational therapist, for program coverage purposes, is an individual who is licensed as an occupational therapist by the state in which they are

***97003: Occupational Therapy Policy for Rehabilitation Services (continued)***

practicing and meets **one** of the following requirements:

- Is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association;
- Is eligible for certification by or for the National Registration Examination of the American Occupational Therapy Association; or
- Has two years of appropriate experience as an occupational therapist, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

Only a qualified occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate a patient's level of function, determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function and, where appropriate, recommend to the physician a plan of treatment.

While the skills of a qualified occupational therapist are required to evaluate the patient's level of function and develop a plan of treatment, the implementation of the plan may be carried out by a qualified occupational therapy assistant functioning under the general supervision of the qualified occupational therapist. General supervision requires initial direction and periodic inspection of the actual activity.

The more common Occupational therapy procedures utilized in the treatment of patients are:

- Evaluation/re-evaluations as required to assess functional status
- Activities of Daily Living (ADLs)
- Therapeutic Range of Motion and Strengthening Exercises
- Bed Mobility
- Adaptive equipment needs
- Functional transfer needs
- Splinting
- Positioning; bed & wheelchair
- Aquatic Therapy
- Education of patient, family, staff
- Cognition
- Home Assessment

When the skills of an occupational therapist are not required to maintain function at the level to which it has been restored, a maintenance condition exists and therapy is no longer covered.

**Activities of Daily Living**

The following services are generally included in ADL training/retraining when used in conjunction with other occupational therapy procedures by or under the supervision of licensed personnel.

*Feeding, eating, drinking*

Feeding evaluations and therapy without other forms of active therapy require documentation for medical necessity.

Medical necessity for feeding evaluations may be shown if the record supports a newly documented loss of function which is accompanied by weight loss and/or muscle wasting.

Feeding programs in a Skilled Nursing Home are not covered for residents who have not had a documented change in their diagnosis or functional status.

Therapeutic feeding programs should follow the completion of an extensive evaluation by the physician. The treatment of dysphagia 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. Please reference Local Medical Review Policy ADYSPHRT for further indications and limitations of coverage and/or medical necessity.

Visits for feeding programs should be completed within 4 weeks at a decreasing frequency of visits. Daily visits for more than one week are not reasonable without supporting documentation for continued therapy.

*Bathing, Dressing, Performing Personal Hygiene, Grooming*

Bathing, dressing and personal hygiene training should be part of an active treatment plan. Where the therapist is actually performing the function(s) of bathing, dressing, grooming or personal hygiene, the services are **noncovered**.

Visits for bathing, dressing and personal hygiene are not covered for patients in a Skilled Nursing Home unless there is adequate documentation to support a newly diagnosed condition or change in their functional status which requires the skills of an occupational therapist.

*Toileting*

Toileting techniques may be covered as part of an active occupational therapy plan of care aimed at restoring a newly lost function.

The teaching of toileting techniques (balance, clothing management, hygiene, assessment of the need for adaptive/assistive equipment) to a Skilled Nursing Home patient may only be covered if there is a newly diagnosed condition or change in their functional status which necessitates training; such as, a new CVA, fractured hip, or exacerbation of a known condition such as, multiple sclerosis or Parkinson's disease.

Frequent visits (daily and/or several times a day) must be documented and medically justified.

Daily visits for longer duration than one week will require documentation to support the medical need.

It would not be reasonable for therapy to continue more than 2 weeks without supporting documentation for continued therapy.

*Advanced ADL Training*

Advanced ADL training may involve such skills as kitchen activities, light housekeeping, and bill paying.

These skills may be covered if the patient has the ability to restore these functions and was previously at this higher level of function prior to their recent illness or injury.

Teaching of these skills may require a more lengthy course of treatment which would be adequately documented in the medical record.

***97003: Occupational Therapy Policy for Rehabilitation Services (continued)***

*Management and Care of Orthoses, Adaptive Equipment or Customized Therapeutic Adaptations*

The type of training and length of treatment for this type of treatment is dependent on the device and the loss of function it was designed to replace.

The medical record will be used to determine frequency and duration of treatment.

**Therapeutic Range of Motion and Strengthening Exercises**

Range of motion (ROM) and strengthening exercises are used to restore the patient's maximum functional ability in self care and mobility.

Passive and active assistive exercises performed **solely** for strengthening and endurance rather than used to devise a maintenance program or restore functional abilities would not be covered.

Passive ROM exercises can be safely performed on a Skilled Nursing Home patient by the nursing staff when minimal precautions are required. The skills of an occupational therapist in this instance would not be required. An occupational therapist may be required to perform passive ROM when the patient has a medical condition that requires the skill of an occupational therapist, such as arthritis with painful joints, mild to moderate joint contracture, subluxation of the gleno-humerol joint, etc. Clinical justification for passive ROM exercises performed by an occupational therapist must be documented.

Once a maintenance exercise program is established and individuals and caregivers can safely carry out the program, skilled services are no longer covered.

Routine re-evaluations are not covered.

Re-evaluations for adjusting a maintenance program may be covered if the functional ability of the patient has changed so that the existing program is no longer appropriate. Objective, measurable changes in function must be documented in order to justify a re-evaluation.

**Adaptive Equipment Needs**

Designing, fabricating and fitting of orthotic and self help devices are covered occupational therapy services when the documentation supports the equipment would enable an individual to restore, compensate for and/or improve lost function.

An evaluation for adaptive equipment needs should occur during the course of active treatment. Additional visits for adaptive equipment fitting/education after active treatment has concluded is not covered unless the documentation supports a change in the beneficiary's functional level. The documentation should support the need for minor re-training or redesign and alteration of the existing adaptive equipment already in use.

**Functional Transfer Needs**

The occupational therapist may be consulted to teach transfers that are used for ADL needs such as bed/wheelchair/bath transfers used during bathing or toileting for example. In addition, occupational therapists may be called upon to teach transfers in conjunction with community re-entry such as automobiles and motorized carts.

Transfer training can safely be accomplished within two weeks. Additional visits for transfer training may be covered with supporting documentation explaining why further treatment is needed.

**Splinting**

Occupational therapy services may be needed to design, fabricate and fit orthotic devices. Splints and orthotics are used to immobilize and stabilize joints in order to maximize and increase functional activities. The following types of splints are the most common ones used by the occupational therapist.

*Static Splints*

Used for maintaining range of motion, reducing spasticity or reducing pain and swelling.

Usually require about three visits to fit and educate the patient or caregiver. Clinical documentation must support the need for additional visits.

Modifications, or the repair of a broken splint are seldom needed, but can be covered if the documentation supports the need to adjust or refit the splint.

*Serial Splinting*

Used to gradually improve range of motion.

Visit frequency is not covered on a daily basis. Changes in the range of motion are not generally found on a daily basis.

Visits should be made to evaluate the effectiveness of the splinting at a frequency of 1 visit per week.

The duration of therapy should be determined by the actual improvement in the ROM and the desired goal. Documentation must support the continued need for serial splinting.

*Dynamic Splinting*

Used to enhance function as part of an active treatment plan.

When addressing a new injury or illness, the frequency and duration of visits are determined by the documented improvement in relation to the treatment goals.

When used for chronic conditions on a long term basis to treat weak muscle strength, usually a maximum of 5 visits are needed to fit and educate the patient and caregiver in its use. Documentation must support the need for further visits.

**Positioning; Bed and Wheelchair**

Patients who are bed/wheelchair bound may occasionally need skilled input on positioning to avoid pressure points, contractions and other medical complications. Therapy performed in a SNF should be of the type that cannot be rendered by the attending professional staff and requires the skills of a qualified therapist.

The skills of an occupational therapist may be needed to evaluate and design a bed/wheelchair positioning plan. Medical documentation must be present to support coverage.

***97003: Occupational Therapy Policy for Rehabilitation Services (continued)***

More than three visits to evaluate, treat and teach caregivers is not considered medically necessary without significant documentation.

Assessments for safety restraints may only be covered if the services are of a level of complexity and sophistication or the condition of the patient is such that the services required can only be safely and effectively performed by a qualified occupational therapist or under the occupational therapist's supervision.

Routine assessments for safety restraints mandated by regulatory agencies are not covered.

**Aquatic Therapy**

Aquatic therapy may be used to lessen stress or resistance on affected joints or limbs. Using the pool as a medium to provide therapeutic exercises may be a covered service when documentation substantiates a treatable functional, neuromuscular or orthopedic deficit.

Documentation must clearly outline therapeutic intent and the patient's progress toward the stated goals.

Group aquatic therapy is **not** covered.

Aquatic therapy is not covered as a general health program used to enhance strength and endurance. Ongoing treatment for chronic conditions is not covered. Up to 3 visits could be covered to set up an exercise maintenance program when it is reasonable and necessary.

**Educational Needs of Patient, Staff, Family**

The teaching of compensatory techniques to improve the level of independence should be conducted in conjunction with therapy.

Visits made only to conduct education are not covered.

Visits for teaching family members how to facilitate recovery or maintenance, without other forms of therapy, should occur within two visits. Further visits to ensure comprehension may be covered with clear, concise documentation explaining the reason for additional visits.

Visits made solely to conduct education following completion of therapy are not covered.

Education of the nursing home staff is covered if the documentation shows that the ongoing care to be provided is a **unique or unusual situation** where the patient requires special needs. Routine instruction of staff is not covered as an ancillary charge.

**Cognition**

Cognition treatment alone is not covered, but may be covered when used in conjunction with other covered occupational therapy procedures. Documentation supporting medical necessity is required. This documentation must support the patient's ability to participate and benefit as well as retain the newly learned information.

*Cognitive Retraining*

Treatment that is focused on restoration of functions (e.g., to know where to locate clothes in order to get dressed) is covered. Services provided to improve memory are not covered.

Cognitive therapy by itself is not covered. It should be incorporated into the plan of care and provided in conjunction with other needed occupational therapy services.

When a patient has chronic conditions (e.g., Dementia, Alzheimer's, etc.), services provided to establish **compensatory** methods for cognitive defects that affect function and safety are covered up to 10 visits. Further coverage is dependent on documentation that supports the patient is making significant progress. An evaluation is not covered where documentation supports the patient is unable to participate, benefit or retain new information. Further visits are not reasonable or necessary.

An evaluation to set up a maintenance program is covered. When the patient's ability to participate, benefit and retain new information is absent, an evaluation is not covered.

Reality orientation, increasing patient's social activities, etc. is not considered skilled intervention alone, but part of routine nursing care. Treatment interventions and staff instruction as part of a total treatment plan is coverable. An example is a CVA patient receiving ADL training, training on wheelchair mobility skills to attend social activities in a facility and providing reality orientation.

**Home Assessment**

A home assessment may be done for patients who are preparing to return home. One visit is sufficient to complete an evaluation and make recommendations.

## CPT/HCPCS Section & Benefit Category

Musculoskeletal System/Surgery
Medicine/Physical Medicine and Rehabilitation

## Type of Bill Code

Hospital – 12x, 13x
Skilled Nursing Facility – 21x, 22x, 23x
Outpatient Rehabilitation Facility – 74x
Comprehensive Outpatient Rehabilitation Facility – 75x
Critical Access Hospital – 85x

## Revenue Codes

430 General Classification

## CPT/HCPCS Codes

| | |
|---|---|
| *29125* | *Application of short arm splint (forearm to hand); static* |
| *29126* | *Application of short arm splint (forearm to hand); dynamic* |
| *29130* | *Application of finger splint; static* |
| *29131* | *Application of finger splint; dynamic* |
| *29260* | *Strapping; elbow or wrist* |
| *29280* | *Strapping; hand or finger* |
| *97003* | *Occupational therapy evaluation* |
| *97004* | *Occupational therapy re-evaluation* |
| *97110* | *Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility* |
| *97112* | *Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities* |

***97003: Occupational Therapy Policy for Rehabilitation Services (continued)***

| | |
|---|---|
| *97113* | *Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises* |
| *97504* | *Orthotic(s) fitting and training, upper extremity(ies), lower extremity(ies), and/or trunk, each 15 minutes* |
| *97530* | *Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes* |
| *97532* | *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* |
| *97533* | *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* |
| *97535* | *Self care/ home management training (e.g., activities of daily living [ADL] and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one on one contact by provider, each 15 minutes* |
| *97537* | *Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/ modification analysis, work task analysis), direct one on one contact by provider, each 15 minutes* |
| *97542* | *Wheelchair management/ propulsion training, each 15 minutes* |
| *97703* | *Checkout for orthotic/ prosthetic use, established patient, each 15 minutes* |
| *97799* | *Unlisted physical medicine/rehabilitation service or procedure (home assessment)* |

Other rehabilitation modalities may be used in addition to those described in this policy. Please reference the Physical Medicine and Rehabilitation Policy for additional indications and limitations for each modality. Occupational therapy services furnished to individuals in Partial Hospitalization Psychiatric treatment programs must meet the indications and limitations set forth within the Local Medical Review Policy APHPPROG.

## Not Otherwise Classified Codes (NOC)

N/A

## ICD-9-CM Codes that Support Medical Necessity

For billing purposes, the following diagnoses usually describe an acute event or a complex medical condition that is generally considered acceptable. This is not an all-inclusive list.

| | |
|---|---|
| 138 | Late effects of acute poliomyelitis |
| 203.00-203.81 | Multiple myeloma and immunoproliferative neoplasms |
| 250.60-250.73 | Diabetes with neurological manifestations, peripheral circulatory disorders |
| 274.0 | Gouty arthropathy |
| 320.0-323.9 | Meningitis, encephalitis, myelitis, and encephalomyelitis |
| 324.0-324.9 | Intracranial and intraspinal abscess |
| 331.0-331.7 | Other cerebral degenerations |
| 331.89 | Other cerebral degeneration |
| 332.0-332.1 | Parkinson's disease |
| 333.0 | Other degenerative diseases of the basal ganglia |
| 333.4-333.99 | Other extrapyramidal disease and abnormal movement disorders |
| 334.0-334.8 | Spinocerebellar disease |
| 335.0-335.8 | Anterior horn cell disease |
| 336.0-336.8 | Other diseases of spinal cord |
| 337.20-337.29 | Reflex sympathetic dystrophy |
| 340 | Multiple sclerosis |
| 341.0-341.8 | Other demyelinating diseases of central nervous system |
| 342.00-342.92 | Hemiplegia and hemiparesis |
| 343.0-343.8 | Infantile cerebral palsy |
| 344.00-344.89 | Quadriplegia and quadriparesis |
| 348.0-348.8 | Other conditions of brain |
| 353.0-359.9 | Disorders of the peripheral nervous system |
| 430-432.9 | Subarachnoid, intracerebral, and other and unspecified intracranial hemorrhage |
| 436 | Acute, but ill-defined, cerebrovascular disease |
| 437.0-437.9 | Other and ill-defined cerebrovascular disease |
| 438.0-438.89 | Late effects of cerebrovascular disease |
| 457.0-457.1 | Post mastectomy and other lymphedema |
| 695.4-695.89 | Lupus erythematosus and other specified erythematous conditions |
| 710.0-710.8 | Diffuse diseases of connective tissue |
| 711.00-711.99 | Arthropathy associated with infection |
| 714.0-714.9 | Rheumatoid arthritis and other inflammatory polyarthropathies |
| 715.00-716.99 | Osteoarthrosis and allied disorders and other and unspecified arthropathies |
| 718.00-718.99 | Other derangement of joint |
| 720.0-724.9 | Dorsopathies |
| 725-729.9 | Rheumatism, excluding the back |
| 733.10-733.19 | Pathological fracture |
| 733.40-733.49 | Aseptic necrosis of bone |
| 733.81-733.99 | Malunion and nonunion of fracture and other and unspecified disorders of bone and cartilage |
| 736.00-736.89 | Other acquired deformities of limbs |
| 738.5 | Other acquired deformity of back or spine |
| 754.1-754.44 | Certain congenital musculoskeletal deformities |
| 755.20-755.39 | Reduction deformities of upper and lower limbs |
| 755.50-755.64 | Other anomalies of upper and lower limbs |
| 781.0 | Abnormal involuntary movements |
| 781.3-781.4 | Lack of coordination and transient paralysis of limb |
| 781.8-781.9 | Neurologic neglect syndrome and other symptoms involving nervous and musculoskeletal systems |
| 782.0 | Disturbance of skin sensation |

***97003: Occupational Therapy Policy for Rehabilitation Services (continued)***

| | |
|---|---|
| 783.3 | Feeding difficulties and mismanagement |
| 799.4 | Cachexia |
| 800.20-800.29 | Fracture of vault of skull, closed with subarachnoid, subdural, and extradural hemorrhage |
| 800.30-800.39 | Fracture of vault of skull, closed with other and unspecified intracranial hemorrhage |
| 800.40-800.49 | Fracture of vault of skull, closed with intracranial injury of other and unspecified nature |
| 800.70-800.79 | Fracture of vault of skull, open with subarachnoid, subdural, and extradural hemorrhage |
| 800.80-800.89 | Fracture of vault of skull, open with other and unspecified intracranial hemorrhage |
| 800.90-800.99 | Fracture of vault of skull, open with intracranial injury of other and unspecified nature |
| 801.20-801.29 | Fracture of base of skull, closed with subarachnoid, subdural, and extradural hemorrhage |
| 801.30-801.39 | Fracture of base of skull, closed with other and unspecified intracranial hemorrhage |
| 801.40-801.49 | Fracture of base of skull, closed with intracranial injury of other and unspecified nature |
| 801.70-801.79 | Fracture of base of skull, open with subarachnoid, subdural, and extradural hemorrhage |
| 801.80-801.89 | Fracture of base of skull, open with other and unspecified intracranial hemorrhage |
| 801.90-801.99 | Fracture of base of skull, open with intracranial injury of other and unspecified nature |
| 803.20-803.29 | Other and unqualified skull fractures, closed with subarachnoid, subdural, and extradural hemorrhage |
| 803.30-803.39 | Other and unqualified skull fractures, closed with other and unspecified intracranial hemorrhage |
| 803.40-803.49 | Other and unqualified skull fractures, closed with intracranial injury of other and unspecified nature |
| 803.70-803.79 | Other and unqualified skull fractures, open with subarachnoid, subdural, and extradural hemorrhage |
| 803.80-803.89 | Other and unqualified skull fractures, open with other and unspecified intracranial hemorrhage |
| 803.90-803.99 | Other and unqualified skull fractures, open with intracranial injury of other and unspecified nature |
| 804.20-804.29 | Multiple fractures involving skull or face with other bones, closed with subarachnoid, subdural, and extradural hemorrhage |
| 804.30-804.39 | Multiple fractures involving skull or face with other bones, closed with other and unspecified intracranial hemorrhage |
| 804.40-804.49 | Multiple fractures involving skull or face with other bones, closed with intracranial injury of other and unspecified nature |
| 804.70-804.79 | Multiple fractures involving skull or face with other bones, open with subarachnoid, subdural, and extradural hemorrhage |
| 804.80-804.89 | Multiple fractures involving skull or face with other bones, open with other and unspecified intracranial hemorrhage |
| 804.90-804.99 | Multiple fracture involving skull or face with other bones, open with intracranial injury of other and unspecified nature |
| 805.00-827.1 | Fractures |
| 830.0-838.19 | Dislocations |
| 840.0-847.9 | Sprains and strains of joints and adjacent muscles |
| 850.4 | Concussion with prolonged loss of consciousness, without return to pre-existing conscious level |
| 851.00-854.19 | Intracranial injury, excluding those with skull fracture |
| 880.00-887.7 | Open wound of shoulder and upper limb |
| 896.0-897.7 | Traumatic amputation of foot or leg(s) (complete) (partial) |
| 905.1-905.9 | Late effects of musculoskeletal and connective tissue injuries |
| 906.0-909.9 | Late effects of injury |
| 927.00-927.9 | Crushing injury of upper limb |
| 928.00-928.9 | Crushing injury of lower limb |
| 929.0-929.9 | Crushing injury of multiple and unspecified sites |
| 941.30-941.59 | Burn of face, head, and neck, 3rd degree |
| 942.30-942.59 | Burn of trunk, 3rd degree |
| 943.30-943.59 | Burn of upper limb, except wrist and hand, 3rd degree |
| 944.30-944.58 | Burn of wrist(s) and hand(s), 3rd degree |
| 946.3-946.5 | Burns of multiple specified sites, 3rd degree |
| 949.3-949.5 | Burn, unspecified, 3rd degree |
| 952.00-953.9 | Spinal cord injury without evidence of spinal bone injury and injury to nerve roots and spinal plexus |
| 955.0-957.8 | Injury to peripheral nerve(s) and other and unspecified nerves |
| 996.4 | Mechanical complication of internal orthopedic device, implant and graft |
| 997.61-997.62 | Amputation stump complication |
| V43.61-V43.69 | Organ or tissue replaced by joint |
| V43.7 | Organ or tissue replaced by limb |
| V49.1-V49.77 | Problems with limbs and other problems |
| V52.0 | Fitting and adjustment of artificial arm (complete) (partial) |
| V52.1 | Fitting and adjustment of artificial leg (complete) (partial) |
| V53.7 | Fitting and adjustment of orthopedic devices |
| V54.0-V54.8 | Other orthopedic aftercare |

While the following ICD-9-CM codes do not necessarily represent a medical condition that would support the need for occupational therapy, it is expected the

*97003: Occupational Therapy Policy for Rehabilitation Services (continued)*

medical record documentation would clearly outline an underlying concurrent medical condition that would.

| | |
|---|---|
| 290.0-290.9 | Senile and presenile organic psychotic conditions |
| 294.9 | Unspecified organic brain syndrome (chronic) |
| 310.9 | Unspecified nonpsychotic mental disorder following organic brain damage |
| 331.0 | Alzheimer's disease |
| 348.8 | Other conditions of brain |
| 435.0-435.9 | Transient cerebral ischemia |
| 780.2-780.4 | Syncope and collapse, convulsions, dizziness and giddiness |
| 780.79 | Other malaise and fatigue |
| 780.9 | Other general symptoms |
| 799.3 | Debility, unspecified |
| 799.8-799.9 | Other ill-defined and unknown and unspecified cause of morbidity and mortality |
| V57.21-V57.22 | Occupational therapy and vocational rehabilitation |
| V58.4-V58.9 | Encounter for other and unspecified procedures and aftercare |
| V66.0-V67.9 | Convalescence and palliative care and follow up examination |
| V71.8 | Observation for other specified suspected conditions |

## 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

No payment may be made for items or services which are not reasonable and medically necessary for the diagnosis or treatment of illness or injury to improve the function of a malformed body member under §1862 (a)(1)(A) of the Social Security Act.

When the documentation indicates a patient has attained the therapy goals or has reached the point where no further significant improvement can be expected, the skills of the Occupational Therapist are not required to maintain function at the level to which it has been restored, such as: daily feeding programs after adapted procedures are in place; routine exercises and strengthening programs; the practice of coordination and self-care skills on a daily basis; presenting information on energy conservation or pacing, but not having the patient perform the activity.

Occupational therapy is not covered when furnished in connection with cardiac rehabilitation unless there also is a diagnosed non cardiac condition requiring such therapy.

Occupational therapy is not covered to treat Skilled Nursing Home patients whose care can safely and effectively be rendered by the Home's trained professional staff.

Occupational therapy is not covered when a patient suffers a temporary loss or reduction of function and could reasonably be expected to improve spontaneously without the services of the occupational therapist. For example, the patient recovering from a short hospital stay for pneumonia would need only time to regain their strength and function.

Occupational therapy is not covered when the documentation fails to support that the functional ability or medical condition was impaired to the degree that it required the skills of a therapist.

Occupational therapy is not covered when the documentation indicates the patient has not reached the therapy goals and is not making significant improvement or progress, and/or is unable to participate and/or benefit from skilled intervention or refused to participate.

Occupational therapy services provided to **identify patients** who might need or benefit from occupational therapy intervention are not covered.

Occupational therapy visits would not be routinely covered on a daily basis through discharge. Normally, visit frequency would decrease as the patient's condition improves. If the patient is undergoing occupational therapy in an acute and/or subacute phase of their medical condition, the medical record documentation would support the intense level of rehabilitation through discharge.

Occupational therapy services which are duplicative of other concurrent rehabilitation services are not covered.

Services which are related solely to specific employment opportunities, work skills, or work settings are not reasonable and necessary for the diagnosis and treatment of an illness or injury and are excluded from coverage by section 1862 (a) (1) of the Social Security Act.

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 Codes

N/A

## Noncovered Diagnosis

N/A

## Coding Guidelines

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

When both a modality/procedure and an evaluation service are billed on the same day, the evaluation may be reimbursed only if the medical necessity for the evaluation is clearly documented.

All Outpatient Skilled Nursing Facility providers (TOB 23x) must indicate occurrence codes 11, 17 and 44 with value code 51 on all bills.

All Outpatient Hospital providers (TOB 13x) must indicate occurrence codes 11, 17 and 44 with value code 51 on all bills.

All CORF providers (TOB 75x) must indicate condition code 79 if applicable, occurrence codes 11, 28, 44 with value code 51 on all bills.

All ORF providers (TOB 74x) must indicate occurrence codes 11, 17, 44 with value code 51 on all bills.

*97003: Occupational Therapy Policy for Rehabilitation Services (continued)*

## Documentation Requirements

The medical record must identify the physician's order for occupational therapy.

The HCFA 700/701 forms are designed to incorporate the essential elements of the plan of care. The use of this form is NOT required. Providers may elect to format the required elements in what ever manner than meets their needs.

The documentation requirements are:

**Evaluations-Re-evaluations**

Evaluations must be performed prior to beginning therapy.

Evaluations must contain the following information. Evaluations without any of these elements will be **denied** as not medically necessary:

- Reason for the physician's referral
- Diagnosis/condition being treated and its date of onset
- Past level of functioning, be specific
- Evaluations must contain physical and cognitive baseline data necessary for assessing rehabilitation potential and measuring progress.
- Current level of function, using illustrations (e.g., cannot comb hair, cannot grip)
- Measurements such as strength, ROM, pain level
- Treatment modalities selected for treating current illness or injury
- Limitations which may influence the length of treatment
- Short and long term measurable goals and their expected date of accomplishment
- Frequency and duration of therapy

Re-evaluations may be required when there is a significant change in the patient's level of functioning (e.g., the patient has suffered a new injury or illness that will impact the current treatment plan).

Routine assessments during admission to a Nursing Home are not covered.

Routine periodic reassessments of Nursing Home patients are not covered.

Routine re-evaluations of a patient's progress toward their therapeutic goals are not separately reimbursed.

**Certification/recertification**

Certifications are required upon initiation of therapy and every **30** days thereafter for outpatient occupational therapy services.

Certifications are required upon initiation of therapy and every **60** days thereafter for CORF occupational therapy services.

Certifications/recertification cannot be signed by anyone other than the attending/referring physician. The signature must be an actual handwritten signature.

Documentation should indicate the prognosis for potential restoration of function in a reasonable and generally predictable period of time, or the need to establish a safe and effective maintenance program.

Patients must be under the care of a physician and being seen by the physician at least once every **30** days.

Certifications/recertification may be verified by Medical Review with the ordering physician either by written or verbal communication.

**Plans of Care**

Written plans of care are to be done as soon as the evaluation is completed and **before** active therapy begins.

The plan of care written by the therapist must be signed by the referring or attending physician.

No rubber stamps are allowed.

All services must be rendered according to the physician approved plan of care.

Any changes to the plan of care must be signed by the physician.

The therapist may not alter a plan of care established by a physician.

Occupational therapy plans of care must contain the following elements. A plan of care without any of these elements will be **denied** as not medically necessary.

- Diagnosis being treated and the specific problems identified that are to be addressed.
- Specific treatment modalities or procedures being used for each specific problem to attain the stated goals.
- Specific functional goals for therapy in measurable terms.
- Amount, frequency, and duration of each therapeutic modality/procedure.
- Rehabilitation potential- therapist's/physician's expectation of the patient's ability to meet the goals at initiation of treatment.

**Progress Notes**

Progress notes are to be maintained in the patient's record and should contain the following:

- subjective status of the patient,
- description of the nature of the treatment/service performed (e.g., modalities, training, education etc.),
- patient's response to the therapeutic intervention, **and**
- its relevance to the goals indicated in the treatment plan.

The progress notes must contain necessary and sufficient information, which indicates the services were actually provided and were reasonable and necessary to treat the patient's condition. Progress notes, which should be submitted at least weekly, must substantiate the medical necessity of the treatment and support that skilled intervention is required.

The progress notes should be written using measurements and functional accomplishments.

Use statements which assess the patient's response to therapy:

"able to perform exercises as prescribed for 15 reps"
"able to safely transfer from bed to wheelchair with stand by assistance"
"can now abduct shoulder 120 "
"can now bridge sufficiently to pull slacks up over hips"

Avoid terms such as:

doing well
improving
less pain
increased range of motion
increased strength
tolerated treatment well

*97003: Occupational Therapy Policy for Rehabilitation Services (continued)*

## Utilization Guidelines

N/A

## Other Comments

Services performed in a Skilled Nursing Facility, personal care home (ACLF, nursing home, etc.):

Therapy performed in a SNF or personal care facility should be of the type that cannot be rendered by the attending professional staff and requires the skills of a qualified therapist.

The facility is responsible for maintaining medical information from the SNF or personal care home facility which may be requested by the Medicare contractor. Types of medical information that may be requested are:

- Nurses' Notes,
- Minimum Data Set,
- Physician Progress Notes, and/or
- Physician Orders

The beneficiary and or their representative may be contacted for additional information regarding the appropriateness or satisfaction of therapy services rendered.

## Sources of Information and Basis for Decision

*Uniform Terminology for Occupational Therapy* (3rd ed.). 1994. American Occupational Therapy Association.

Neistadt, M. E., and Crepeau, E. B. (1998). Cognitive-perceptual retraining and rehabilitation. *Occupational Therapy* (9th ed.). Philadelphia: Lippincott-Raven.

## 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 groups, which includes representatives from the Florida Physical Medicine and Rehabilitation Society and the Florida Hospital Association.

## Start Date of Comment Period

N/A

## End Date of Comment Period

N/A

## Start Date of Notice Period

02/01/2002

## Revision History

| | |
|---|---|
| Revision Number: | 3 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 02/01/2002<br>2nd Qtr 2002 *Bulletin* |
| Revised Effective Date: | 01/01/2002 |
| Explanation of Revision: | Annual 2002 HCPCS Update. |

| | |
|---|---|
| Revision Number | 2 |
| Start Date of Comment Period | N/A |
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| Revised Effective Date | 01/01/2001 |
| Explanation of Revision: | Annual 2001 HCPCS Update. |

| | |
|---|---|
| Revision Number | 1 |
| Start Date of Comment Period | |
| Start Date of Notice Period | |
| Revised Effective Date | 10/01/1998 |
| Explanation of Revision: | Annual 1999 ICD-9-CM Update. |

| | |
|---|---|
| Revision Number | Original |
| Start Date of Comment Period: | 07/02/1997 |
| Start Date of Notice Period: | 09/18/1998 |
| Original Effective Date | 10/18/1998 ❖ |

# 97010: Physical Medicine and Rehabilitation

*Revision Overview: Policy has been revised as a result of the annual 2002 HCPCS update. "Type of Bill Code" section of the policy has been revised.*

## Policy Number
97010

## Contractor Name
First Coast Service Options, Inc.

## Contractor Number
090

## Contractor Type
Intermediary

## LMRP Title
Physical Medicine and Rehabilitation

## AMA CPT Copyright Statement


## CMS National Coverage Policy
Medicare Intermediary Manual, Part 3, Sections 3101.8, 3112.4, and 3148.3
Hospital Manual, Sections 241-242.4
Outpatient Rehabilitation and CORF Manual, Sections 200-205.3, 403.3
Skilled Nursing Manual, Section 230.3
Coverage Issues Manual, Sections 35-2, 35-3, 35-20, 35-41, 35-56, 35-72, 35-77, 35-98
Code of Federal Regulation, Sections 3128, 16,838G, and 16,959

## Primary Geographic Jurisdiction
Florida

## Secondary Geographic Jurisdiction
N/A

## CMS Region
Region IV

## CMS Consortium
Southern

## Original Policy Effective Date
11/02/1998

## Original Policy Ending Date
N/A

## Revision Effective Date
03/28/2002

## Revision Ending Date
03/27/2002

## LMRP Description
Physical medicine and rehabilitative services are those services designed to improve or restore physical functioning following disease, injury, or loss of a body part. These services utilize the therapeutic properties of exercise, heat, cold, electricity, ultraviolet, ultrasound, hydrotherapy, massage, and manual therapy to improve circulation, strengthen muscles, maintain or restore motion, and train or retrain an individual to perform the activities of daily living.

## Indications and Limitations of Coverage and/or Medical Necessity

**General PM&R Guidelines**

Physical Medicine and Rehabilitation Services are covered services, provided the services are of a level of complexity and sophistication, or the patient's condition is such that, the services can be safely and effectively performed only by a qualified physical therapist or under their supervision. Services normally considered to be a routine part of nursing care are not covered as physical therapy (e.g., turning patients to prevent pressure injuries or walking a patient in the hallway postoperatively).

Effective January 1, 2000, optometrists may refer patients for therapy services as well as establish and review the plan of treatment. The plan of treatment established and/or reviewed by an optometrist must relate to disease conditions that are treated by an optometrist.

The physician or optometrist must document an adequate assessment of the patient that will provide justification for the need of a physical therapist (the physician or optometrist has evaluated the patient and has determined that a medical need and rehabilitation potential exists). The assessment must occur prior to the initiation of the referral process.

Covered physical therapy services must relate directly and specifically to an active written treatment regimen established by the physician or optometrist, after any needed consultation with the qualified physical therapist; or the therapist caring for the patient. This plan must be reasonable and necessary for the treatment of the individual's illness or injury.

Additionally, in order for the plan of care to be covered, it must address a condition for which physical therapy is an accepted method of treatment as defined by standards of medical practice. It must also outline a condition that is expected to improve significantly within a reasonable and generally predictable period of time or establishes a safe and effective maintenance program.

Therefore, physical therapy is only covered when it is rendered:

- under a written treatment plan developed by the individual's physician, optometrist, and/or physical therapist; and
- to address specific therapeutic goals for which modalities and procedures are planned out specifically in terms of type, frequency and duration.

**Functional Improvement Requirements**

The physician, optometrist, and therapist must document the patient's functional limitations in terms that are objective and measurable.

**Specific Procedure and Modality Guidelines**
**Hot or Cold Modality (CPT code 97010)**

Hot or cold packs are used primarily in conjunction with therapeutic procedures to provide analgesia, relieve muscle spasm and reduce inflammation and edema. Typically, cold packs are used for acute, painful conditions, and hot packs for subacute or chronic painful conditions.

***97010: Physical Medicine and Rehabilitation (continued)***

The payment for hot or cold packs is bundled into the payment for other services. Therefore, when hot or cold packs are used in conjunction with other procedures or modalities, the payment for the hot or cold packs is **not separately reimbursable.**

**Hot or cold packs applied in the absence of associated procedures or modalities, or used alone to reduce discomfort are considered not medically necessary and therefore, are not covered.**

**Traction/Mechanical Modality (CPT code 97012)**

Traction is generally used for joints, especially of the lumbar or cervical spine, with the expectation of relieving pain in or originating from those areas, or increasing the range of motion of the joint. Specific indications for the use of Mechanical Traction include, but are not limited to, neck and back disorders such as disc herniation, lumbago, cervicalgia, sciatica, cervical and lumbar radiculopathy. This modality is generally used in conjunction with therapeutic procedures and not as an isolated treatment.

**Electrical Stimulation Modality (97014):**

Effective April 1, 2001, pelvic floor electrical stimulation with a non-implantable stimulator is covered for the treatment of stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training. A failed trial of PME is defined as no clinically significant improvement in urinary continence after completing 4 weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength.

This modality **does not** require direct (one-on-one) patient contact by the provider.

Please refer to procedure code 97032 for clinical guidelines for procedure code 97014.

**Vasopneumatic Devices (CPT code 97016)**

The use of Vasopneumatic Devices may be considered medically necessary for the application of pressure to an extremity for the purpose of reducing edema.

Specific indications for the use of Vasopneumatic Devices include:

- reduction of edema after acute injury;
- lymphedema of an extremity; and/or
- education on the use of a lymphedema pump for home use.

**Note:** Further treatment of lymphedema by a provider after the educational visits are generally not medically necessary.

Education on the use of a lymphedema pump for home use can typically be completed in no more than three (3) visits.

The use of vasopneumatic devices would not be covered as a temporary treatment while awaiting receipt of ordered Jobst stockings.

**Paraffin Bath (CPT code 97018)**

Paraffin Bath, also known as hot wax treatment, is primarily used for pain relief in chronic joint problems of the wrists, hands, and feet.

Specific indications for the use of Paraffin Baths include:

- the patient has a contracture as a result of rheumatoid arthritis;
- the patient has a contracture as a result of scleroderma;
- the patient has acute synovitis;
- the patient has post-traumatic conditions;
- the patient has hypertrophic scarring;
- the patient has degenerative joint disease;
- the patient has osteoarthritis;
- the patient has post-surgical conditions or tendon repairs, or;
- the patient who is status post sprains or strains.

**Microwave Application (CPT code 97020)**

Because there is no evidence from published, controlled clinical studies demonstrating the efficacy of this modality, this service will be denied as not reasonable and necessary.

**Whirlpool (CPT code 97022)/Hubbard Tank (CPT code 97036)**

Whirlpool Bath and Hubbard Tanks are the most common forms of hydrotherapy. The use of **sterile** whirlpool is considered medically necessary when used as part of a plan directed at facilitating the healing of an open wound (e.g., burns).

Specific indications for the use of **sterile** whirlpools include:

- the patient has a documented open wound which is draining, has a foul odor, or evidence of necrotic tissue; and/or
- the patient has a documented need for wound debridement/bandage removal.

General Whirlpool Therapies (CPT code 97022)/ Hubbard Tank (CPT code 97036) are considered medically necessary when used to enhance the patient's ability to perform therapeutic exercise.

Specific indications for the use of General Whirlpool Therapies include:

- the patient who suffers from generalized weakness in addition to a specific functional limitation, and requires the buoyancy provided in the whirlpool in order to perform the therapeutic exercise, and/or
- the patient who requires joint stretching (joint range of motion) prior to exercise on dry land.

General Whirlpool Therapies/Hubbard Tank may be considered medically necessary when the patient's condition is complicated by either circulatory deficiency or areas of desensitization, and the therapeutic goal is to increase circulation or decrease skin sensitivity.

**Fluidized Therapy for Dry Heat (CPT code 97022)**

Fluidized Therapy is a high intensity heat modality consisting of a dry whirlpool of finely divided solid particles suspended in a heated air stream, the mixture having properties of a liquid. Use of fluidized therapy dry heat is considered medically necessary when provided as part of a plan of care for patients having acute or subacute traumatic or nontraumatic musculoskeletal disorders of the extremities.

***97010: Physical Medicine and Rehabilitation (continued)***

**Diathermy (CPT code 97024)**

Short wave diathermy is an effective modality for heating skeletal muscle. Because heating is accomplished without physical contact between the modality and the skin, it can be used even if skin is abraded, as long as there is no significant edema. The use of Diathermy is considered medically necessary for the delivery of heat to deep tissues such as skeletal muscle and joints for the reduction of pain, joint stiffness, and muscle spasms.

Specific indications for the use of Diathermy include:

- the patient has osteoarthritis, rheumatoid arthritis, or traumatic arthritis;
- the patient has sustained a strain or sprain;
- the patient has acute or chronic bursitis;
- the patient has sustained a traumatic injury to muscle, ligament, or tendon resulting in functional loss;
- the patient has a joint dislocation or subluxation;
- the patient requires treatment for a post surgical functional loss;
- the patient has an adhesive capsulitis; and/or
- the patient has a joint contracture.

Diathermy is not considered medically necessary for the treatment of asthma, bronchitis, or any other pulmonary condition. Please refer to the Noncovered ICD-9-CM Codes Section of the policy.

**Diathermy/Diapulse (CPT code 97024)**

High energy pulsed wave diathermy machines have been determined to produce the same therapeutic benefit as standard diathermy; therefore, any reimbursement for diathermy will be made at the same level as standard diathermy.

**Infrared Application (CPT code 97026)**

The application of infrared therapy is considered medically necessary for patients requiring the application of superficial heat in conjunction with other procedures or modalities, to reduce or decrease pain/produce analgesia, reduce stiffness/tension, myalgia, spasm, or swelling.

Specific indications for the use of infrared application include:

- the patient with a painful superficial condition for which heat is beneficial (e.g., neuropathy), **or**
- the patient having muscle spasm for which heat application has been ordered, **and**
- the patient s condition is acute or subacute.

**Infrared Application applied in the absence of associated procedures or modalities, or used alone to reduce discomfort, are considered not medically necessary and therefore, are not covered.**

**Ultraviolet Therapy (CPT code 97028)**

Photons in the ultraviolet (UV) spectrum are more energetic than those in the visible or infrared regions. Their interaction with tissue and bacteria can produce nonthermal photochemical reactions, the effects of which provide the rationale for ultraviolet treatment. Ultraviolet light is highly bacteriocidal to motile bacteria, and it increases vascularization at the margins of the wounds.

The application of Ultraviolet Therapy is considered medically necessary for the patient requiring the application of a drying heat. The specific indications for this therapy are:

- A patient having an open wound. Minimal erythema dosage must be documented.
- Severe psoriasis limiting range of motion.

**Electrical Stimulation (Manual) (CPT code 97032)**

This modality includes the following types of electrical stimulation:

- Transcutaneous electrical nerve stimulation which produces analgesia, strengthening, and functional electrical stimulation. The use of electrical stimulation is considered medically necessary to reduce pain and/or edema and achieve muscular contraction during exercise.
- High voltage pulsed current, also called electrogalvanic stimulation, which may be useful for the reduction of swelling and the control of pain.
- Neuro-muscular stimulation which is used for retraining weak muscles following surgery or injury and is taken to the point of visible muscle contraction.
- Interferential current/medium current units, which use a frequency that allows the current to go deeper. IFC is used to control swelling and pain.

Specific indications for the use of Electrical Stimulation include:

- the patient has documented dependent peripheral edema with an accompanying reduction in the ability to contract muscles;
- the patient has a documented reduction in the ability to contract muscles or in the strength of the muscle contraction;
- the patient has a condition that requires an educational program for self-stimulation of denervated muscle (educational program should be limited to 5-7 sessions);
- the patient has a condition that requires muscle re-education involving a training program (e.g., functional electrical stimulation);
- the patient has a painful condition that requires analgesia or a muscle spasm that requires reduction prior to an exercise program; or
- the patient is undergoing treatment for disuse atrophy using a specific type of neurostimulator (NMES) which transmits an electrical impulse to the skin over selected muscle groups by way of electrodes. **Coverage for this indication is limited to those patients where the nerve supply to the muscle is intact, including brain, spinal cord, and peripheral nerves, and other non-neurological reasons for disuse are causing the atrophy (e.g., post casting or splinting of a limb, and contracture due to soft tissue scarring).

Standard treatment is 3 to 4 sessions a week for one month when used as adjunctive therapy or for muscle retraining.

This modality requires direct (one-on-one) patient contact by the provider.

**Electrical Stimulation (CPT code 97032) used in the treatment of facial nerve paralysis, commonly known as Bell's Palsy, is considered investigational and *noncovered.* Please refer to the Noncovered ICD-9-CM Codes section.**

*97010: Physical Medicine and Rehabilitation (continued)*

**Electrical Nerve Stimulation (CPT code 97032) used to treat motor function disorders, such as multiple sclerosis, is considered investigational and, therefore, *noncovered.***

**Electrical Stimulation (CPT code 97032) is not medically necessary for the treatment of strokes when there is no potential for restoration of function.**

As of April 1, 2001, pelvic floor electrical stimulators, whether inserted into the vaginal canal or rectum, that are used as a treatment for urinary incontinence (e.g., as a bladder pacer or a retraining mechanism) are covered. Please see procedure code 97014 for coverage guidelines for this indication.

**Iontophoresis Application (CPT code 97033)**

Iontophoresis is a process in which electrically charged molecules or atoms (e.g., ions) are driven into tissue with an electric field. Voltage provides the driving force. Parameters such as drug polarity and elecrophoretic mobility must be known in order to be able to assess whether iontophoresis can deliver therapeutic concentrations of a medication at sites in or below the skin.

The application of Iontophoresis is considered medically necessary for the topical delivery of medications into a specific area of the body. The medication and dosage information may be recorded in the plan of treatment or maintained on a separate prescription signed by the health care provider responsible for certifying the plan of treatment.

Specific indications for the use of Iontophoresis Application include:

- the patient has tendonitis or calcific tendonitis;
- the patient has bursitis; or
- the patient has adhesive capsulitis.

**Contrast Baths (CPT code 97034)**

Contrast Baths are a special form of therapeutic heat and cold that can be applied to distal extremities. The effectiveness of contrast baths is thought to be due to reflex hyperemia produced by the alternating exposure to heat and cold. Although a variety of applications are possible, contrast baths often are used in treatment programs for rheumatoid arthritis and reflex sympathetic dystrophy.

The use of Contrast Baths is considered medically necessary to desensitize patients to pain by reflex hyperemia produced by the alternating exposure to heat and cold.

Specific indications for the use of Contrast Baths include:

- the patient has rheumatoid arthritis or other inflammatory arthritis;
- the patient has reflex sympathetic dystrophy; or
- the patient has a sprain or strain resulting from an acute injury.

**Ultrasound Application (CPT code 97035)**

Therapeutic ultrasound is a deep heating modality that produces a sound wave of 0.8 to 3.0 Mhz. In the human body ultrasound has several pronounced effects on biologic tissues. It is attenuated by certain tissues and reflected by bone. Thus, tissues lying immediately next to bone can receive an even greater dosage of ultrasound, as much as 30% more. Because of the increased extensibility ultrasound produces in tissues of high collagen content, combined with the close proximity of joint capsules, tendons, and ligaments to cortical bone where they receive a more intense irradiation, it is an ideal modality for increasing mobility in those tissues with restricted range of motion.

The application of ultrasound is considered medically necessary for patients requiring deep heat to a specific area for reduction of pain, spasm, and joint stiffness, and the increase of muscle, tendon and ligament flexibility.

Specific indications for the use of Ultrasound Application include:

- the patient has tightened structures limiting joint motion that require an increase in extensibility; or
- the patient has symptomatic soft tissue calcification.

When phonopheresis is performed, use procedure code 97035.

Ultrasound Application is **not** considered to be medically necessary for the treatment of asthma, bronchitis, or any other pulmonary condition.

Standard treatment is 3-4 treatments per week for one month.

**Hubbard Tank (97036):**

Please refer to procedure code 97022 for clinical guidelines for procedure code 97036.

**Unlisted Therapeutic Procedure (CPT Code 97039)**

All claims submitted with an unlisted service or procedure must be accompanied by:

- A description of the service or procedure, and
- The appropriate documentation listed under the "Documentation Requirements" section of this policy.

**Therapeutic Exercise (CPT code 97110)**

Therapeutic exercise is performed on dry land with a patient either actively, active-assisted, or passively participating (e.g., treadmill, isokinetic exercise, lumbar stabilization, stretching, strengthening).

Therapeutic exercise is considered medically necessary if at least one of the following conditions is present and documented:

- the patient having weakness, contracture, stiffness secondary to spasm, spasticity, decreased range of motion, gait problem, balance and/or coordination deficits, abnormal posture, muscle imbalance, or
- the patient needing to improve mobility, stretching, strengthening, coordination, control of extremities, dexterity, range of motion, or endurance as part of activities of daily living training, or re-education.

Documentation for therapeutic exercise must show objective loss of joint motion, strength, mobility (e.g., degrees of motion, strength grades, levels of assistance).

**Note:** For guidelines regarding Complex Decongestive Physiotherapy services, please refer to the Complex Decongestive Physiotherapy Policy (97110).

**Neuromuscular Reeducation (CPT code 97112)**

This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, and proprioception (e.g., proprioceptive neuromuscular

***97010: Physical Medicine and Rehabilitation (continued)***

facilitation, Feldenkreis, Bobath, BAP's boards, and desensitization techniques).

Neuromuscular Reeducation may be considered medically necessary if at least one of the following conditions is present and documented:

- the patient has the loss of deep tendon reflexes and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers;
- the patient has nerve palsy, such as peroneal nerve injury causing foot drop; or
- the patient has muscular weakness or flaccidity as a result of a cerebral dysfunction, a nerve injury or disease, or having had a spinal cord disease or trauma.

**Aquatic Therapy with Therapeutic Exercise (CPT code 97113)**

This procedure uses the therapeutic properties of water (e.g., buoyancy, resistance). Hydrotherapy is useful in post-operative extremity (joint) rehabilitation (e.g., total hip or knee arthroplasty, total shoulder, elbow, wrist arthroplasty).

Aquatic therapy with therapeutic exercise may be considered medically necessary if at least one of the following conditions is present and documented:

- the patient has rheumatoid arthritis;
- the patient has had a cast removed and requiring mobilization of limbs;
- the patient has paraparesis or hemiparesis;
- the patient has had a recent amputation;
- the patient is recovering from a paralytic condition;
- the patient requires limb mobilization after a head trauma; or
- the patient is unable to tolerate exercise for rehabilitation under gravity based weight bearing.

Aquatic Therapy (CPT code 97113) should not be billed in situations where no exercise is being performed in the water environment (e.g., debridement of ulcers).

Aquatic therapy with therapeutic exercise (97113) should not be billed when there is not one-on-one contact between therapist and patient. For example, an aqua aerobic class of more than one patient with the instructor directing the class from a distance would not be considered reasonable and necessary and therefore, not a covered service.

**Gait Training (CPT code 97116)**

This procedure may be medically necessary for training patients whose walking abilities have been impaired by neurological, muscular, or skeletal abnormalities or trauma.

Specific indications for gait training include:

- the patient has suffered a cerebral vascular accident resulting in impairment in the ability to ambulate, now stabilized and ready to begin rehabilitation;
- the patient has recently suffered a musculoskeletal trauma, either due to an accident or surgery, requiring ambulation education;
- the patient has a chronic, progressively debilitating condition for which safe ambulation has recently become a concern;
- the patient has had an injury or condition that requires instruction in the use of a walker, crutches, or cane;
- the patient has been fitted with a brace prosthesis and requiring instruction in ambulation; and/or
- the patient has a condition that requires retraining in stairs/steps or chair transfer in addition to general ambulation.

**Gait training is *not* considered medically reasonable and necessary when the patient s walking ability is not expected to improve.**

**This procedure is *not* considered medically necessary when the goal is to increase the patient s strength and endurance.**

**Therapeutic Massage Therapy (CPT code 97124)**

Massage is the application of systemic manipulation to the soft tissues of the body for therapeutic purposes. Although various assistive devices and electrical equipment are available for the purpose of delivering massage, use of the hands is considered the most effective method of application, because palpation can be used as an assessment as well as a treatment tool.

Massage therapy, including effleurage, petrissage, and/ or tapotement (stroking, compression, percussion) may be considered medically necessary if at least one of the following conditions is present and documented:

- the patient has paralyzed musculature contributing to impaired circulation;
- the patient has excessive fluids in interstitial spaces or joints;
- the patient has sensitivity of tissues to pressure;
- the patient has tight muscles resulting in shortening and/or spasticity of affective muscles;
- the patient has abnormal adherence of tissue to surrounding tissue;
- the patient requires relaxation in preparation for neuromuscular re-education or therapeutic exercise; or
- the patient has contractures and decreased range of motion.

**Unlisted Therapeutic Procedure (CPT Code 97139)**

All claims submitted with an unlisted service or procedure must be accompanied by:

- A description of the service or procedure, and
- The appropriate documentation listed under the "Documentation Requirements" section of this policy.

**Manual Therapy (97140):**

Manual therapy includes the following modalities:

- Manual traction may be considered reasonable and necessary for cervical radiculopathy.
- Joint mobilization (peripheral or spinal) may be considered reasonable and necessary if restricted joint motion is present and documented. It may be reasonable and necessary as an adjunct to therapeutic exercises when loss of articular motion and flexibility impedes the therapeutic procedure.
- Myofascial release/soft tissue mobilization, one or more regions, may be medically necessary for treatment of restricted motion of soft tissues in involved extremities, neck, and trunk. Skilled manual techniques (active or passive) are applied to soft tissue to effect changes in the soft tissues, articular structures, neural or vascular

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systems. Examples are facilitation of fluid exchange, or stretching of shortened muscular or connective tissue. This procedure may be medically necessary as an adjunct to other therapeutic procedures such as 97110, 97112, and 97530.

- Manipulation may be medically necessary for treatment of painful spasm or restricted motion of soft tissues. It may also be used as an adjunct to other therapeutic procedures such as 97110, 97112, and 97530.

**Note:** For guidelines regarding Complex Decongestive Physiotherapy services, please refer to the Complex Decongestive Physiotherapy Policy (97110).

If 97140 is billed on the same day as Osteopathic Manipulation Therapy (CPT code 98925-98929), the service will be denied as not medically necessary.

**Therapeutic procedure(s), group (2 or more individuals) (CPT Code 97150)**

If a therapist or physician performs any of the Physical Medicine procedures with two or more individuals concurrently or during the same time period, then only 97150 is reported for each patient.

Documentation must be submitted with the claim identifying the specific treatment technique(s) used in the group, how the treatment technique will restore function, the frequency and duration of the particular group setting, and the treatment goal in the individualized plan. The number of persons in the group must also be furnished.

**Orthotics Fitting and Training (97504):**

Orthotic(s) fitting and training, upper extremity(ies), lower extremity(ies), and/or trunk may be considered reasonable and necessary if there is an indication for education for the application of orthotics and the functional use of orthotics is present and documented in the patient's medical records maintained by the provider.

Orthotic(s) fitting and training, upper extremity(ies), lower extremity(ies), and/or trunk reflects the fitting as well as the training, as the training in the use of the orthotic is done at the time of the fitting. Typically, orthotic training can be completed in three (3) visits, but based on patient condition/status, may require additional visits. In addition, subsequent visits may be necessary for re-evaluation in modification of the orthotic and/or program.

Orthotic training (CPT code 97504) for a lower extremity performed during the same visit as gait training (CPT code 97116) or self-care/home management training (CPT code 97535) should not be reported unless documentation in the medical record shows that distinct treatments were rendered.

In addition, the casting and strapping codes should not be reported in addition to code 97504. If casting and strapping of a fracture, injury, or dislocation is performed, procedure codes 29000-29590 should be reported. Please refer to the LMRP policy (29580) for further guidelines regarding strapping.

**Prosthetic Training (CPT code 97520)**

This procedure may be considered medically necessary if there is a documented indication for education for the application and functional use of the prosthetic.

The medical record should document the distinct treatments rendered when prosthetic training for a lower extremity is done during the same visit as gait training (CPT code 97116) or self care/home management training (CPT code 97535).

Periodic revisits beyond the third month may require documentation to support medical necessity.

One would not expect to see more than 30 minutes of prosthetic training billed on a given date. The medical record must document the medical necessity of the additional time.

**Therapeutic Activities (CPT code 97530)**

Therapeutic activities are considered medically necessary for patients needing a broad range of rehabilitative techniques that involve movement. Movement activities can be for a specific body part or could involve the entire body. This procedure involves the use of functional activities (e.g., bending, lifting, carrying, reaching, catching, and overhead activities) to improve functional performance in a progressive manner. The activities are usually directed at a loss or restriction of mobility, strength, balance, or coordination. They require the professional skills of a therapist and are designed to address a specific functional need of the patient. These dynamic activities must be part of an active treatment plan and be directed at a specific outcome.

In order for Therapeutic Activities to be covered, the following requirements must be met:

- the patient has a condition for which therapeutic activities can reasonably be expected to restore or improve functioning;
- the patient's condition is such that he/she is unable to perform therapeutic activities except under the direct supervision of a physician or physical therapist; and
- there is a clear correlation between the type of exercise performed and the patient s underlying medical condition for which the therapeutic activities were prescribed.

**Other Therapeutic Procedures (97532 and 97533):**

Development of cognitive skills to improve attention, memory, problem solving may be considered reasonable and necessary for patients having neurologic conditions such as head injury or trauma, stroke, muscular dystrophy, and/or multiple sclerosis. It is not appropriate for patients with chronic, progressive, or stable brain conditions who do not have potential for restoration.

Reassessment of the patient's progress should occur every 2-3 months with documentation indicating drastic improvement, as opposed to slow/subtle improvement. This service is not considered to be outpatient physical therapy and is, therefore, noncovered when billed by an Independent Practicing Physical Therapist (Specialty 65).

**Self-Care/Home Management Training (CPT Code 97535)**

This procedure is medically necessary only when it requires the professional skills of a therapist, is designed to address specific needs of the patient, and is part of an active treatment plan directed at a specific outcome.

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The patient must have a condition for which training in activities of daily living is medically reasonable and necessary, and such training must be reasonably expected to restore or improve the functioning of the patient.

The patient must have the capacity to learn from instructions.

Services provided concurrently by physicians, physical therapists, and occupational therapists may be covered if separate and distinct goals are documented in the treatment plans.

**Community/Work Reintegration Training (CPT Code 97537)**

Community reintegration is performed in conjunction with other therapeutic procedures such as gait training and selfcare/home management training. The payment for community reintegration training is bundled into the payment for those other services. Therefore, these services are not separately reimbursable by Florida Medicare.

Services which are related **solely** to specific employment opportunities, work skills, or work settings are not reasonable and necessary for the diagnosis and treatment of an illness or injury and are excluded from coverage by section 1862(a)(1) of the Social Security Act.

**Wheelchair Management/Propulsion Training (CPT Code 97542)**

This service trains the patient in functional activities that promote optimal safety, mobility and transfers. Patients who are wheelchair bound may occasionally need skilled input on positioning to avoid pressure points, contractures, and other medical complications.

This procedure is medically necessary only when it requires the professional skills of a therapist, is designed to address specific needs of the patient, and must be part of an active treatment plan directed at a specific goal.

The patient must have the capacity to learn from instructions.

Typically 3-4 total sessions should be sufficient to teach the patient these skills.

When billing 97542 for wheelchair propulsion training, documentation must relate the training to expected functional goals that are attainable by the patient.

**Work Hardening/Conditioning (CPT Codes 97545-97546)**

This service is not covered by Florida Medicare. These services are related solely to specific work skills and will be denied as not medically necessary for the diagnosis or treatment of an illness or injury.

**Checkout for Orthotic/Prosthetic Use, Established Patient (CPT Code 97703)**

These assessments are medically necessary when a device is newly issued or when there is a modification or re-issue of the orthotic/prosthetic device.

These assessments may also be medically necessary when patients experience a loss of function directly related to the device (e.g., pain, skin breakdown, or falls).

These assessments are **not** medically necessary when a device is replaced after normal wear.

**Unlisted Physical Medicine/Rehabilitiation Service or Procedure (97799):**

When using an unlisted service or procedure code, providers must submit documentation to support the medical necessity and rationale for using this treatment modality. Please refer to the "Documentation Requirements" section of this policy.

Electrical Stimulation used in the treatment of wound healing will be reviewed for coverage on a case-by-case basis. This policy applies to all electrical stimulation devices including but not limited to those that produce the stimulation by direct current, alternating current, pulsed current, pulsed electromagnetic induction, and pulsed electromagnetic field. It applies to treatment of wounds including pressure ulcers, venous ulcer wounds, and arterial wounds. Providers should bill these procedures with procedure code 97799 (Unlisted physical medicine/ rehabilitation service or procedure). Providers must include documentation to support the medical necessity and rationale for using this treatment modality for wound treatment.

**Note:** In order to achieve accelerated wound healing, it may be medically necessary to perform these treatments two to three times per day to each wound site.

**Designing and Implementing a Maintenance Program**

Periodic evaluations of the patient's condition and response to treatment may be covered when medically necessary if the judgment and skills of a professional provider are required.

**A.** The design of a maintenance regimen required to delay or minimize muscular and functional deterioration in patients suffering from a chronic disease may be considered medically necessary.

**B.** Limited services may be considered medically necessary to establish and assist the patient and/or his caregiver with the implementation of a rehabilitation maintenance program.*

**C.** Training of a nursing home staff to implement specific physical care needs of a patient may be covered on a very limited basis when the needs of the patient are above and beyond what would be considered normal nursing care.

**D.** The infrequent reevaluations required to assess the patient s condition and adjust the program may be considered medically necessary.

***Note:** Additional sessions at the end of a course of physical therapy designed to teach the patient or caregiver a home program or to transition the patient to home therapy are not considered to be medically necessary. It is expected that this type of training is carried out during the normal course of therapy.

It is not medically necessary for a therapist to perform or supervise maintenance programs that do not require the professional skills of a therapist. These situations include:

- services related to activities for the general good and welfare of patients (i.e., general exercises to promote overall fitness and flexibility;

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- repetitive exercises to maintain gait or maintain strength and endurance, and assisted walking, such as that provided in support for feeble and unstable patients;
- range of motion and passive exercises that are not related to restoration of a specific loss of function, but are useful in maintaining range of motion in paralyzed extremities; and
- maintenance therapies after the patient has achieved therapeutic goals or for patients who show no further meaningful progress.

The above referenced indications do not apply to Pain Rehabilitation, Pulmonary Rehabilitation, and Cardiac Rehabilitation. These programs require individual plans of care and involve procedures and modalities which target a different set of clinical conditions than does physical therapy. For specific guidelines targeted at Cardiac Rehabilitation and Pulmonary Rehabilitation, see previously published Local Medical Review Policies.

## CPT/HCPCS Section & Benefit Category

Medicine/Physical Medicine and Rehabilitation

## Type of Bill Code

Hospital – 12x, 13x
Skilled Nursing Facility – 21x, 22x, 23x
Outpatient Rehabilitation Facility – 74x
Comprehensive Outpatient Rehabilitation Facility – 75x
Critical Access Hospital – 85x

## Revenue Code

420 Physical Therapy/General Classification

## CPT/HCPCS Codes

| | |
|---|---|
| *97001* | *Physical therapy evaluation* |
| *97002* | *Physical therapy re-evaluation* |
| *97010* | *Application of a modality to one or more areas; hot or cold packs* |
| *97012* | *traction, mechanical* |
| *97014* | *electrical stimulation (unattended)* |
| *97016* | *vasopneumatic devices* |
| *97018* | *paraffin bath* |
| *97020* | *microwave* |
| *97022* | *whirlpool* |
| *97024* | *diathermy* |
| *97026* | *infrared* |
| *97028* | *ultraviolet* |
| *97032* | *Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes* |
| *97033* | *iontophoresis, each 15 minutes* |
| *97034* | *contrast baths, each 15 minutes* |
| *97035* | *ultrasound, each 15 minutes* |
| *97036* | *Hubbard tank, each 15 minutes* |
| *97039* | *Unlisted modality (specify type and time if constant attendance)* |
| *97110* | *Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility exercises to develop strength and endurance, range of motion and flexibility* |
| *97112* | *neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities* |
| *97113* | *aquatic therapy with therapeutic exercises* |
| *97116* | *gait training (includes stair climbing)* |
| *97124* | *massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)* |
| *97139* | *unlisted therapeutic procedure (specify)* |
| *97140* | *Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes* |
| *97150* | *Therapeutic procedure(s), group (2 or more individuals)* |
| *97504* | *Orthotic(s) fitting and training, upper extremity(ies), lower extremity(ies), and/or trunk, each 15 minutes* |
| *97520* | *Prosthetic training, upper and/or lower extremities, each 15 minutes* |
| *97530* | *Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes* |
| *97535* | *Self care/home management training (e.g., activities of daily living [ADL] and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one on one contact by provider, each 15 minutes* |
| *97537* | *Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/ modification analysis, work task analysis), direct one on one contact by provider, each 15 minutes* |
| *97542* | *Wheelchair management/propulsion training, each 15 minutes* |
| *97545* | *Work hardening/conditioning; initial 2 hours* |
| *97546* | *each additional hour* |
| *97703* | *Checkout for orthotic/prosthetic use, established patient, each 15 minutes* |
| *97750* | *Physical performance test or measurement (e.g., musculo-skeletal, functional capacity), with written report, each 15 minutes* |
| *97799* | *Unlisted physical medicine/rehabilitation service or procedure* |

## ICD-9-CM Codes That Support Medical Necessity (not an all inclusive list)

For billing purposes, the following diagnoses usually describe an acute event or a complex medical condition that is generally considered acceptable.

| | |
|---|---|
| 138 | Late effects of acute poliomyelitis |
| 274.0 | Gouty arthropathy |
| 332.0-332.1 | Parkinson's disease |
| 333.0 | Other degenerative diseases of the basal ganglia |
| 333.6 | Idiopathic torsion dystonia |
| 333.7 | Symptomatic torsion dystonia |
| 333.83 | Spasmodic torticollis |
| 333.84 | Organic writers' cramp |
| 333.91 | Stiff-man syndrome |
| 334.0-334.8 | Spinocerebellar disease |
| 335.0-335.8 | Anterior horn cell disease |

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| | |
|---|---|
| 336.0-336.8 | Other diseases of spinal cord |
| 337.20-337.29 | Reflex sympathetic dystrophy |
| 340 | Multiple sclerosis |
| 341.1 | Schilder's disease |
| 341.8 | Other demyelinating diseases of central nervous system |
| 342.00-342.92 | Hemiplegia and hemiparesis |
| 343.0-343.8 | Infantile cerebral palsy |
| 344.00-344.89 | Other paralytic syndromes |
| 353.0-353.8 | Nerve root and plexus disorders |
| 354.0-354.8 | Mononeuritis of upper limb and mononeuritis multiplex |
| 355.0-355.79 | Mononeuritis of lower limb |
| 356.0-356.8 | Hereditary and idiopathic peripheral neuropathy |
| 357.0-357.8 | Inflammatory and toxic neuropathy |
| 358.0-358.8 | Myoneural disorders |
| 359.0-359.8 | Muscular dystrophies and other myopathies |
| 430 | Subarachnoid hemorrhage |
| 431 | Intracerebral hemorrhage |
| 432.0 | Nontraumatic extradural hemorrhage |
| 432.1 | Subdural hemorrhage |
| 436 | Acute, but ill-defined, cerebrovascular disease |
| 438.0-438.89 | Late effects of cerebrovascular disease |
| 440.23 | Atherosclerosis of native arteries of extremities with ulceration |
| 440.24 | Atherosclerosis of native arteries of extremities with gangrene |
| 454.0-454.2 | Varicose veins of lower extremities |
| 457.0 | Postmastectomy lymphedema syndrome |
| 457.1 | Other lymphedema |
| 681.00-681.11 | Cellulitis and abscess of finger and toe |
| 682.3-682.7 | Other cellulitis and abscess |
| 695.81-695.89 | Other specified erythematous conditions |
| 696.0 | Psoriatic arthropathy |
| 696.1 | Other psoriasis |
| 707.0-707.8 | Chronic ulcer of skin |
| 709.2 | Scar conditions and fibrosis of skin |
| 710.1 | Systemic sclerosis |
| 710.3 | Dermatomyositis |
| 710.4 | Polymyositis |
| 710.8 | Other specified diffuse diseases of connective tissue |
| 711.00-711.99 | Arthropathy associated with infections |
| 712.10-712.99 | Crystal arthropathies |
| 713.0-713.8 | Arthropathy associated with other disorders classified elsewhere |
| 714.0-714.9 | Rheumatoid arthritis and other inflammatory polyarthropathies |
| 715.00-715.98 | Osteoarthrosis and allied disorders |
| 716.00-716.99 | Other and unspecified arthropathies |
| 717.0-717.43 | Internal derangement of knee |
| 718.00-718.89 | Other derangement of joint |
| 719.00-719.89 | Other disorders of joint |
| 720.0-720.9 | Ankylosing spondylitis and other inflammatory spondylopathies |
| 721.0-721.91 | Spondylosis and allied disorders |
| 722.0-722.93 | Intervertebral disc disorders |
| 723.0-723.9 | Other disorders of cervical region |
| 724.0-724.8 | Other disorders of back |
| 725 | Polymyalgia rheumatica |
| 726.0-726.91 | Peripheral enthesopathies and allied syndromes |
| 727.00-727.89 | Other disorders of synovium, tendon, and bursa |
| 728.0-728.89 | Disorders of muscle, ligament, and fascia |
| 729.0-729.9 | Other disorders of soft tissues |
| 733.10-733.19 | Pathologic fracture |
| 754.1 | Certain congenital musculoskeletal deformities of sternocleidomastoid muscle |
| 755.30-755.39 | Reduction deformities of lower limb |
| 755.60-755.64 | Other anomalies of lower limb, including pelvic girdle |
| 781.0 | Abnormal involuntary movements |
| 781.2 | Abnormality of gait |
| 781.3 | Lack of coordination |
| 781.4 | Transient paralysis of limb |
| 781.8 | Neurologic neglect syndrome |
| 782.3 | Edema |
| 799.4 | Cachexia |
| 805.00-805.9 | Fracture of vertebral column without mention of spinal cord injury |
| 806.00-806.9 | Fracture of vertebral column with spinal cord injury |
| 807.00-807.4 | Fracture of rib(s) and sternum |
| 808.0-808.9 | Fracture of pelvis |
| 809.0-809.1 | Ill-defined fractures of bones of trunk |
| 810.00-810.13 | Fracture of clavicle |
| 811.00-811.19 | Fracture of scapula |
| 812.00-812.59 | Fracture of humerus |
| 813.00-813.93 | Fracture of radius and ulna |
| 814.00-814.19 | Fracture of carpal bone(s) |
| 815.00-815.19 | Fracture of metacarpal bone(s) |
| 816.00-816.13 | Fracture of one or more phalanges of hand |
| 817.0-817.1 | Multiple fractures of hand bones |
| 818.0-818.1 | Ill-defined fractures of upper limb |
| 820.00-820.9 | Fracture of neck of femur |
| 821.00-821.39 | Fracture of other and unspecified parts of femur |
| 822.0-822.1 | Fracture of patella |
| 823.00-823.92 | Fracture of tibia and fibula |
| 824.0-824.9 | Fracture of ankle |
| 825.0-825.39 | Fracture of one or more tarsal and metatarsal bones |
| 826.0-826.1 | Fracture of one or more phalanges of foot |
| 827.0-827.1 | Other, multiple, and ill-defined fractures of lower limb |
| 831.00-831.19 | Dislocation of shoulder |
| 832.00-832.19 | Dislocation of elbow |
| 833.00-833.19 | Dislocation of wrist |
| 834.00-834.12 | Dislocation of finger |
| 835.00-835.13 | Dislocation of hip |
| 836.0-836.69 | Dislocation of knee |
| 837.0-837.1 | Dislocation of ankle |
| 838.00-838.19 | Dislocation of foot |
| 840.0-840.9 | Sprains and strains of shoulder and upper arm |
| 841.0-841.9 | Sprains and strains of elbow and forearm |
| 842.00-842.19 | Sprains and strains of wrist and hand |
| 843.0-843.9 | Sprains and strains of hip and thigh |
| 844.0-844.9 | Sprains and strains of knee and leg |

***97010: Physical Medicine and Rehabilitation (continued)***

| | |
|---|---|
| 845.00-845.19 | Sprains and strains of ankle and foot |
| 846.0-846.9 | Sprains and strains of sacroiliac region |
| 847.0-847.9 | Sprains and strains of other and unspecified parts of back |
| 880.00-880.29 | Open wound of shoulder and upper arm |
| 881.00-881.22 | Open wound of elbow, forearm, and wrist |
| 882.0-882.2 | Open wound of hand except finger(s) alone |
| 883.0-883.2 | Open wound of finger(s) |
| 884.0-884.2 | Multiple and unspecified open wound of upper limb |
| 885.0-885.1 | Traumatic amputation of thumb (complete) (partial) |
| 886.0-886.1 | Traumatic amputation of other finger(s) (complete) (partial) |
| 887.0-887.7 | Traumatic amputation of arm and hand (complete) (partial) |
| 890.0-890.2 | Open wound of hip and thigh |
| 891.0-891.2 | Open wound of knee, leg [except thigh], and ankle |
| 892.0-892.2 | Open wound of foot except toe(s) alone |
| 893.0-893.2 | Open wound of toe(s) |
| 896.0-896.3 | Traumatic amputation of foot (complete) (partial) |
| 897.0-897.7 | Traumatic amputation of leg(s) (complete) (partial) |
| 905.1-905.9 | Late effects of musculoskeletal and connective tissue injuries |
| 923.00-923.9 | Contusion of upper limb |
| 924.00-924.4 | Contusion of lower limb |
| 926.0-926.8 | Crushing injury of trunk |
| 927.00-927.8 | Crushing injury of upper limb |
| 928.00-928.8 | Crushing injury of lower limb |
| 929.0 | Crushing injury of multiple sites, not elsewhere classified |
| 942.20-942.59 | Burn of trunk |
| 943.20-943.59 | Burn of upper limb, except wrist and hand |
| 944.20-944.58 | Burn of wrist(s) and hand(s) |
| 945.20-945.59 | Burn of lower limb(s) |
| 946.2-946.5 | Burns of multiple specified sites |
| 948.00-948.99 | Burns classified according to extent of body surface involved |
| 951.4 | Injury to facial nerve |
| 952.00-952.9 | Spinal cord injury without evidence of spinal bone injury |
| 953.0-953.8 | Injury to nerve roots and spinal plexus |
| 955.0-955.9 | Injury to peripheral nerve(s) of shoulder girdle and upper limb |
| 956.0-956.9 | Injury to peripheral nerve(s) of pelvic girdle and lower limb |
| 997.61-997.62 | Amputation stump complication |
| V43.61-V43.69 | Organ or tissue replaced by joint |
| V43.7 | Organ or tissue replaced by limb |
| V49.1-V49.77 | Problems with limbs and other problems |
| V52.0 | Fitting and adjustment of artificial arm (complete) (partial) |
| V52.1 | Fitting and adjustment of artificial leg (complete) (partial) |
| V53.7 | Fitting and adjustment of orthopedic devices |
| V54.0-V54.8 | Other orthopedic aftercare |
| V57.81 | Orthotic training |

## Not Otherwise Classified Codes (NOC)

N/A

## ICD-9-CM Codes that Support Medical Necessity

N/A

## 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

No payment may be made for items or services which are not reasonable and medically necessary for the diagnosis or treatment of an illness or injury to improve the function of a malformed body member under Section 1862(a)(1)(A) of the Social Security Act.

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

Vertebral Axial Decompression (VAD) therapy is considered "investigational" and is a noncovered service under Florida Medicare. VAD therapy should be billed with code 22899.

The professional skills of a provider are not required to effect improvement or restoration of function where a patient suffers a temporary loss or reduction of function which could reasonably be expected to improve as the patient gradually resumes normal activities.

General activity programs and all activities which are primarily social or diversional in nature will be denied because the professional skills of a provider are not required.

Services related to activities for the general good and welfare of patients (e.g., general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation), do not constitute physical therapy services for Medicare purposes.

When the documentation indicates a patient has attained the therapy goals or has reached the point where no further significant improvement can be expected, the skills of the Physical Therapist are not required to maintain function at the level to which it has been restored.

Physical therapy is not covered when the documentation indicates the patient has not reached the therapy goals and is not making significant improvement or progress, is unable to participate and/or benefit from skilled intervention or refused to participate.

Physical therapy services provided to **identify patients** who might need or benefit from physical therapy intervention are not covered.

Diathermy (97024) or ultrasound (97035) heat treatments performed for respiratory conditions or diseases (ICD-9-CM codes 460-519.9) are investigational under the Medicare program.

***97010: Physical Medicine and Rehabilitation (continued)***

Electrical Stimulation (CPT codes 97014, 97032) used to treat motor function disorders, such as multiple sclerosis, is considered investigational and therefore, noncovered.

Electrical Stimulation (CPT codes 97014, 97032) used in the treatment of facial nerve paralysis, commonly known as Bell's Palsy (ICD-9-CM code 351.0), is considered investigational and noncovered.

Physical therapy is not covered to treat Skilled Nursing Home patients whose care can safely be rendered by the SNF's trained professional staff.

Services furnished as part of a maintenance program involving repetitive activities do not require the skilled services of a therapist and are therefore, not considered reasonable and necessary.

Work hardening/conditioning (CPT codes 97545-97546) is a noncovered service. These services relate solely to specific work skills and do not provide any diagnostic or therapeutic benefit for the patient that requires physical rehabilitation.

Physical therapy is not covered when the documentation fails to support that the functional condition was impaired to the degree that required the skills of a therapist.

Physical therapy services which are duplicative of other concurrent rehabilitation services are not covered**.**

The following services should not be billed as therapeutic activities (97530):

- General exercise programs to improve a patient's general cardiovascular fitness;
- Pulmonary rehabilitation;
- Cardiac rehabilitation; or
- A maintenance program of therapeutic activities.

Aquatic therapy with therapeutic exercise (97113) should not be billed when there is not one-on-one contact between therapist and patient. For example, an aqua aerobic class of more than one patient with the instructor directing the class from a distance would not be considered reasonable and necessary and therefore, not a covered service.

Diapulse and Rolfing (97799) treatment is a noncovered service.

## Noncovered ICD-9-CM Codes

**For Procedure Code 97032 (Electrical-Stimulation)**

351.0 Bell's palsy

**For Procedure Codes 97024 (Diathermy) and 97035 (Ultrasound)**

460-519.9 Diseases of the Respiratory System

## Noncovered Diagnosis

N/A

## Coding Guidelines

It is usually not medically necessary to have more than one form of heat treatment (paraffin bath, infrared, diathermy, contrast baths) for a single condition per day. Therefore, documentation of the medical necessity of multiple heating modalities on the same date of service must be available for review.

It is usually not medically necessary to have more than one form of hydrotherapy (Whirlpool, Hubbard Tank, Aquatic therapy with therapeutic exercise) for a single condition per day. Therefore, documentation of the medical necessity of multiple forms of hydrotherapy on the same date of service must be available for review.

When both a modality/procedure and an evaluation service are billed on the same day, the evaluation may be reimbursed only if the medical necessity for the evaluation is clearly documented.

## Documentation Requirements

The medical record must identify the physician's order for physical therapy.

The HCFA 700/701 forms are designed to incorporate the essential elements of the plan of care. The use of this form is NOT required. Providers may elect to format the required elements in whatever manner meets their needs. The documentation requirements are:

**Evaluation/Re-evaluations**

The Physician/Optometrist Patient Evaluation/Re-evaluation assesses the area for which physical therapy treatment is being planned. It must be completed prior to beginning therapy. Evaluations must contain the following information. Evaluations without any of these elements will be **denied** as not medically necessary.

- Reason for referral
- Diagnosis/condition being treated
- Past level of function (be specific)
- Evaluations must contain physical and cognitive baseline data necessary for assessing rehab potential and measuring progress
- Current level of function
- Measurements such as strength, ROM, pain level
- Treatment modalities selected for treating current illness or injury
- Limitations which may influence the length of treatment
- Short and long term goals stated in measurable terms, and their expected date of accomplishment
- Frequency and duration of therapy
- Routine assessments during admission to a Nursing Home are not covered
- Routine periodic reassessments of Nursing Home patients not currently involved in active physical therapy are not covered
- Re-evaluations may be required when there is a significant change in the patient's level of functioning (e.g., the patient has suffered a new injury or illness that will impact the current treatment plan)
- Routine re-evaluations of a patient's progress toward their therapeutic goals are not separately reimbursed

**Treatment Plan**

Services are to be furnished according to a written treatment plan determined by the physician or optometrist:

- After any needed consultation with the qualified physical therapist;
- After an appropriate assessment (evaluation) of the condition (illness or injury) is completed; and
- Before active therapy begins.

***97010: Physical Medicine and Rehabilitation (continued)***

If the treatment plan is written by the therapist, it must be signed and dated by the referring or attending physician or optometrist. The signature and date must be handwritten, not stamped, or written by someone else. The physician or optometrist should sign the plan within 2 to 3 treatment sessions after the evaluation/plan of treatment is completed. Electronic signatures will be accepted as long as the date that the certification was electronically signed can be determined.

The treatment plan established by a physician or optometrist may not be altered by a physical therapist. All services must be rendered according to the physician or optometrist approved treatment plan. The treatment plan must contain the following elements:

- Diagnosis being treated and the specific problems identified that are to be addressed.
- Specific treatment modalities or procedures being used for each specific problem to attain the stated goals.
- Specific functional goals for therapy in measurable terms.
- Amount, frequency, and duration of each therapeutic modality.
- Rehabilitation potential – therapists/physician's expectation of the patient's ability to meet the goals at initiation of treatment.

Physical therapy plans of care that lack any of these elements will be denied as not medically necessary.

**Progress Notes**

Progress notes are to be maintained in the patient's record and should contain the following:

- subjective status of the patient,
- description of the nature of the treatment/service performed (e.g., modalities, training, education etc.),
- patient's response to the therapeutic intervention, **and**
- its relevance to the goals indicated in the treatment plan.

The progress notes must contain necessary and sufficient information, which indicates the services were actually provided and were reasonable and necessary to treat the patient's condition. Progress notes, which should be submitted at least weekly, must substantiate the medical necessity of the treatment and support that skilled intervention is required.

The progress note should document any treatment variations with the associated rationale.

The progress notes should be written using measurements and functional accomplishments. Use statements which can be used to assess the patient s response to therapy such as:

- "able to perform exercises as prescribed for 15 reps"
- "able to safely transfer from bed to wheelchair with standby assistance"
- "can now abduct shoulder 120 degrees" sufficiently to pull slacks up over hips"

Avoid terms such as:

- doing well
- improving
- less pain
- increased range of motion
- increased strength
- tolerated treatment well

**Certification/Re-certification**

Certifications are required upon initiation of therapy and every 30 days thereafter for Outpatient Physical Therapy Services.

Certifications are required upon initiation of therapy and every 60 days thereafter for Comprehensive Outpatient Rehabilitation Facilities (CORF) physical therapy services.

All certifications/re-certifications must be signed and dated only by the referring/attending physician or optometrist. The signature and date must be handwritten, not stamped, or written by someone else. Electronic signatures will be accepted as long as the date that the certification was electronically signed can be determined.

Documentation should indicate the prognosis for potential restoration of function in a reasonable and generally predictable period of time, or the need to establish a safe and effective maintenance program.

## Utilization Guidelines

N/A

## Other Comments

Services performed in a Skilled Nursing Facility, Personal Care Home (such as ACLF, nursing home, etc.)

- Therapy performed in a SNF or personal care facility should be of the type that cannot be rendered by the attending professional staff and requires the skills of a qualified therapist.
- The facility is responsible for maintaining medical information which may be requested by the Medicare contractor. Types of medical information that may be requested are:
  - Nurses' notes,
  - Minimum data set,
  - Physician progress notes, and/or
  - Physician order.

## Sources of Information and Basis for Decision

American Medical Association. (1995). Significant revisions: Physical medicine and rehabilitation. *cpt™ Assistant,* 5(2), 5-11. This source was used to clarify the various modalities.

American Medical Association. (1998). A comparative look at the physical medicine and rehabilitation codes. *cpt™ Assistant,* 8(12), 1-4. This source was used to clarify the various modalities and procedure codes.

American Medical Association. (1999). Physical medicine and rehabilitation. *cpt™ Assistant,* 9(3), 1-11. This source was used to clarify the various modalities.

Andrews, J. and Harrelson, G. *Physical rehabilitation of the injured athlete.* Philadelphia: W.B. Saunders Company.

Birrer, R. (1994). *Sports medicine for the primary care physician* (Second Edition). Boca Raton: CRC Press.

DeLisa, J. and Gans, B. (Eds.). (1993). *Rehabilitation medicine: Principles and practice.* Philadelphia: J.B. Lippincott Company.

***97010: Physical Medicine and Rehabilitation (continued)***

Grabois, M., McCann, M., Schramm, D., Straja, A., & Smith, K. (1996). Chronic pain syndromes: Evaluation and treatment. In R.L. Braddock (Ed.), *Physical medicine and rehabilitation (pp. 876-891).* Philadelphia, PA: W.B. Saunders Company. This source was used to establish indications and limitations.

Kottke, F. and Lehmann, J. (Eds.). (1990 *Krusen's handbook of physical medicine and rehabilitation* (4th edition). Philadelphia: W.B. Saunders Company.

Tan, J.C. (1998). *Practical manual of physical medicine and rehabilitation.* St. Louis, MO: Mosby, Inc. This source was used to clarify the various modalities.

## 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 advisory groups, which includes representatives from numerous societies.

## Start Date of Comment Period

N/A

## End Date of Comment Period

N/A

## Start Date of Notice Period

02/01/2002

## Revision History

Revision Number: 4
Start Date of Comment Period N/A
Start Date of Notice Period 02/01/2002
2nd Qtr 2002 *Bulletin*
Revised Effective Date: 03/28/2002
Explanation of Revision: Clarifications made to various modalities which include electrical stimulation for wound care. Further clarification regarding the certification statement was provided.

Revision Number: 3
Start Date of Comment Period N/A
Start Date of Notice Period 02/01/2002
2nd Qtr 2002 *Bulletin*
Revised Effective Date: 01/01/2002
Explanation of Revision: Annual 2002 HCPCS Update and changes to progress note documentation based on clarification from the Centers of Medicare and Medicaid Services (CMS).

Revision Number: 2
Start Date of Comment Period N/A
Start Date of Notice Period 01/21/1999
Revised Effective Date: 01/01/1999
Explanation of Revision: This policy is being reformatted to add fluidotherapy modality to existing whirlpool therapy section. (CPT Code 97022).

Revision Number: 1
Start Date of Comment Period N/A
Start Date of Notice Period 01/21/1999
Revised Effective Date:
Explanation of Revision: The policy is being revised as a result of 1999 HCPCS update.

Revision Number: Original
Start Date of Comment Period 07/25/1997
Start Date of Notice Period 09/18/1998
Original Effective Date: 11/02/1998 ❖

# 97110: Complex Decongestive Physiotherapy

*Revision Overview: Policy has been revised as a result of the annual 2002 HCPCS update. "Type of Bill Code" section of the policy has been revised.*

### Policy Number
97110

### Contractor Name
First Coast Service Options, Inc.

### Contractor Number
090

### Contractor Type
Intermediary

### LMRP Title
Complex Decongestive Physiotherapy

### AMA CPT Copyright Statement


### CMS National Coverage Policy
Medicare Intermediary Manual, Part 3, 3101.8 and 3148.3
Hospital Manual, Section 241-242.4
Outpatient Rehabilitation and CORF Manual, Section 200-205.3, 403.3
Skilled Nursing Manual, Section 230.3
Coverage Issues Manual, Sections 35-2, 35-3, 35-20, 35-41, 35-56, 35-72, 35-77, 60-16
Code of Federal Regulation, Sections 3128, 16,838G, and 16,959

### Primary Geographic Jurisdiction
Florida

### Secondary Geographic Jurisdiction
N/A

### CMS Region
Region IV

### CMS Consortium
Southern

### Original Policy Effective Date
03/19/1998

### Original Policy Ending Date
N/A

### Revision Effective Date
01/01/2002

### Revision Ending Date
12/31/2001

### LMRP Description
The lymphatic system has two primary immunologic functions: activating the inflammatory response and controlling infections. In addition, the lymphatic system drains protein-containing fluid from the tissue and conducts it in a unidirectional flow to the circulatory system. When there is a blockage in this drainage, the result is the swelling of a body part, often an extremity. This is referred to as lymphedema, an abnormal accumulation of lymph fluid.

Lymphedema is categorized as primary or secondary. Primary lymphedema is defined as impaired lymphatic flow due to lymph vessel aplasia, hypoplasia, or hyperplasia. This type is an inherited deficiency in the lymphatic channels of unknown origin. Secondary lymphedema is caused by known precipitating factors. The most common causes in the United States are surgical removal of the lymph nodes (e.g., in connection with a mastectomy), fibrosis secondary to radiation, and traumatic injury to the lymphatic system. Filariasis is the leading cause of lymphedema throughout much of the tropical world.

Currently, lymphedema can be treated by many methods such as: Compressive garments, wrapping, elevation, surgery, pneumatic compression devices or Complex Decongestive Physiotherapy (CDP). This policy addresses only the CDP method.

Complex Decongestive Physiotherapy has been referred to by several terms including: non-invasive complex lymphedema therapy (CLT), early conservative lymphedema management, complicated physiotherapeutics, manual lymphedema treatment (MLT), multi-modal lymphedema therapy, and palliative lymphedema therapy. For purposes of consistency, the term CDP will be used.

Each CDP session normally consists of four phases:

- Skin care including cleansing, lubrication, debriding and administration of antimicrobial therapy;
- Manual lymph drainage involving a gentle massage technique that is carried out in a predetermined manner aimed at redirecting lymph and edema fluid towards adjacent, functioning lymph systems;
- Multi-layered compression wrapping (bandages) to prevent any reaccumulation of excavated edema fluid and to prevents the ultrafiltration of additional fluid into the interstitial space; and
- Individualized exercises with the bandage to enhance lymphatic flow from peripheral to central drainage components. These exercises are aimed at augmenting muscular contraction, enhancing joint mobility, strengthening the limb, and reducing the muscle atrophy that frequently occurs secondary to lymphedema.

### Indications and Limitations of Coverage and/or Medical Necessity
As mentioned earlier, CDP consists of skin care, manual lymph drainage, compression wrapping, and exercises. Although there is no means for Medicare to allow payment of the total treatment via one treatment code, payment will be allowed for the physical therapy services associated with the treatment. Other services such as skin care and the supplies associated with the compression wrapping are included in the physical therapy services performed during each session.

The goal of this therapy is not to achieve maximum volume reduction, but to ultimately transfer the responsibility of the care from the clinic, hospital, or doctor, to home care by the patient, patient's family or patient's caregiver. Unless the patient is able to continue therapy at home, there is only temporary benefit from the treatment.

***97110: Complex Decongestive Physiotherapy (continued)***

The endpoint of treatment is not when the edema resolves or stabilizes, but when the patient and/or their cohort are able to continue the treatments at home. Patients who do not have the capacity or support system to accomplish these skills in a reasonable time are not good candidates for Complex Decongestive Physiotherapy.

It is expected that physical therapy education sessions would usually last for 1 to 2 weeks, with the patient attending 3-5 times per week, depending on the progress of the therapy. After that time, there should have been enough teaching and instruction that the care could be continued by the patient or patient caregiver in the home setting. The maximum benefits of treatment are not expected unless the patient continues treatment at home.

The physical therapy billed in conjunction with the manual lymph drainage therapy will be subject to all national and local policies for physical therapy.

The coverage of the physical therapy would only be allowed if all of the following conditions have been met:

- There is a physician documented diagnosis of lymphedema; and the physician specifically orders CDP.
- The patient is symptomatic for lymphedema, with limitation of function related to self care, mobility and/or safety.
- The patient or patient caregiver has the ability to understand and comply with home care continuation of treatment regimen.
- The services are being performed by a health care professional who has received specialized training in this form of treatment.

Currently, Medicare covers services for lymphedema by the lymphedema pump. Some providers are proposing noninvasive Complex lymphedema therapy as an alternative to pumps. A patient requiring both modes of treatment should be rare. In addition, it is not expected that PT and OT would be performed concurrently; (i.e., both PT and OT providing the therapeutic exercise portion of the session).

The physical therapy services for CDP must be provided either by or under the direct personal supervision of the physician or independently practicing therapist.

## CPT/HCPCS Section & Benefit Category

Medicine/Physical Medicine and Rehabilitation

## Type of Bill

Hospital – 13x
Skilled Nursing Facility – 21x, 22x, 23x
Outpatient Rehab Facility – 74x
Comprehensive Outpatient Rehab Facility – 75x
Critical Access Hospital – 85x

## Revenue Codes

270 Medical/Surgical Supplies and Devices: General Classification
420 Physical Therapy: General Classification
430 Occupational Therapy: General Classification

## CPT/HCPCS Codes

| | |
|---|---|
| *97001* | *Physical therapy evaluation* |
| *97002* | *Physical therapy re-evaluation* |
| *97003* | *Occupational therapy evaluation* |
| *97004* | *Occupational therapy re-evaluation* |
| *97110* | *Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility* |
| *97140* | *Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes* |
| *97535* | *Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes* |

## Not Otherwise Classified Codes (NOC)

N/A

## ICD-9-CM Codes that Support Medical Necessity

| | |
|---|---|
| 457.0 | Postmastectomy lymphedema syndrome |
| 457.1 | Other lymphedema |
| 757.0 | Hereditary edema of legs (congenital lymphedema) |

## 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 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 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

It is expected that procedure code 97140 will be utilized when the manual lymph drainage is performed, procedure code 97535 for the instruction of bandaging, exercises and self care, and procedure code 97110 when performing the individual exercises.

When an initial evaluation or periodic re-evaluation is performed, separate reimbursement may be made. For these evaluations, physical and occupational therapists should use codes 97001, 97002, 97003, and 97004.

The supplies associated with the compression bandages can be billed separately using revenue code 270 for all Type of Bill listed in this policy except an outpatient rehab facility (74x). The cost of the bandages for 74x must be billed with the other physical medicine services under revenue code 420 or 430.

***97110: Complex Decongestive Physiotherapy (continued)***

When billing for supplies, the outpatient hospital facility (13x) must indicate the applicable HCPCS level II procedure code in addition to revenue code 270.

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

## Documentation Requirements

The medical record documentation maintained by the provider must clearly document the medical necessity of the services being performed.

The documentation for the initial evaluation and treatment must include the following:

- A physician documented diagnosis of lymphedema and a specific order for CDP.
- A statement as to the ability of the patient/patient caregiver to follow through with the continuation of treatment on a long term home treatment plan.
- History and physical including: the cause of the lymphedema and any prior treatment, measurements of body part/extremity prior to treatment, specific areas of indurated tissue, hardness of edema, condition of nails and skin, infected sites, scars, distal pulses, pain, discomfort and the affects the lymphedema has on the patient's Activities of Daily Living (i.e, symptomatic for lymphedema, with limitation of function related to self care, mobility and/or safety).
- Treatment plan identifying specific short and long term goals; the type, amount, frequency and duration of the services.
- The services/modalities performed including a response to treatment.

The documentation for any subsequent treatment must include:

- A report showing the progress of the therapy including periodic measurements of the applicable extremity(ies).
- The response of the patient /patient caregiver to the education and their understanding and ability to take on some of the responsibilities of the treatment.
- The services/modalities performed including a response to treatment.

## Utilization Guidelines

N/A

## Other Comments

**Terms Defined**

*Filariasis* – A chronic disease due to one of the filarial species. Inflammatory elephantiasis results from filariasis or local infection of the lymph nodes.

*Elephantiasis* – A chronic infectious condition characterized by pronounced hypertrophy of the skin and subcutaneous tissues resulting from obstruction of the lymphatic vessels.

*Lymphedema* – Edema due to obstruction of lymphatics

## Sources of Information and Basis for Decision

Boris, M., Weindorf, S., Lasinski, B., & Boris, G. (1994). *Lymphedema reduction by noninvasive complex lymphedema therapy*, Oncology, September 1994, p. 94.

Clodius, L., Foldi, M. (1984). *Therapy for lymphedema today*, International Angiology, 3(2). 207-213.

Thomas, C.L. (1993). *Taber's cyclopedic medical dictionary* (17th ed.) Philadelphia: F.A. Davis Company.

Zanolla, R., Monzeglio, C., Balzarini, A., & Martino, G. (1984). *Evaluation of the results of three different methods of postmastectomy lymphedema treatment*, Journal of Surgical Oncology, 26. 210-213.

## 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 multiple societies.

## Start Date of Comment Period

N/A

## End Date of Comment Period

N/A

## Start Date of Notice Period

02/01/2002

## Revision History

| | |
|---|---|
| Revision Number: | 3 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 02/01/2002 |
| | 2nd Qtr 2002 *Bulletin* |
| Revised Effective Date: | 01/01/2002 |

Explanation of Revision: Annual 2002 HCPCS Update.

| | |
|---|---|
| Revision Number: | 2 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 01/21/1999 |
| Revised Effective Date: | 01/01/1999 |

Explanation of Revision: Annual 1999 HCPCS

| | |
|---|---|
| Revision Number: | 1 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 09/18/1998 |
| Revised Effective Date: | 11/02/1998 |

Explanation of Revision: Coding guidelines have been revised due to HCFA release of Transmittal number A-98-24.

| | |
|---|---|
| Revision Number: | Original |
| Start Date of Comment Period | 12/01/1997 |
| Start Date of Notice Period | 02/18/1998 |
| Original Effective Date: | 03/19/1998 ❖ |

# G0030: Positron Emission Tomography (PET) Scan

*Revision Overview: " Indication and Limitations of Coverage and/or Medical Necessity" section of the policy has been revised to incorporate clarification regarding the types of allowable PET scanners. "CPT/HCPCS" section has been revised as a result of the annual 2002 HCPCS update. "Type of Bill Code" section of the policy has also been revised.*

### Policy Number
G0030

### Contractor Name
First Coast Service Options, Inc.

### Contractor Number
090

### Contractor Type
Intermediary

### LMRP Title
Positron Emission Tomography (PET) Scan

### AMA CPT Copyright Statement


### CMS National Coverage Policy
Coverage Issues Manual, Section 50-36

### Primary Geographic Jurisdiction
Florida

### Secondary Geographic Jurisdiction
N/A

### CMS Region
Region IV

### CMS Consortium
Southern

### Original Policy Effective Date
12/03/1998

### Original Policy Ending Date
N/A

### Revision Effective Date
01/01/2002

### Revision Ending Date
12/31/2001

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

### Indications and Limitations of Coverage and/or Medical Necessity
The following indications may be covered for PET under certain circumstances. Details of Medicare PET coverage are discussed later in this policy. Unless otherwise indicated, the clinical conditions below are covered when PET utilizes FDG as the tracer.

**Note:** All other uses of PET scans not listed in this policy are NOT covered.

| Clinical Condition | Effective Date | Coverage |
|---|---|---|
| Solitary Pulmonary Nodules (SPNs) | January 1, 1998 | Characterization |
| Lung Cancer (Non Small Cell) | January 1, 1998 | Initial Staging |
| Lung Cancer (Non Small Cell) | July 1, 2001 | Diagnosis, staging, and restaging |
| Esophageal Cancer | July 1, 2001 | Diagnosis, staging, and restaging |
| Colorectal Cancer | July 1, 1999 | Determining location of tumors if rising CEA level suggests recurrence |
| Colorectal Cancer | July 1, 2001 | Diagnosis, staging, and restaging |
| Lymphoma | July 1, 1999 | Staging and restaging only when used as an alternative to Gallium scan |
| Lymphoma | July 1, 2001 | Diagnosis, staging, and restaging |
| Melanoma | July 1, 1999 | Evaluating recurrence prior to surgery as an alternative to Gallium scan |
| Melanoma | July 1, 2001 | Diagnosis, staging, and restaging; noncovered for evaluating regional nodes |
| Refractory Seizures | July 1, 2001 | Covered for pre-surgical evaluation only |
| Perfusion of the heart using Rubidium 82* tracer | March 14, 1995 | Covered for noninvasive imaging of the perfusion of the heart |
| Head and Neck Cancer | July 1, 2001 | Diagnosis, staging, and restaging; noncovered for CNS and thyroid cancers |
| Myocardial Viability | July 1, 2001 | Covered only following an inconclusive SPECT |

*Not FDG PET

***G0030: Positron Emission Tomography (PET) Scan (continued)***

**General Conditions of Coverage for FDG PET**

A. Allowable FDG PET Systems

1. Definitions: For purposes of this section,
   a. "Any FDA approved" means all systems approved or cleared for marketing by the FDA to image radionuclides in the body.
   b. "FDA approved" means that the system indicated has been approved or cleared for marketing by the FDA to image radionuclides in the body.
   c. "Certain coincidence systems" refers to the systems that have all the following features:
      - Crystal at least 5/8-inch thick
      - Techniques to minimize or correct for scatter and/or randoms, and
      - Digital detectors and iterative reconstruction.

Scans performed with gamma camera PET systems with crystals thinner than 5/8-inch will not be covered by Medicare. In addition, scans performed with systems with crystals greater than or equal to 5/8-inch in thickness, but that do not meet the other listed design characteristics are not covered by Medicare.

2. Allowable PET systems by covered clinical indication:

| | **Allowable Type of FDG PET System** | | |
|---|---|---|---|
| Covered Clinical Condition | Prior to July 1, 2001 | July 1, 2001 through December 31, 2001 | On or after January 1, 2002 |
| Characterization of single pulmonary nodules | Effective 1/1/1998, any FDA approved | Any FDA approved | FDA approved: Full ring<br>Partial ring<br>Certain coincidence systems |
| Initial staging of lung cancer (non small cell) | Effective 1/1/1998, any FDA approved | Any FDA approved | FDA approved: Full ring<br>Partial ring<br>Certain coincidence systems |
| Determining location of colorectal tumors if rising CEA level suggests recurrence | Effective 7/1/1999, any FDA approved | Any FDA approved | FDA approved: Full ring<br>Partial ring<br>Certain coincidence systems |
| Staging or restaging of lymphoma only when used as an alternative to a gallium scan | Effective 7/1/1999, any FDA approved | Any FDA approved | FDA approved: Full ring<br>Partial ring<br>Certain coincidence systems |
| Evaluating recurrence of melanoma prior to surgery as an alternative to a gallium scan | Effective 7/1/1999, any FDA approved | Any FDA approved | FDA approved: Full ring<br>Partial ring<br>Certain coincidence systems |
| Diagnosis, staging, and restaging of colorectal cancer | Not covered by Medicare | Full ring | FDA approved: Full ring<br>Partial ring |
| Diagnosis, staging, and restaging of esophageal cancer | Not covered by Medicare | Full ring | FDA approved: Full ring<br>Partial ring |
| Diagnosis, staging, and restaging of head and neck cancers (excluding CNS and thyroid) | Not covered by Medicare | Full ring | FDA approved: Full ring<br>Partial ring |
| Diagnosis, staging, and restaging of lung cancer (non small cell) | Not covered by Medicare | Full ring | FDA approved: Full ring<br>Partial ring |
| Diagnosis, staging, and restaging of lymphoma | Not covered by Medicare | Full ring | FDA approved: Full ring<br>Partial ring |
| Diagnosis, staging, and restaging of melanoma (noncovered for evaluating regional nodes) | Not covered by Medicare | Full ring | FDA approved: Full ring<br>Partial ring |
| Determination of myocardial viability only following an inconclusive SPECT | Not covered by Medicare | Full ring | FDA approved: Full ring<br>Partial ring |
| Presurgical evaluation of refractory seizures | Not covered by Medicare | Full ring | FDA approved: Full ring<br>Partial ring |

***G0030: Positron Emission Tomography (PET) Scan (continued)***

B. Regardless of any other terms or conditions, all uses of FDG PET scans, in order to be covered by the Medicare program, must meet the following general conditions prior to June 30, 2001:
   1. Submission of claims for payment must include any information Medicare requires to assure that the PET scans performed: (a) were medically necessary; (b) did not unnecessarily duplicate other covered diagnostic tests; and (c) did not involve investigational drugs or procedures using investigational drugs as determined by the FDA.
   2. The PET scan entity submitting claims for payment must keep such patient records as Medicare requires on file for each patient for whom a PET scan claim is made.

C. Regardless of any other terms or conditions, all uses of FDG PET scans, in order to be covered by the Medicare program, must meet the following general conditions as of July 1, 2001:
   1. The provider should maintain on file the doctor's referral and documentation that the procedure involved only FDA approved drugs and devices, as is normal business practice.
   2. The ordering physician is responsible for certifying the medical necessity of the study and that it meets the conditions specified in the instructions. The physician should have documentation in the beneficiary's medical record to support the referral to the PET scan provider.

**Covered Indications for PET Scans and Limitations/ Requirements for Usage**

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

**Diagnosis** – PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers, as well as in melanoma, should be rare. PET is not covered for other diagnostic uses, and is not covered for screening (testing of patients without specific signs and symptoms of disease).

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

**Note:** PET is not covered for other diagnostic uses, and is not covered for screening (testing of patients without specific symptoms).

**Monitoring** – Use of PET to monitor tumor response during the planned course of therapy (i.e. when no change in therapy is being contemplated) is NOT covered. Restaging only occurs after a course of treatment is completed, and this is covered, subject to the conditions above.

**Coverage of PET Scans for Noninvasive Imaging of the Perfusion of the Heart**

Effective for services performed on or after March 14, 1995, PET scans done at rest or with pharmacological stress used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease using the FDA-approved radiopharmaceutical Rubidium 82 (Rb82) are covered, provided the requirements below are met:

The PET scan, whether rest alone or rest with stress, is used in place of, but not in addition to, a single photon emission computed tomography (SPECT); or

The PET scan, whether rest alone or rest with stress, is used following a SPECT that was found inconclusive. In these cases, the PET scan must have been considered necessary in order to determine what medical or surgical intervention is required to treat the patient. (For purposes of this requirement, an inconclusive test is a test(s) whose results are equivocal, technically uninterpretable, or discordant with a patient's other clinical data and must be documented in the beneficiary's file.)

For any PET scan for which Medicare payment is claimed for dates of service prior to July 1, 2001, the claimant must submit additional specified information on the claim form (including proper codes and/or modifiers), to indicate the results of the PET scan. The claimant must also include information on whether the PET scan was done after an inconclusive noninvasive cardiac test. The information submitted with respect to the previous noninvasive cardiac test must specify the type of test done prior to the PET scan and whether it was inconclusive or unsatisfactory. These codes are in the form of special G codes used for billing PET scans using Rb 82. Beginning July 1, 2001 claims should be submitted with the appropriate codes.

**Coverage of FDG PET for Lung Cancer**

The coverage for FDG PET for lung cancer, effective January 1, 1998, has been expanded. Beginning July 1,

***G0030: Positron Emission Tomography (PET) Scan (continued)***

2001 usage of FDG PET for lung cancer has been expanded to include diagnosis, staging, and restaging of the disease.

A. Effective for services performed on or after January 1, 1998, Medicare covers regional FDG PET chest scans, on any FDA approved scanner, for the characterization of single pulmonary nodules (SPNs). The primary purpose of such characterization should be to determine the likelihood of malignancy in order to plan future management and treatment for the patient.

**Requirements:**

There must be evidence of primary tumor. Claims for regional PET chest scans for characterizing SPNs should include evidence of the initial detection of a primary lung tumor, usually by computed tomography (CT). This should include, but is not restricted to, a report on the results of such CT or other detection method, indicating an indeterminate or possible malignant lesion, not exceeding four centimeters (cm) in diameter.

PET scan claims must include the results of concurrent thoracic CT, which is necessary for anatomic information, in order to ensure that the PET scan is properly coordinated with other diagnostic modalities.

In cases of serial evaluation of SPNs using both CT and regional PET chest scanning, such PET scans will not be covered if repeated within 90 days following a negative PET scan.

**Note:** A tissue sampling procedure is not routinely covered in the case of a negative PET scan for characterization of SPNs, since the patient is presumed not to have a malignant lesion, based upon the PET scan results. When there has been a negative PET scan, the provider must submit additional information with the claim to support the necessity of a Tissue Sampling Procedure (TSP), for review by the Medicare contractor.

B. Effective for services performed from January 1, 1998 through June 30, 2001, Medicare approved coverage of FDG PET for initial staging of non-small-cell lung carcinoma (NSCLC).

**Limitations:**

This service is covered only when the primary cancerous lung tumor has been pathologically confirmed; claims for PET must include a statement or other evidence of the detection of such primary lung tumor. The evidence should include, but is not restricted to, a surgical pathology report, which documents the presence of an NSCLC. Whole body PET scan results and results of concurrent computed tomography (CT) and follow-up lymph node biopsy must be properly coordinated with other diagnostic modalities. Claims must include both:

- The results of a concurrent thoracic CT, necessary for anatomic information, and
- The results of any lymph node biopsy performed to finalize whether the patient will be a surgical candidate. The ordering physician is responsible for providing this biopsy result to the PET facility.

**Note:** Where the patient is considered a surgical candidate, (given the presumed absence of metastatic NSCLC unless medical review supports a determination of medical necessity of a biopsy) a lymph node biopsy will not be covered in the case of a negative CT and negative PET. A lymph node biopsy will be covered in all other cases, (i.e., positive CT + positive PET; negative CT + positive PET; positive CT + negative PET).

C. Beginning July 1, 2001, Medicare covers FDG PET for diagnosis, staging, and restaging of NSCLC. Documentation should be maintained in the beneficiary's medical file to support the medical necessity of the procedure, as is normal business practice.

Requirements: PET is covered in either/or both of the following circumstances:

**Diagnosis** – PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers, as well as in melanoma, should be rare.

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

**Coverage of FDG PET for Esophageal Cancer**

A. Beginning July 1, 2001, Medicare covers FDG PET for the diagnosis, staging, and restaging of esophageal cancer. Medical evidence is present to support the use of FDG PET in pre-surgical staging of esophageal cancer.

Requirements: PET is covered in either/or both of the following circumstances:

**Diagnosis** – PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal

***G0030: Positron Emission Tomography (PET) Scan (continued)***

anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers, as well as in melanoma, should be rare.

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

**Coverage of FDG PET for Colorectal Cancer**

Medicare coverage of FDG PET for colorectal cancer where there is a rising level of carcinoembryonic antigen (CEA) was effective July 1, 1999 through June 30, 2001. Beginning July 1, 2001, usage of FDG PET for colorectal cancer has been expanded to include diagnosis, staging, and restaging of the disease.

A. Effective July 1, 1999, Medicare covers FDG PET for patients with recurrent colorectal carcinomas, which are suggested by rising levels of the biochemical tumor marker CEA.

**Frequency Limitations:**

Whole body PET scans for assessment of recurrence of colorectal cancer cannot be ordered more frequently than once every 12 months unless medical necessity documentation supports a separate re-elevation of CEA within this period.

**Limitations:**

Because this service is covered only in those cases in which there has been a recurrence of colorectal tumor, claims for PET should include a statement or other evidence of previous colorectal tumor, through June 30, 2001.

B. Beginning July 1, 2001, Medicare coverage has been expanded for colorectal carcinomas for diagnosis, staging, and restaging. New medical evidence supports the use of FDG PET as a useful tool in determining the presence of hepatic/extrahepatic metastases in the primary staging of colorectal carcinoma, prior to selecting a treatment regimen. Use of FDG PET is also supported in evaluating recurrent colorectal cancer beyond the limited presentation of a rising CEA level where the patient presents with clinical signs or symptoms of recurrence.

Requirements: PET is covered in either/or both of the following circumstances:

**Diagnosis** – PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers, as well as in melanoma, should be rare.

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

**Coverage of FDG PET for Lymphoma**

Medicare coverage of FDG PET to stage and re-stage lymphoma as an alternative to a Gallium scan, was effective July 1, 1999. Beginning July 1, 2001, usage of FDG PET for lymphoma has been expanded to include diagnosis, staging, and restaging of the disease.

A. Effective July 1, 1999, FDG PET is covered for the staging and restaging of lymphoma.

**Requirements:**

FDG PET is covered only for staging or follow-up restaging of lymphoma. Claims must include a statement or other evidence of previous diagnosis of lymphoma when used as an alternative to a Gallium scan.

To ensure that the PET scan is properly coordinated with other diagnostic modalities, claims must include results of concurrent computed tomography (CT) and/or other diagnostic modalities when they are necessary for additional anatomic information.

***G0030: Positron Emission Tomography (PET) Scan (continued)***

No PET scan may be covered in cases where it is done within 50 days of a Gallium scan done by the same facility where the patient has remained during the 50-day period. Gallium scans done by another facility less than 50 days prior to the PET scan will not be counted against this screen.

**Frequency Limitations for Restaging:**

PET scans will be allowed for restaging no sooner than 50 days following the last staging PET scan or Gallium scan, unless the medical necessity documentation supports that the restaging at an earlier date is medically necessary.

B. Effective for services performed on or after July 1, 2001, the Medicare program has broadened coverage of FDG PET for the diagnosis, staging, and restaging of lymphoma.

**Requirements:**

PET is covered in either/or both of the following circumstances:

**Diagnosis** – PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers, as well as in melanoma, should be rare.

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

**Coverage of FDG PET for Melanoma**

Medicare covered the evaluation of recurrent melanoma prior to surgery when used as an alternative to a Gallium scan, effective July 1, 1999. For services performed on or after July 1, 2001, FDG PET is covered for the diagnosis, staging, and restaging of malignant melanoma. FDG PET is not covered for the use of evaluating regional nodes in melanoma patients.

A. Effective for services furnished July 1, 1999 through June 30, 2001, in the case of patients with recurrent melanoma prior to surgery, FDG PET (when used as an alternative to a Gallium scan) is covered for tumor evaluation.

**Frequency Limitations:**

Whole body PET scans cannot be ordered more frequently than once every 12 months, unless medical necessity documentation, maintained in the beneficiary's medical record, supports the specific need for anatomic localization of possible recurrent tumor within this period.

**Limitations:**

The FDG PET is covered only as an alternative to a Gallium scan. No PET scan may be covered in cases where it is done within 50 days of a Gallium scan done by the same facility where the patient has remained during the 50-day period. Gallium scans done by another facility less than 50 days prior to the PET scan will not be counted against this screen.

B. Effective for services performed on or after July 1, 2001, FDG PET scan coverage for the diagnosis, staging, and restaging of malignant melanoma (not the evaluation of regional nodes) has been broadened.

**Limitations:**

PET scans are not covered for the evaluation of regional nodes.

**Requirements:**

PET is covered in either/or both of the following circumstances:

**Diagnosis** - PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers, as well as in melanoma, should be rare.

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

***G0030: Positron Emission Tomography (PET) Scan (continued)***

reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

**Coverage of FDG PET for Head and Neck Cancers (Cancers of the Central Nervous System [CNS] and thyroid are noncovered)**

Effective for services performed on or after July 1, 2001, Medicare will provide coverage for cancer of the head and neck, excluding the central nervous system (CNS) and thyroid.

**Limitations:**

PET scans for head and neck cancers are not covered for CNS or thyroid cancers.

**Requirements:**

PET is covered in either/or both of the following circumstances:

**Diagnosis** – PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers, as well as in melanoma, should be rare.

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

**Coverage of FDG PET for Myocardial Viability**

Beginning July 1, 2001, Medicare covers FDG PET for the determination of myocardial viability, following an inconclusive SPECT.

**Limitations:**

In the event that a patient has received a single photon computed tomography test (SPECT) with inconclusive results, a PET scan may be covered.

**Coverage of FDG PET for Refractory Seizures**

Beginning July 1, 2001, Medicare will cover FDG PET for pre-surgical evaluation for the purpose of localization of a focus of refractory seizure activity.

**Limitations:**

Covered only for pre-surgical evaluation.

## CPT/HCPCS Section & Benefit Category

Radiology/Nuclear Medicine

## Type of Bill Code

Hospital – 12x, 13x, 14x
Skilled Nursing Facility – 21x
Critical Access Hospital – 85x

## Revenue Codes

404 Positron Emission Tomography (PET)

## CPT/HCPCS Codes

| | |
|---|---|
| G0030 | PET myocardial perfusion imaging, (following previous PET, G0030-G0047); single study, rest or stress (exercise and/or pharmacologic) |
| G0031 | PET myocardial perfusion imaging, (following previous PET, G0030-G0047); multiple studies, rest or stress (exercise and/or pharmacologic) |
| G0032 | PET myocardial perfusion imaging, (following rest SPECT, 78464); single study, rest or stress (exercise and/or pharmacologic) |
| G0033 | PET myocardial perfusion imaging, (following rest SPECT, 78464); multiple studies, rest or stress (exercise and/or pharmacologic) |
| G0034 | PET myocardial perfusion imaging, (following stress SPECT, 78465); single study, rest or stress (exercise and/or pharmacologic) |
| G0035 | PET myocardial perfusion imaging, (following stress SPECT, 78465); multiple studies, rest or stress (exercise and/or pharmacologic) |
| G0036 | PET myocardial perfusion imaging, (following coronary angiography, 93510-93529); single study, rest or stress (exercise and/or pharmacologic) |
| G0037 | PET myocardial perfusion imaging, (following coronary angiography, 93510-93529); multiple studies, rest or stress (exercise and/or pharmacologic) |
| G0038 | PET myocardial perfusion imaging, (following stress planar myocardial perfusion, 78460; single study, rest or stress (exercise and/or pharmacologic) |
| G0039 | PET myocardial perfusion imaging, (following stress planar myocardial perfusion, 78460; multiple studies, rest or stress (exercise and/or pharmacologic) |
| G0040 | PET myocardial perfusion imaging, (following stress echocardiogram, 93350); single study, rest or stress (exercise and/or pharmacologic) |
| G0041 | PET myocardial perfusion imaging, (following stress echocardiogram, 93350); multiple studies, rest or stress (exercise and/or pharmacologic) |
| G0042 | PET myocardial perfusion imaging, (following stress nuclear ventriculogram, 78481 or 78483); single study, rest or stress (exercise and/or pharmacologic) |

***G0030: Positron Emission Tomography (PET) Scan (continued)***

| | |
|---|---|
| G0043 | PET myocardial perfusion imaging, (following stress nuclear ventriculogram, 78481 or 78483); multiple studies, rest or stress (exercise and/or pharmacologic) |
| G0044 | PET myocardial perfusion imaging, (following rest ECG, 93000); single study, rest or stress (exercise and/or pharmacologic) |
| G0045 | PET myocardial perfusion imaging, (following rest ECG, 93000); multiple studies, rest or stress (exercise and/or pharmacologic) |
| G0046 | PET myocardial perfusion imaging, (following stress ECG, 93015); single study, rest or stress (exercise and/or pharmacologic) |
| G0047 | PET myocardial perfusion imaging, (following stress ECG, 93015); multiple studies, rest or stress (exercise and/or pharmacologic) |
| G0125 | PET lung imaging of solitary pulmonary nodules, using 2-[fluorine-18]-fluoro-2-deoxy-D-glucose (FDG), following CT (71250/71260 or 71270) |
| G0210 | PET Imaging whole body; full- and partial-ring pet scanners only, diagnosis; lung cancer, non-small cell |
| G0211 | PET Imaging whole body; full- and partial-ring pet scanners only, initial staging; lung cancer; non-small cell |
| G0212 | PET Imaging whole body; full- and partial-ring pet scanners only, restaging; lung cancer; non-small cell |
| G0213 | PET Imaging whole body; full- and partial-ring pet scanners only, diagnosis; colorectal cancer |
| G0214 | PET Imaging whole body; full- and partial-ring pet scanners only, initial staging; colorectal cancer |
| G0215 | PET Imaging whole body; full- and partial-ring pet scanners only, restaging; colorectal cancer (replaces G0163) |
| G0216 | PET Imaging whole body; full- and partial-ring pet scanners only, diagnosis; melanoma |
| G0217 | PET Imaging whole body; full- and partial-ring pet scanners only, initial staging; melanoma |
| G0218 | PET Imaging whole body; full- and partial-ring pet scanners only, restaging; melanoma (replaces G0165) |
| G0220 | PET Imaging whole body; full- and partial-ring pet scanners only, diagnosis; lymphoma |
| G0221 | PET Imaging whole body; full- and partial-ring pet scanners only, initial staging; lymphoma (replaces G0164) |
| G0222 | PET Imaging whole body; full- and partial-ring pet scanners only, restaging; lymphoma (replaces G0164) |
| G0223 | PET Imaging whole body or regional; full- and partial-ring pet scanners only, diagnosis; head and neck cancer; excluding thyroid and CNS cancers |
| G0224 | PET Imaging whole body or regional; full- and partial-ring pet scanners only, initial staging; head and neck cancer; excluding thyroid and CNS cancers |
| G0225 | PET Imaging whole body or regional; full- and partial-ring pet scanners only, restaging; head and neck cancer, excluding thyroid and CNS cancers |
| G0226 | PET Imaging whole body; full- and partial-ring pet scanners only, diagnosis; esophageal cancer |
| G0227 | PET Imaging whole body; full- and partial-ring pet scanners only, initial staging; esophageal cancer |
| G0228 | PET Imaging whole body; full- and partial-ring pet scanners only, restaging; esophageal cancer |
| G0229 | PET Imaging; Metabolic brain imaging for pre-surgical evaluation of refractory seizures; full- and partial-ring pet scanners only |
| G0230 | PET Imaging; Metabolic assessment for myocardial viability following inconclusive SPECT study; full- and partial-ring pet scanners only |
| G0231 | PET, whole body, for recurrence of colorectal or colorectal metastatic cancer; gamma cameras only |
| G0232 | PET, whole body, for staging and characterization of lymphoma; gamma cameras only |
| G0233 | PET, whole body, for recurrence of melanoma or melanoma metastatic cancer; gamma cameras only |
| G0234 | PET, regional or whole body, for solitary pulmonary nodule following CT or for initial staging of pathologically diagnosed non-small cell lung cancer; gamma cameras only |

### Not Otherwise Classified Codes (NOC)

N/A

### ICD-9-CM Codes that Support Medical Necessity

The following ICD-9-CM codes are applicable to HCPCS codes G0030-G0047 only:

| | |
|---|---|
| 411.81 | Acute coronary occlusion without myocardial infarction |
| 414.00-414.03 | Coronary atherosclerosis |
| 414.11 | Aneurysm of coronary vessels |
| 414.8 | Other specified forms of chronic ischemic heart disease |

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

***G0030: Positron Emission Tomography (PET) Scan (continued)***

HCPCS code G0219 Pet Imaging whole body; (full- and partial-ring pet scanners), for non-covered indications is noncovered by Medicare, effective for dates of service on/ after 07/01/2001.

### 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

N/A

### Documentation Requirements

Documentation that the required conditions (as indicated in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy) for each of the FDG PET scans performed has been met must be maintained by the referring physician in the beneficiary's medical record. PET scan facilities must keep patient record information on file for each Medicare patient for whom such a PET scan claim is made. The medical record must include standard information (e.g., age, sex, and height) along with any annotations regarding body size or type, which indicate a need for a PET scan to determine the patient's condition.

### Utilization Guidelines

N/A

### Other Comments

N/A

### Sources of Information and Basis for Decision

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 advisory groups, which includes representatives from numerous societies.

### Start Date of Comment Period

N/A

### End Date of Comment Period

N/A

### Start Date of Notice Period

02/01/2002

### Revision History

Revision Number: 6
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Start Date of Notice Period 02/01/2002
2nd Qtr 2002 *Bulletin*
Revised Effective Date: 01/01/2002
Explanation of Revision: Annual 2002 HCPCS Update and changes related to Transmittals AB-01-168 and 147 (Change Request 1886) dated November 27, 2001, which provide clarification regarding the types of allowable PET scanners.

Revision Number: 5
Start Date of Comment Period N/A
Start Date of Notice Period 11/01/2001
1st Qter 2002 *Bulletin*
Revised Effective Date: 10/01/2001Explanation of Revision: Annual ICD-9-CM Update

Revision Number: 4
Start Date of Comment Period N/A
Start Date of Notice Period 11/01/2001
1st Qtr 2002 *Bulletin*
Revised Effective Date: 07/01/2001
Explanation of Revision: Transmittal AB-01-108 (Final Update to the 2001 Medicare Physician Fee Schedule Database) changed the procedure status for HCPCS code G0219 (PET Imaging whole body; melanoma for non-covered indications) to N (noncovered), effective for dates of service on/after 07/01/2001.

Revision Number 3
Start Date of Comment Period N/A
Start Date of Notice Period 08/01/2001
4th Qtr 2001 *Bulletin*
Revised Effective Date 07/01/2001
Explanation of Revision: Transmittals 136 and AB-01-54 expanded coverage of PET scans effective July 1, 2001.

Revision Number 2
Start Date of Comment Period N/A
Start Date of Notice Period 06/07/1999
June/July 1999 *Bulletin*
Revised Effective Date 07/01/1999
Explanation of Revision: Changes required due to PROFs 672A and 686A/B

Revision Number 1
Start Date of Comment Period N/A
Start Date of Notice Period 06/07/1999
Revised Effective Date 06/07/1999

Revision Number Original
Start Date of Comment Period 05/13/1998
Start Date of Notice Period 09/18/1998
Original Effective Date 12/03/1998 ❖

# G0117: Screening Glaucoma Services

### Policy Number
G0117

### Contractor Name
First Coast Service Options, Inc.

### Contractor Number
090

### Contractor Type
Intermediary

### LMRP Title
Screening Glaucoma Services

### AMA CPT Copyright Statement


### CMS National Coverage Policy
Program Memorandum A-01-132 (Change Request 1914, dated 11/02/01)

### Primary Geographic Jurisdiction
Florida

### Secondary Geographic Jurisdiction
N/A

### CMS Region
Region IV

### CMS Consortium
Southern

### Original Policy Effective Date
01/01/2002

### Original Policy Ending Date
N/A

### Revision Effective Date
N/A

### Revision Ending Date
N/A

### LMRP Description
Glaucoma is not a single disease, but a collection of conditions that have in common the tendency to produce a characteristic type of optic nerve damage called cupping. While some glaucomas are acute and associated with symptoms at onset, most glaucoma patients have a chronic disease that slowly develops and does not produce symptoms until the optic nerve damage and visual loss are far advanced. Glaucoma is treated in order to preserve vision. Glaucoma exams on a screening basis are covered annually for eligible Medicare beneficiaries.

The glaucoma exam includes (1) a dilated eye examination with an intraocular pressure measurement; and (2) a direct ophthalmoscopy examination, or a slit lamp, biomicroscopic examination.

### Indications and Limitations of Coverage and/or Medical Necessity
Medicare will consider annual glaucoma screening for Medicare beneficiaries with diabetes mellitus, or a family history of glaucoma, or African-Americans age 50 and over.

Glaucoma screening examinations must be furnished by or under the direct supervision of an ophthalmologist or optometrist, who is legally authorized to perform the services under State law.

### CPT/HCPCS Section & Benefit Category
Procedures/Professional Services

### Type of Bill Code
Hospital – 13x
Skilled Nursing Facility – 22x, 23x
Rural Health Clinic – 71x
Comprehensive Outpatient Facility – 75x
Critical Access Hospital – 85x

### Revenue Codes
770 Preventive Care Services
Critical Access Hospital electing the optional method of payment for outpatient services report this service under revenue codes 96x, 97x, or 98x.
96x Professional Fees
97x Professional Fees
98x Professional Fees

### CPT/HCPCS Codes
G0117 Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist
G0118 Glaucoma screening for high risk patients furnished under the direct supervision of an optometrist or ophthalmologist.

### Not Otherwise Classified Codes (NOC)
N/A

### ICD-9-CM Codes that Support Medical Necessity
V80.1 Special screening for glaucoma

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

***G0117: Screening Glaucoma Services (continued)***

## Noncovered Diagnosis

N/A

## Coding Guidelines

The following revenue codes should be reported when billing for screening glaucoma services: Comprehensive outpatient rehabilitation facilities (CORFs), critical access hospitals (CAHs), standing and provider-based FQHCs bill for this service under revenue code 770. CAHs electing the optional method of payment for outpatient services report this service under revenue codes 96X, 97X,or 98X.

Hospital outpatient departments may bill for this service under any valid/appropriate revenue code. They are not required to report revenue code 770.

## Documentation Requirements

Medical record documentation must support that the patient has diabetes mellitus, a family history of glaucoma, or is an African-American age 50 and older. In addition, the documentation must support that a dilated eye exam with intraocular pressure measurement; and a direct ophthalmoscopy examination, or a slit lamp, biomicroscopic examination, was performed. This information is normally found in the office/progress notes, and test results.

## Utilization Guidelines

Screening glaucoma services are allowed annually for eligible Medicare beneficiaries.

## Other Comments

N/A

## Sources of Information and Basis for Decision

Werner, E. B. (1999). Visual field perimetry testing in glaucoma. In Yanoff (ed.), *Ophthalmology* (1st ed.). Mosby International Ltd. Retrieved December 13, 2001, from MDConsult database on the World Wide Web: **http://home.mdconsult.com/das/book/body/73553882/889/223.html**. Source used for the definition of glaucoma.

## Advisory Committee Notes

N/A

## Start Date of Comment Period

N/A

## End Date of Comment Period

N/A

## Start Date of Notice Period

02/01/2002

## Revision History

| | |
|---|---|
| Revision Number: | Original |
| Start Date of Comment Period: | N/A |
| Start Date of Notice Period: | 02/01/2002 |
| | 2nd Qtr 2002 *Bulletin* |
| Original Effective Date | 01/01/2002 ❖ |

# J2915: Ferrlecit®

### Policy Number
J2915

### Contractor Name
First Coast Service Options, Inc.

### Contractor Number
090

### Contractor Type
Intermediary

### LMRP Title
Ferrlecit®

### AMA CPT Copyright Statement


### CMS National Coverage Policy
Coverage Issues Manual, Section 45-29
Intermediary Manual, Section 3644E
Hospital Manual, Section E405
Renal Dialysis Facility Manual, Section 319.4
Change Request 1682, dated June 01, 2001

### Primary Geographic Jurisdiction
Florida

### Secondary Geographic Jurisdiction
N/A

### CMS Region
Region IV

### CMS Consortium
Southern

### Original Policy Effective Date
03/28/2002

### Original Policy Ending Date
N/A

### Revision Effective Date
N/A

### Revision Ending Date
N/A

### LMRP Description
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 transport oxygen. Without this important building block, anemic patients experiencing difficulty in restoring adequate, healthy RBCs that improve hematocrit levels. Clinical management of iron deficiency involves treating patients with iron replacement products while they undergo dialysis. 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 products which must be absorbed through the gastrointestinal (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 indicates 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. Ferrlecit® has demonstrated no life-threatening anaphylaxis and a less severe adverse-reaction rate when compared to iron dextran products.

### Indications and Limitations of Coverage and/or Medical Necessity
Effective for services performed on or after December 1, 2000, Medicare covers sodium ferric gluconate complex in sucrose injection (Ferrlecit®) when used as a first line treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental erythropoietin therapy.

According to Drug Facts and Comparisons® (2000), Ferrlecit® is administered by infusion during the dialysis session itself. The recommended dosage for repletion therapy is 10 ml (125 mg of elemental iron) diluted in 100 ml of 0.9% Sodium Chloride for Injection, administered immediately after dilution in a one-hour IV infusion. Most patients will require a minimum cumulative dose of 1.0 gram of elemental iron, administered over eight sessions at sequential dialysis treatments, to achieve favorable hemoglobin or hematocrit response. Patients may continue to require therapy with Ferrlecit® or other iron preparations at the lowest dose necessary to maintain target levels of hemoglobin, hematocrit, and laboratory parameters of iron storage within acceptable limits.

Dosages in excess of iron needs may lead to accumulation of iron in iron storage sites and hemosidrosis. Periodic monitoring of laboratory parameters of iron storage levels may assist in recognition of iron accumulation. Ferrlecit® should not be administered to patients with iron overload. The Ferrlecit® iron complex is not dialyzable.

### CPT/HCPCS Section & Benefit Category
Drugs and Biologicals

### Type of Bill Code
Hospital – 13x
End Stage Renal Disease – 72x
Critical Access Hospital – 85x

### Revenue Codes
636 Drug Requiring Detailed Coding

### CPT/HCPCS Codes
J2915 Injection, sodium ferric gluconate complex in sucrose injection, 62.5 mg

***J2915: Ferrlecit® (continued)***

## Not Otherwise Classified Codes (NOC)

J3490 Unclassified drugs (for services provided in December 2000)

## ICD-9-CM Codes that Support Medical Necessity

| | |
|---|---|
| 280.0 | Iron deficiency anemia, secondary to blood loss (chronic) |
| 280.1 | Iron deficiency anemia, secondary to inadequate dietary iron intake |
| 280.8 | Other specified iron deficiency anemias |
| 280.9 | Iron deficiency anemia, unspecified |
| *585 | Chronic renal failure |

*The billing of Ferrlecit® for renal disease requires a dual diagnosis. ICD-9-CM codes 585 and one of the secondary codes for iron deficiency anemia (ICD-9-CM codes 280.0, 280.1, 280.8, or 280.9) must be submitted to ensure reimbursement.

## 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 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 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

For services performed on and after January 1, 2001, bill for the drug utilizing HCPCS J2915.

## Documentation Requirements

Medical record documentation maintained by the performing provider must substantiate the medical necessity for the use of Ferrlecit® by clearly indicating the condition for which this drug is being used. The documentation must support the criteria as set forth in the "Indications and Limitation of Coverage and/or Medical Necessity" section of this policy. The managing physician's target values for hemoglobin, hematocrit, transferrin saturation and/or serum ferritin levels must be recorded. Laboratory results must be maintained. In addition, documentation that the service was performed must be included in the patient's medical record. This documentation is normally found in the history and physical or in the office/facility progress notes.

## Utilization Guidelines

N/A

## Other Comments

Iron deficiency in ESRD patients has been classically defined as:

*Absolute* – transferrin saturation (TSAT) less than 16 percent and/or serum ferritin less than 50ng/mL; or

*Relative* – transferrin saturation (TSAT) 16 to 20 percent and/or serum ferritin 50-100 ng/mL.

## Sources of Information and Basis for Decision

Facts and Comparisons (2000, January). Sodium ferric gluconate complex. *Drug Facts and Comparisons*, 35-36.

Food and Drug Administration (1999). New drug application (NDA) 20-955 Ferrlecit. [On-line]. Available: **http://www.fda.gov/cder/approval/main2.htm**

Health Care Financing Administration (2000, December). *Sodium ferric gluconate complex in sucrose injection* (CAG-00046). [On-line]. Available: **http://www.hcfa.gov/coverage/8b3-p2.htm**

Matzke, G.R. & Nolin, T.D. (1999). Concise review: Intravenous iron in end-stage renal disease. *In Harrison's*. [On-line]. Available: http://www.harrisonsonline.com/server-java/Arknoid/harrisons/1096-7133/U…/ed12265.htm

## Advisory Committee Notes

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

## Start Date of Comment Period

02/28/2001

## End Date of Comment Period

04/14/2001

## Start Date of Notice Period

02/01/2002

## Revision History

| | |
|---|---|
| Revision Number: | Original |
| Start Date of Comment Period: | 02/28/2001 |
| Start Date of Notice Period: | 02/01/2002 |
| | 2nd Qtr 2002 *Bulletin* |
| Original Effective Date | 03/28/2002 ❖ |

# VISCO: Viscosupplementation Therapy For Knee

*Revision Overview: Policy has been revised as a result of the annual 2002 HCPCS update. "Type of Bill Code" section of the policy has been revised.*

### Policy Number
VISCO

### Contractor Name
First Coast Service Options, Inc.

### Contractor Number
090

### Contractor Type
Intermediary

### LMRP Title
Viscosupplementation Therapy For Knee

### AMA CPT Copyright Statement


### CMS National Coverage Policy
N/A

### Primary Geographic Jurisdiction
Florida

### Secondary Geographic Jurisdiction
N/A

### CMS Region
Region IV

### CMS Consortium
Southern

### Original Policy Effective Date
06/22/1998

### Original Policy Ending Date
N/A

### Revision Effective Date
01/01/2002

### Revision Ending Date
12/31/2001

### LMRP Description
Osteoarthritis (OA) is a degenerative joint disease caused by loss of elastoviscosity in the synovial fluid. The elastoviscosity of the synovial fluid is entirely due to hyaluronan content. The large molecules made up of hyaluronan exhibit both viscous fluid characteristics when movement is slow, as well as, elastic characteristics when movement is increased.

Major traumas and repetitive joint use contribute to the development of this disease. In addition, obesity is another cause of the development of osteoarthritis. Genetic factors also may play a role in the development of osteoarthritis. Pain is the major symptom and effects mostly the knee and hip.

Because of the loss of elastoviscosity, the substance used for viscosupplementation must have a greater elastoviscosity due to dilution with the pathological fluid in the joint. Therefore, to compensate for this dilution, the viscosupplementation must provide the same or better protection for the cells and surrounding joints and tissues as the normal synovial fluid.

In the pathological joint, synovial fluid is more abundant and less viscous (i.e., the concentration of hyaluronan is decreased) Viscosupplementation attempts to return the synovial fluid to its pre-pathological state.

By dividing the effects of viscosupplementation into short term and long-term components, one may analyze its mode of action. The overall effect of viscosupplementation is the restoration of the physiological homeostasis of the joint. In a pathological joint, such as an OA joint, this means providing the means for the joint to function normally. Maintaining homeostasis allows the joint to move more freely. Reduction of pain and resulting increase in joint mobility are requisites for maintenance of the joint improvement.

However, this effect does not last indefinitely because the cause of the original problem is not resolved (i.e., the structure of the joint is still compromised). Therefore, the problem will resurface when the joint homeostasis is impaired again.

Synvisc and Hyalgan are new drugs used for viscosupplementation of the knee's synovial space for those patients with mild to moderate osteoarthritis of the knee.

### Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider Synvisc or Hyalgan medically necessary in the following situations:

- The patient must have mild to moderate osteoarthritis of the knee, and
- The patient must have an intolerance to non-steroidal anti-inflammatory drugs (NSAIDs) with a condition such as peptic ulcer disease, and
- Mild analgesics such as acetaminophen have not been effective in pain reduction, and/or
- The patient has failed other conservative treatment, and
- The patient must not have large effusions of the knee, which may be characterized as a tense, bulging knee, and/or
- The patient should not be markedly obese, and
- The joint(s) injected must be the knee(s), and
- The patient has not had a previous reaction to an earlier administration of one of these medications.

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

### Type of Bill
Hospital – 13x
Skilled Nursing Facility – 21x, 23x
Comprehensive Outpatient Rehabilitation Facility – 75x
Critical Access Hospital – 85x

### Revenue Code
360 Operating Room Services, General Classification
636 Drugs Requiring Detailed Coding

### CPT/HCPCS Codes
J7316 Sodium hyaluronate, 5mg for intra-articular injection
J7320 Hylan G-F 20, 16mg, for intra-articular injection

***VISCO: Viscosupplementation Therapy For Knee (continued)***

*20610 Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)*

## Not Otherwise Classified Codes (NOC)

N/A

## ICD-9-CM Codes that Support Medical Necessity

715.96 Osteoarthrosis, unspecified whether generalized or localized, lower leg

## 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

Use of viscosupplementation for an indication other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Also, when the patient receives more than one injection per week times 3 weeks with Synvisc and more than one injection per week times 5 weeks with Hyalgan, the additional dosage(s) may be denied. In addition, a sequence of either of these medications should be given no more than once every six months.

When the patient has severe osteoarthritis and/or has large effusions, the claim will be denied on a prepayment basis.

When there is no indication in the documentation that the patient cannot take NSAIDs and/or that NSAIDs or acetaminophen and/or other conservative treatment has not been effective in treating the patient's osteoarthritis, the claim will be denied.

## 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

For each injection given, procedure code J7316 or J7320 and 20610 (Arthrocentesis, aspiration and/or injection major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa) may be billed when viscosupplementation of the knee is performed.

## Documentation Requirements

The physician should indicate in the patient's medical documentation, the severity of the osteoarthritis. The severity of osteoarthritis; inability to take NSAIDS and for what reason; the lack of pain relief with mild analgesics such as acetaminophen and/or the failure of other conservative treatment; presence of effusions and the size of the effusions; and the height and weight of the patient should all be documented. The dosage and specific drug given (Synvisc, Hyalgan) should also be documented. In addition, if the patient receives more injections in a certain timeframe that exceeds the recommended use of these drugs, the claim may be reviewed and denied on a prepayment basis. The physician should also indicate which knee is being injected or if both knees are being injected by appropriate modifiers (i.e., LT and/or RT) on the claim form and in the documentation. This information may be found in a recent history and physical, office notes, progress notes and/or a procedure note.

## Utilization Guidelines

N/A

## Other Comments

Due to the recent FDA approval of Synvisc and Hyalgan and because the carrier has received several inquiries on this subject, medical policy was deemed necessary to define the service, its medically necessary and appropriate indications, and limitations of usage.

## Sources of Information and Basis for Decision

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

## Advisory Committee Notes

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

## Start Date of Comment Period

N/A

## End Date of Comment Period

N/A

## Start Date of Notice Period

02/01/2002

## Revision History

| | |
|---|---|
| Revision Number: | 3 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 02/01/2002<br>2nd Qtr 2002 *Bulletin* |
| Revised Effective Date: | 01/01/2002 |
| Explanation of Revision: | Annual 2002 HCPCS Update. |

| | |
|---|---|
| Revision Number: | 2 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 01/21/1999 |
| Revised Effective Date: | 01/01/1999 |
| Explanation of Revision: | Annual 1999 HCPCS Update |

| | |
|---|---|
| Revision Number: | 1 |
| Start Date of Comment Period | N/A |
| Start Date of Notice Period | 08/26/1998 |
| Revised Effective Date: | 10/10/1998 |
| Explanation of Revision: | Revenue Code changed to reflect Revenue Code 250; all references to modifiers have been deleted; all references to Prepayment Review have been deleted. ❖ |

## 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 following diagnosis codes have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy to ensure that a service initiated as a screening colonoscopy, however, during the course of the exam resulted in the diagnostic service, are covered:

| | |
|---|---|
| V16.0 | Family history of malignant neoplasm, gastrointestinal tract |
| V18.5 | Family history of certain other specific conditions, digestive disorders |
| V76.50-V76.52 | Special screening for malignant neoplasms, intestine |

This addition is effective for claims processed **on or after January 1, 2002.** ❖

## 87086: Urine Bacterial Culture—Addition to Policy

The local medical review policy for Urine Bacterial Culture – 87086 was published in the December/January 2000 *Medicare A Bulletin* (pages 22-23). Since that time, the diagnosis code 601.1 for chronic prostatitis has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy.

This addition is effective for claims processed **on or after January 28, 2002.** ❖

## 71250: Computerized Axial Tomography of the Thorax—Addition to Policy

The local medical review policy for Computerized Axial Tomography of the Thorax – 71250 was published in the 4th Quarter 2001 *Medicare A Bulletin* (pages 29-30). Since that time, the diagnosis code 518.89 for other diagnosis of lung, not elsewhere classified has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy. This addition is effective for claims processed **on or after December 5, 2001.**

Additionally, the diagnosis for bronchiectasis was changed from 494 to 494.0-494.1. This addition is effective for claims processed **on or after January 28, 2001.** ❖

## 82378: Carcinoembryonic Antigen (CEA)—Addition to Policy

The local medical review policy for Carcinoembryonic Antigen (CEA) – 82378 was published in the First Quarter 2001 *Medicare A Bulletin* (pages 23-24). Since that time, the diagnosis code range 150.0-150.9 for malignant neoplasm of esophagus has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy.

This addition is effective for claims processed **on or after January 28, 2002.** ❖

## J9999: Antineoplastic Drugs—Addition to Policy

The complete local medical review policy for Antineoplastic Drugs – J9999 was published in the First Quarter 2002 *Medicare A Bulletin* (pages 70-77). Since that time, three additional drugs, Epirubicin HCl (Ellence™), Gemtuzumab ozogamicin (Mylotarg™) and Alemtuzumab (Campath®) have been added to the policy. In addition, the following ICD-9 CM code ranges have been added to J9045, Carboplatin: 200.00-200.88, 201.00-201.98 and 202.00-202.98. This addition is effective for claims processed **on or after January 225, 2001**

### J9180/C1167 – Epirubicin HCl (Ellence™)

Epirubicin HCl is an anthracycline antineoplastic agent and is FDA approved for the adjuvant treatment of patients with axillary-node tumor involvement following resection in primary breast cancer.

Florida Medicare will consider Epirubicin HCl medically reasonable and necessary when provided for its FDA approved uses, as well as for the treatment of the following off-labeled indications:

- As a single agent and in combination therapy with other agents for the treatment of locally unresectable and metastatic gastric carcinoma.
- In combination with other agents for the treatment of esophageal and esophagogastric junction carcinomas and adenocarcinomas.
- As a single agent and in combination therapy for the treatment of non-small cell lung cancer (NSCLC) and small cell lung cancer (SCLC).
- As a single agent and in combination therapy for the treatment of stage III and stage IV ovarian carcinoma.
- In combination therapy for the treatment of Hodgkin's lymphoma.
- As a single agent and in combination therapy for the treatment of non-Hodgkin's lymphoma.
- As a single agent and in combination therapy for the treatment of soft tissue sarcoma in place of Doxorubicin.
- As a single agent and in combination therapy with other agents, for the treatment of metastatic breast carcinoma.

### J9300 – Gemtuzumab ozogamicin (Mylotarg™)

Gemtuzumab ozogamicin is a monoclonal antibody and is used as an antineoplastic. Gemtuzumab ozogamicin is FDA approved for the treatment of patients with CD33 positive acute myeloid leukemia in first relapse who are 60 years of age or older and who are not considered candidates for cytotoxic chemotherapy.

### J9999/C9110 – Alemtuzumab (Campath®)

Alemtuzumab is a monoclonal antibody, which causes the lysis of lymphocytes by binding to CD52, a highly expressed antigen that is present on the surface of all B- and T-cell lymphocytes. Alemtuzumab is FDA approved for the treatment of B-cell chronic lymphocytic leukemia (B-CLL) in patients who have been treated with alkylating agents and who have failed fludarabine therapy.

### HCPCS CODES

| | |
|---|---|
| C1167 | Epirubicin hydrochloride, 2 mg |
| C9110 | Alemtuzumab, per 10 mg/ml |

***J9999: Antineoplastic Drugs—Addition to Policy (continued)***

J9180 Epirubicin HCl (Ellence™), 50 mg
J9300 Gemtuzumab ozogamicin (Mylotarg™), 5 mg
J9999 Alemtuzumab (Campath®)

### ICD-9-CM Codes That Support Medical Necessity

**J9180/C1167 Epirubicin HCl (Ellence™)**
150.0-150.9 Malignant neoplasm of esophagus
151.0-151.9 Malignant neoplasm of stomach
162.2-162.9 Malignant neoplasm of lung (non-small/ small cell lung carcinoma)
171.0-171.9 Malignant neoplasm of connective and other soft tissue (soft tissue sarcomas)
174.0-174.9 Malignant neoplasm of female breast
175.0-175.9 Malignant neoplasm of male breast
183.0-183.9 Malignant neoplasm of ovary and other uterine adnexa
200.00-200.88 Lymphosarcoma and reticulosarcoma
201.00-201.98 Hodgkin's disease
202.00-202.98 Other malignant neoplasms of lymphoid and histiocytic tissue (non-Hodgkin's and cutaneous T cell lymphoma)

**J9300 Gemtuzumab ozogamicin (Mylotarg™)**
205.00-205.01 Acute myeloid leukemia

**J9999/C9110 Alemtuzumab (Campath®)**
204.10-204.11 Chronic lymphoid leukemia

### Documentation Requirements

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

### Effective Date

These additions will be effective for services processed **on or after March 28, 2002.** ❖

## PHPPROG: Documentation Requirements for Certification/Recertification of Psychiatric Partial Hospitalization Services—Revision to Policy

The documentation requirements for certifications/recertifications for Psychiatric Partial Hospitalization (PHP) services were previously published in the Second Quarter 2001 *Medicare A Bulletin* page 89. Since that time, a transmittal further clarifying the documentation requirements for certifications/recertifications for PHP services has been received. Therefore, the local medical review policy for Psychiatric Partial Hospitalization Programs has been revised to reflect this change.

Please ensure that the medical record documentation for certifications/recertification statements for PHP services uses the following language: "I certify that the beneficiary would require inpatient psychiatric care in the absence of partial hospitalization services, and services will be furnished under the care of a physician, and under a written plan of treatment." ❖

## Medical Record Documentation

The Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history. An appropriately documented record affords payers the ability to determine if billed services have been documented as having been performed, coded appropriately, medically necessary and represent a covered service. As coverage is often affected by whether or not a service has been either ordered, or performed, by a physician/provider, the presence of a signature or other identification in the documentation is often an issue.

General principles of medical record documentation were originally published in the Medicare B Update, Special Issue, September 1997. These principles are applicable to all types of medical and surgical services in all settings. Certain principles may be modified to account for services provided in facilities that have documentation requirements. These principles (listed below) may be applied to Part B services, and Part A services when applicable.

1. All portions of the medical record must be legible and complete. Providers may submit a translation of illegible documentation for review in addition to the original documentation. However, it must be clear that the translation is identical and does not embellish upon the original record.
2. The documentation of the patient's identity must be legible and appear on each page of the record. Examples of documentation meeting this criterion could include:
   - Printed standard patient identification
   - Hand written first and last name and date of birth
   - Patient's social security number
   - Any reasonable form of identification that would be recognized by any reader
3. The documentation of each patient encounter must include (to the extent possible):
   - The reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   - Assessment, clinical impression or diagnosis;
   - Plan of care.
4. The documentation of each patient encounter must include the date and legible identity of the observer (physician/provider).
   Examples of documentation meeting the criteria could include:
   - In a single physician/provider office:
     a. The physician's letterhead along with an initial at the time of treatment
     b. A complete signature at the time of treatment
     c. The physician's signature on the first page with an initial at the time of treatment in the rest of the chart
     d. If notes were dictated, an electronic signature would be acceptable.
   - In a multi-physician/provider office:

***Medical Record Documentation (continued)***

a. A signature page included with the medical record with each physician/provider's signature and an initial of the treating physician/provider at the time of treatment
b. A complete signature at the time of treatment
c. If notes were dictated, an electronic signature would be acceptable.

5. The medical record must support the physician/provider order for diagnostic and other ancillary services. Furthermore, if the rationale for ordering diagnostic and other ancillary services is not clearly documented, it should be easily inferred.
6. Past and present diagnoses must (to the extent possible) be accessible to the treating and/or consulting physician.
7. Appropriate health risk factors should be identified.
8. The patient's progress, response to and changes in treatment, and revision of diagnosis must (to the extent possible) be documented.
9. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement must be supported by the documentation in the medical record.
10. When services are performed by an employee of the provider as "Incident to" the physician/provider, documentation **must** clearly meet **all** "Incident to" requirements. Furthermore, upon request, documentation should be available to verify the physician/provider was present in the office suite on the date of the service.

    Examples of documentation meeting this criteria could include, but is not limited to, the following:

    - A clear signature or initial (as described above) of the person rendering care and the clear signature or initial (as described above) of the physician/provider.
    - A statement in the treatment notes by the person rendering care regarding the whereabouts of the physician/provider during the course of treatment.
    - An addendum to the treatment notes, by the physician/provider, stating their whereabouts during the treatment.

    Other office records that would verify the physician/provider was present in the office suite on the date of service (e.g., office schedule, patient schedule with provider/physician name, etc.). ❖

## 2002 HCPCS Local Medical Review Policy Changes

Florida Medicare has revised local medical review policies (LMRPs) impacted by the 2002 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and removed accordingly.

| LMRP Title | 2002 Changes | Last Publication |
|---|---|---|
| 44388 – Colonoscopy | Descriptor changes for codes 44391 and 45382 | Oct/Nov 2000, p. 18 |
| 67221 – Ocular Photodynamic Therapy (OPT) with Verteporfin | Changed G0184 to code 67225 Changed Q3013 to code J3395 | 4th Quarter 2001, p. 27 |
| 76075 – Bone Mineral Density Studies | Descriptor change for code 76078 | 1st Quarter 2002, p. 35 |
| 76090 – Diagnostic Mammography | Added code G0236<br>Descriptor changes for codes G0204 and G0206<br>Discontinued codes G0205 and G0207<br>Added GG modifier | 3rd Quarter 2001, p. 42 |
| 76092 – Screening Mammograms | Discontinued code G0203<br>Added code 76085<br>Added GG modifier | 3rd Quarter 2001, p. 44 |
| 82270 – Fecal Occult Blood Testing | Descriptor change for code 82270<br>Added code 82274 | 1st Quarter 2002, p. 47 |
| 93724 – Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator | Discontinued codes 93737 and 93738 | 2nd Quarter 2001, p. 56 |
| 95115 – Allergen Immunotherapy | Descriptor change for code 95165 | 1st Quarter 2002, p. 63 |
| 97010 – Physical Medicine and Rehabilitation | Descriptor changes for codes 97112, 97504 and 97535 | January 21, 1999, G-360 |
| DYSPHRT – Dysphagia/Swallowing Diagnosis and Therapy | Descriptor changes for codes 74230 and 76536 | 2nd Quarter 2001, p. 72 |
| J0001 – Self-Administered Drugs | Changed Q2016 to code J2941 | Oct/Nov 2000, p. 45 |
| J3240 – Thyrotropin Alfa (Thyrogen®) | HCPCS code C9108 added to policy | Jun/July 2000, p. 53 |
| J7190 – Hemophilia Clotting Factors | Changed Q0160 to code J7193<br>Changed Q0161 to code J7195 | 1st Quarter 2002, p. 68 |
| J9999 – Antineoplastic Drugs | Discontinued code C1084 effective June 30, 2001 | 1st Quarter 2002, p. 70 |
| M0302 – Cardiac Output by Electrical Bioimpedance | Changed policy number to 93701<br>Changed M0302 to code 93701 | 4th Quarter 2001, p. 82 |

Final LMRPs are available on the Florida Medicare provider Web site–**www.floridamedicare.com.** ❖

# PATIENT FRIENDLY ADVISORY

## Medicare Sets its "Sights" on Healthy Eyes

Medicare cares about keeping people with Medicare healthy, including their eyes. In this edition of the Patient Friendly Advisory, we will look at the new screening glaucoma benefit and a program that helps diabetics receive free eye exams.

Effective January 1, 2002, a new provision under the Benefits Improvement and Protection Act of 2000 adds Medicare coverage for glaucoma screenings every 12 months for persons determined to be at high risk for glaucoma, individuals with a family history of glaucoma, and individuals with diabetes.

The service has to be furnished by or under the supervision of an optometrist or ophthalmologist who is legally authorized to perform such services in the state where the services are furnished.

Glaucoma is an eye disease in which the normal fluid pressure inside the eyes slowly rises, leading to vision loss—or even blindness. According to the National Eye Institute, nearly 3 million people have glaucoma, a leading cause of blindness in the United States. Although anyone can get glaucoma, some people are at higher risk. African Americans, for example, are at a higher risk.

Glaucoma is:

- Five times more likely to occur in African Americans than in whites.
- About four times more likely to cause blindness in African Americans than in whites.
- Fifteen times more likely to cause blindness in African Americans between the ages of 45-64 than in whites of the same age group.

The National Eye Institute also emphasizes that the early detection and treatment of glaucoma, before it causes major vision loss, is the best way to control the disease.

Diabetics who have Medicare may be eligible for free eye exams. The Centers for Medicare & Medicaid Services, in collaboration with the American Academy of Ophthalmology and the American Optometric Association, have initiated a National program for people with Medicare who have diabetes to encourage them to get their eyes examined. Under the initiative, people with Medicare age 65 and older who have diabetes and haven't had a medical eye exam in the past three years, will be matched with a volunteer ophthalmologist in their area. Participants receive a free comprehensive eye exam and up to one year of follow-up care for any condition diagnosed at the initial exam. To get the name of an ophthalmologist participating in the EyeCare AmericaSM – National Eye Care Project® in a specific area, call the 24 hour toll-free number at 1-800-222-3937.

People with Medicare can also call the American Optometric Association's Diabetes Hot Line at 1-800-262-3947 (7AM – 7PM Monday through Friday CST) to be matched with an optometrist in their area who will perform an eye exam and arrange for subsequent care. Depending on financial need, the optometrist may waive the Medicare deductible and co-payment for this service.

For more information about Medicare's coverage of glaucoma screenings or diabetes benefits, call 1-800-MEDICARE (1-800-633-4227). TTY/TDD for the hearing and speech impaired is available at 1-877-486-2048. Additional information is available on the Medicare Internet Web site at **www.medicare.gov** and in the *Medicare and You 2002 Handbook.* ❖

**Please continue to look for**
**"The Patient Friendly Advisory"**
**in future issues of the Medicare A Bulletin**

**Editor Note:** *The Patient Friendly Advisory section provides assistance to Medicare Part A facility medical staff in answering patients' questions and concerns related to the Medicare program. The Medicare Beneficiary Education staff provides the information in this section.*

# BASIC SKILLS WORKSHOP FOR MEDICARE PART A PROVIDERS

***Presented by First Coast Service Options, Inc.***
***Your Florida Medicare Contractor***

## Designed for New Office Personnel!

The Medicare Education and Outreach Department has created a new workshop that provides an overview of Medicare benefits, administrative and claims processes, reimbursement methodologies, components of various Part A facilities, UB-92 claim form, and the reconsideration process. This workshop includes hands-on exercises that underscore the training and provides the basic tools needed to bill for Medicare Part A services. This educational event is a *must* for new (or relatively) new Medicare billers.

**Have your questions answered by the Medicare experts.**
**Register today for one of the sessions listed below!**

| Date | Location |
|---|---|
| **February 21, 2002**<br>**8:30 a.m. – 4:30 p.m.**<br>**Registration deadline 2/14/02** | **Embassy Suites Hotel**<br>**International Drive**<br>**Orlando, FL** |

**All sessions include a continental breakfast and afternoon snack.**

**Lunch will *not* be provided.**

## Don't Delay – Register Today – Only $249

**Centers for Medicare & Medicaid Services**
**(formerly Health Care Financing Administration)**

# SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM AND CONSOLIDATED BILLING SEMINAR

***Presented by First Coast Service Options, Inc.***
***Your Florida Medicare Contractor***

## Four Good Reasons Why You Can't Afford to Miss These Free Seminars!

- ☑ **You'll receive a comprehensive overview of Skilled Nursing Facility (SNF) Prospective Payment System (PPS), with an emphasis on the consolidated billing guidelines**
- ☑ **You'll learn which Medicare Part B services are affected by consolidated billing**
- ☑ **You'll discover how to submit SNF consolidated billing correctly to help prevent claim rejects or denials**
- ☑ **Your questions will be answered directly by a Medicare expert**

## Seminar Dates and Locations

| | |
|---|---|
| **March 12, 2002**<br>**9:00 a.m. – 12:00 noon**<br>**Registration deadline 3/05/02** | **March 13, 2002**<br>**9:00 a.m. – 12:00 noon**<br>**Registration deadline 3/06/02** |
| **Embassy Suites Tampa**<br>**3705 Spectrum Blvd.**<br>**Tampa, FL** | **Ft. Lauderdale Hilton**<br>**1870 Griffin Rd.**<br>**Ft. Lauderdale, FL** |

**All sessions include a continental breakfast.**

**Don't Delay – Register Today – Only $149**

Registration hot line (904) 791-8103
**For more information visit our Web site at** www.floridamedicare.com

Centers for Medicare & Medicaid Services
**(formerly Health Care Financing Administration)**

## MEDICARE EDUCATION & OUTREACH EVENT REGISTRATION FORM

**PLEASE complete all portions of this form.**

**DO NOT include your Medicare Provider Number on this form.**

**ONLY one form per-person, per-registration, please.**

### 1 Who are you?

**Name** _____

**Title/Position** _____

**Company/Organization** _____

**Address** _____

**City** _____ **State** _____ **Zip Code** _____

**Phone Number** (  ) _____ **Fax Number** (  ) _____

**Email Address** _____

### 2 Which event do you want to attend?

**Event Name** _____

**Event Date** _____

**Amount Enclosed** $ _____

**City** _____ **State** _____

### Payment information (if applicable)

| | |
|---|---|
| **Mail this form with your check or money order payable to:** | First Coast Service Options, Inc., Account #756240 (for Part B events), or #756241 (for Part A events)<br>P.O. Box 45157, Jacksonville, FL 32231 |

### Important!

| | |
|---|---|
| **Seating Is Limited** | Please submit your registration form and mail your payment (if applicable) as soon as possible. Seating for most events is limited. |
| **Bring Your Confirmation** | Be sure to bring your event confirmation notice with you to the event. It will be treated as proof of registration and payment (if applicable) when you sign in at the event and receive your materials. |
| **Substitutions** | If you cannot attend an event, you may send only one person to substitute in your place for the duration of the event. |
| **Refund Policy** | Refunds are available if your written request is received 7 days prior to the event. There is a $20 refund processing fee per person. |
| **Questions?** | Call our registration hotline at (904) 791-8103. |

### 3 Fax your completed form to (904) 791-6035.

# The Ultimate Medicare Expo

First Coast Service Options, Inc. is proud to present this year's most spectacular Medicare event, the Ultimate Medicare Expo (UME). This two-day symposium is structured to offer a variety of educational sessions and you can enroll in courses of your choice. The UME is open to Florida providers, People with Medicare (PWM), caregivers, pre-retirees, and billing staff. The UME will also offer an "interactive" session. This session will include PWM, caregivers, pre-retirees, providers, and billing staff working together to understand the important issue of the Advance Beneficiary Notice (ABN).

This Expo is packed with everything needed to help optimize Medicare providers' performance and offers PWM information needed to make informed healthcare decisions. All participants will have an opportunity to participate in a panel discussion featuring a panel of experts (including FCSO representatives) available to answer questions about the Medicare program.

***When:*** **May 16 & 17, 2002**

***Where:*** **Grenelefe Golf and Tennis Resort**
**3200 State Road 546**
**Haines City, Florida 33844**

***Registration:*** **Complete the registration form and the class schedules and fax to:**
**(904) 791-6035**

You can't afford to miss this Expo. Some of the many benefits to the provider are:

- ❖ You'll gain strategies for implementing processes to improve reimbursement efficiency.
- ❖ You'll discover proven ways to resolve your Medicare denials.
- ❖ Medicare experts will answer your questions.

***The Ultimate Medicare Expo is a one-of-a-kind event guaranteed to increase your Medicare Knowledge.***

# ULTIMATE MEDICARE EXPO
## CLASS SCHEDULE
## May 16, 2002
(DAY 1)

**REGISTRANT'S NAME:** _____ **PROVIDER #:** _____

**IMPORTANT CLASS SCHEDULE INSTRUCTIONS**

**REGISTRATION DEADLINE 05/02/02**

1. Submit one registration form per person
2. Select **only one class** per time slot
3. Your registration form must accompany your class schedule(s)
4. If attending both days, please complete UME Class Schedule for Day 2

**9:00 – 9:15**

**General Session (All UME attendees)**

**9:30 – 11:00**

- ☐ Anesthesia (B)
- ☐ Dermatology (B)
- ☐ HIPAA (A/B)
- ☐ Primary Care (B)
- ☐ UB-92/Direct Data Entry (A)

**11:30 – 12:30**

**Panel Discussion (All UME Attendees)**

(A) – Part A Course
(B) – Part B Course
(A/B) – Part A & B Course

**1:30 – 3:00**

- ☐ E/M Documentation (B)
- ☐ Fraud and Abuse (A/B)
- ☐ HCFA -1500 (B)
- ☐ HOPPS (A)
- ☐ Vision (B)

**3:30 – 5:00**

- ☐ Advanced Modifiers (A/B)
- ☐ Fraud and Abuse (A/B)
- ☐ Medical Review (A/B)
- ☐ Medicare Secondary Payer (A)
- ☐ Reimbursement Efficiency (B)

# ULTIMATE MEDICARE EXPO
## CLASS SCHEDULE
## May 17, 2002
(DAY 2)

**REGISTRANT'S NAME:** _____ **PROVIDER #:** _____

**IMPORTANT CLASS SCHEDULE INSTRUCTIONS**

1. Submit one registration form per person
2. Select **only one class** per time slot
3. Your registration form must accompany your class schedule(s)

**REGISTRATION DEADLINE 05/02/02**

(A) – Part A Course
(B) – Part B Course
(A/B) – Part A & B Course

**8:00 – 9:30**

- ☐ Advanced Modifiers (A/B)
- ☐ E/M Coding (B)
- ☐ IRF/PPS (A)
- ☐ Orthopedics (B)
- ☐ Provider Enrollment (A/B)

**9:45 – 11:15**

**Interactive Session (All UME Attendees)**

**Topic: Advanced Beneficiary Notices**

**11:30 – 1:00**

- ☐ HIPAA (A/B)
- ☐ Partial Hospital Program (A)
- ☐ Medicare Secondary Payer (B)
- ☐ Rehabilitation Services (A/B)
- ☐ Reimbursement Efficiency (A)

# ULTIMATE MEDICARE EXPO
# REGISTRATION FORM
# May 16 & 17, 2002

**FOUR EASY STEPS TO REGISTER**

**NOTE: ALL REGISTRATIONS MUST BE RECEIVED BY 5/02/02**

1. Fax both registration form and class schedule(s) to **(904) 791-6035**
2. Make checks payable to: **FCSO Account #756240**
3. Mail the forms (after you have faxed them) and payment to:
   **UME Seminar Registration**
   **PO Box 45157**
   **Jacksonville, Florida 32231**
4. Bring your UME Confirmation notice (or number) to the event

Registrant's Name _____

Provider's Name _____

Medicare Billing Provider # _____ Sender Number: _____

Address _____

City, State, ZIP Code _____

Phone (  ) _____ Fax (  ) _____ E-mail: _____

**Payment is being issued for:**

| Seminar/Material<br>**UME Course Materials will be provided at the event (upon arrival)* | Quantity | Price (each) | Total |
|---|---|---|---|
| ☐ **Ultimate Medicare Expo (UME)**<br>***Note: UME Course Materials are not included.*** | N/A | **$299.00** | |
| ☐ **UME Part A Handbook*** *(see course descriptions for a list of the courses included)* | | $75.00 | |
| ☐ **UME Part B Handbook*** *(see course descriptions for a list of the courses included)* | | $75.00 | |
| ☐ **UME Individual Course Material*** *(see course descriptions for a list of the courses available)*<br>**Please list course topics you are ordering:**<br>_____ | | $30.00 | |

**Method of payment:** Cash, Visa, MasterCard, American Express, Discover, and other credit cards are not acceptable forms of payment. Please send only checks or money orders.

**All payments must be received prior to the registration deadline 5/02/02.**

☐ **Check (#_____)** ☐ **Money Order**

| | |
|---|---|
| **Subtotal:** | |
| **Tax (add 7%):** | |
| **Total:** | |

**Important Registration Information:**

| Cancellations and Refunds | Substitutions | Confirmation Number | Hotel Information |
|---|---|---|---|
| All cancellation requests must be received **14 days** prior to the event.<br><br>All refunds are subject to a $35.00 cancellation fee per person. (Rain checks will not be issued for cancellations. Additionally, rain checks issued for previous seminars may not be applied towards this event) | If you are unable to attend, your company may send **one substitute** to take your place for the **entire seminar**. **Remember:** Registration must be informed of all changes.<br><br>Once you have signed in at the registration desk, substitutions will not be permitted during the remainder of the event. | A confirmation number will be faxed to you within 14 days of receiving your registration form.<br><br>If you do not receive a confirmation number (not the confirmation form generated from your fax machine, but the confirmation notice provided by Medicare Education and Training), please contact us at (904) 791-8103. | **Grenelefe Golf and Tennis Resort**<br>**3200 State Road 546**<br>**Haines City, Florida 33844**<br>**(8634) 421-5004**<br><br>**Ask for FCSO's Special Room Rate** |

*For additional information, please visit our Web site at* **www.floridamedicare.com** *or call our registration hotline at (904) 791-8103.*

# MEDICARE EDUCATION AND OUTREACH SURVEY FORM

## Ultimate Medicare Expo (UME) -- May 16-17, 2002

This educational symposium includes five workshops and seventeen classes. The presentations are designed to include advanced topics and specific issues. To ensure that we include the appropriate material in these sessions, we are seeking your input.

Please complete **one survey form for each course or workshop** you plan to attend. This survey form is designed for input specifically related to courses and workshops scheduled for UME. (A separate survey form for other upcoming educational events is provided for your use elsewhere in this publication).

**NOTE: Check one course per survey submission**

**Part A**

- ❑ **HOPPS**
- ❑ **IRF/PPS**
- ❑ **MSP (workshop)**
- ❑ **PHP**
- ❑ **Reimbursement Efficiency**
- ❑ **UB-92/DDE (workshop)**

**Part B**

- ❑ **Anesthesia**
- ❑ **Dermatology**
- ❑ **E/M Coding**
- ❑ **E/M Documentation**
- ❑ **HCFA-1500/EMC (workshop)**
- ❑ **MSP (workshop)**
- ❑ **Orthopedics**
- ❑ **Primary Care**
- ❑ **Reimbursement Efficiency**
- ❑ **Vision**

**Parts A and B**

- ❑ **Advanced Modifiers**
- ❑ **Fraud and Abuse**
- ❑ **HIPAA**
- ❑ **Medical Review**
- ❑ **Provider Enrollment (workshop)**
- ❑ **Rehabilitation Services**

Include examples and/or any supporting documentation.

Claims submission: (e.g., claim filing questions, denials)

---

Electronic Claims Submission:

---

Inquiries, Appeals and Overpayments: (e.g., questions about reviews, returning money to Medicare)

---

Medical Policy/Review: (e.g., review process, utilization denials)

---

Other: (e.g., your specialty)

---

What type of provider or facility do you represent? Part A _____ Part B _____

Field: (e.g., general practice, cardiology, podiatry): _____

Fax your completed survey (one per course or workshop) to (904) 791-6035 no later than **03/04/02** to allow sufficient time for your questions/concerns to be considered.

# Free Seminar!

## MEDICARE BUILDING BLOCKS FOR BEGINNERS PART A

***Presented by First Coast Service Options, Inc.***
***Your Florida Medicare Contractor***

## Designed for New and Experienced Office Personnel!

**The Medicare Education and Outreach department has designed a session that provides general information about Medicare guidelines. Each three-hour session consists of two topics.**

**Session I - Direct Data Entry (DDE), UB-92 claims processing**

**Session II - Direct Data Entry (DDE), UB-92 claims processing**

**These sessions are designed for providers new to the Medicare program or for those who want a refresher course.**

**Have your questions answered by the Medicare experts.**
**Register today for one of the sessions listed below!**

## Seminar date, times and location (check one)

| SESSION I | | SESSION II |
|---|---|---|
| **February 28, 2002**<br>**9:00 a.m. – 12:00 p.m.**<br>**Registration deadline 2/21/02** | **OR** | **February 28, 2002**<br>**1:00 p.m. – 4:00 p.m.**<br>**Registration deadline 2/21/02** |
| **Hilton Tampa Airport**<br>**Tampa, FL** | | |

**Registrant's Name:** _____

**Provider's Name:** _____

**Medicare Billing Provider/Group Number:** _____

**Address:** _____

**City, State, Zip Code:** _____

**Phone Number: (  )** _____ **Fax (  )** _____

**E-mail:** _____

**Fax completed form to (904) 791-6035, attention: Michelle Jackson**

**Centers for Medicare & Medicaid Services**
**(Formerly Health Care Financing Administration)**

# MEDICARE EDUCATION AND OUTREACH SURVEY FORM

To ensure that we include material addressing your issues and concerns, we are seeking your input for upcoming events Please complete **one survey form for each event** you plan to attend. (Note: A separate survey is provided for the Ultimate Medicare Expo scheduled for May 16-17, 2002.)

## CHECK ONE:

- ❑ **Building Blocks for Beginners (Part A)**
- ❑ **Building Blocks for Beginners (Part B)**
- ❑ **Basic Skills Workshop (Part A)**
- ❑ **Basic Skills Workshop (Part B)**
- ❑ **Beyond the Basics (Part B)**
- ❑ **ABN Workshop (Part B)**
- ❑ **MSP Workshop (Part A)**
- ❑ **PET Advisory Group Meeting**
- ❑ **SNF/PPS Specialty Seminar**
- ❑ **ARNP/PA Specialty Seminar**
- ❑ **Provider Enrollment Specialty Seminar**
- ❑ **Teleconference Part A (SNP/PPS)**
- ❑ **Teleconference Part B (HIPAA)**
- ❑ **Teleconference Part B (ASC)**

Describe specific topics that require further clarification. Include examples and/or any supporting documentation.

Claims submission: (e.g., claim filing questions, denials)

Electronic Claims Submission:

Inquiries, Appeals and Overpayments: (e.g., questions about reviews, returning money to Medicare)

Medical Policy/Review: (e.g., review process, utilization denials)

Other: (e.g., your specialty)

What type of provider or facility do you represent? Part A _____ Part B _____

Field: (e.g., general practice, cardiology, podiatry): _____

Fax your completed survey (one per event) to (904) 791-6035 no later than **three weeks** before the event to allow sufficient time for your questions/concerns to be considered.

# FLORIDA MEDICARE EDUCATION AND OUTREACH
# MEDICARE PART A
# Resource Manual Order Form

**INSTRUCTIONS:** Complete all portions of this form and follow the payment instructions outlined in #3 below.

| **1. TELL US ABOUT YOURSELF.** *PLEASE PRINT* | |
|---|---|
| **Name** | |
| **Title/Position** | |
| **Company/Organization** | |
| **Address** | |
| **City, State, Zip Code** | |
| **Phone Number** | ( ) - **Extension:** |
| **Fax Number** | ( ) - |
| **E-Mail Address** | |

**2. PLEASE INDICATE THE MATERIALS YOU WOULD LIKE TO PURCHASE.**

| QUANTITY | TITLE | PRICE (EA.) | TOTAL |
|---|---|---|---|
| | **Medicare Part A Resource Manual**<br>**Includes our most popular subjects**: Direct Data Entry (DDE); Fraud and Abuse; HIPAA; How to Help Patients Understand Medicare; Introduction to Cost Report Auditing; Introduction to Cost Reports; Medical Review; Medicare Part C; Medicare Secondary Payer; PC-ACE™ for UB-92; Provider Enrollment; Provider-Based Regulations; Reconsiderations, Reviews, and Inquiries; Reimbursement Efficiency; and UB-92 Claims Filing | $80.00 | $ |
| | | **Sub-Total** | $ |
| | | **Add 7% Tax** | $ |
| | | **Total** | $ |

**3. PLEASE SUBMIT YOUR PAYMENT**

| | |
|---|---|
| ☛ **SEND YOUR PAYMENT** | Submit the completed form with your check or money order:<br>▪ *Payable to* **First Coast Service Options, Inc. #756241**<br>▪ *Mail to* **Medicare Education and Outreach, Attn: Phyllis Brooks, 17 Tower, P.O. Box 2078, Jacksonville, FL 32231**<br>Your order will be shipped within four to six weeks. |

# FLORIDA MEDICARE EDUCATION AND OUTREACH
# MEDICARE PART A
# INDIVIDUAL MODULE ORDER FORM

**INSTRUCTIONS:** Complete all portions of this form and follow the payment instructions outlined in #3 below.

| **1. TELL US ABOUT YOURSELF.** *PLEASE PRINT* | |
|---|---|
| **Name** | |
| **Title/Position** | |
| **Company/Organization** | |
| **Address** | |
| **City, State, Zip Code** | |
| **Phone Number** | ( ) - **Extension:** |
| **Fax Number** | ( ) - |
| **E-Mail Address** | |

**2. PLEASE INDICATE WHICH INDIVIDUAL MODULES YOU WANT BY CLEARLY PRINTING THEIR NAMES IN THE LINES PROVIDED BELOW THE LIST. EACH MODULE COSTS $35.00.** ***(Modules followed by * are included in a resource manual)***

| | | |
|---|---|---|
| **Advanced Beneficiary Notice*** | **How to Help Patients Understand Medicare*** | **PC-ACE™ for UB-92*** |
| **Ambulance Regulations** | **ICD-9-CM Coding*** | **Provider Enrollment*** |
| **CPT Coding*** | **Introduction to Cost Report Auditing*** | **Provider-Based Regulations*** |
| **Direct Data Entry (DDE)*** | **Introduction to Cost Reports*** | **Reconsiderations, Reviews, & Inquiries*** |
| **Electronic Media Claims (EMC)*** | **Medical Review*** | **Rehabilitation Services** |
| **End Stage Renal Disease (ESRD)** | **Medicare Part C*** | **Reimbursement Efficiency: Part A*** |
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***Your opinion matters, so we want to hear from you!***

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Please cut out this page and mail it to the address below.

Medicare Communication & Education
Reader Survey
P.O. Box 2078 -18T
Jacksonville, FL 32231-0048

Or you may **fax** your survey to (904) 791-6292.

***Thank you for taking the time to complete this survey!***

# A



# B



# C



## *C (continued)*



# D



# E

### *Diagnostic Tests, 70010-89399 (continued)*



## *Medicine, 90281-99199*



### *Medicine, 90281-99199 (continued)*



## *HCPCS Codes*

### *HCPCS Codes (continued)*



### *HCPCS Codes (continued)*



## Special *Bulletins*



* This special issue is available only on the provider Web site *www.floridamedicare.com*

## 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***
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