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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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

Communication in the Information Age

In his thought provoking 1998 book, *New Rules for the New Economy – 10 Radical Strategies for a Connected World*, Kevin Kelly highlights "plentitude, not scarcity – as manufacturing techniques refine the art of making copies plentiful, value is carried by abundance, rather than scarcity, inverting traditional business propositions." This idea and others in the book emphasize information and relationships and point to communication and networks as the basis for the new economy.

Currently, the average Medicare provider may not find comfort in this type of environment. A provider is one node in a complex network of beneficiaries, other providers, and other stakeholders each with differing priorities. The General Accounting Office (GAO) in its report to Congress in February of this year entitled *Medicare: Communications with Physicians Can be Improved* stated that information given to physicians by contractors is often difficult to use, out of date, inaccurate, and incomplete. Though one could find flaws in the GAO report, the need for improvements in communication and network in the complex Medicare program cannot be overstated.

The Medicare program is operated by the Centers for Medicare & Medicaid Services (CMS) with the assistance of some 50 contractors that annually process approximately 900 million claims submitted by approximately one million providers. The regulations and policies that implement statutory provisions of the Medicare program are a continuous process. Information on the program is available on Web sites (contractors and CMS), on paper (bulletins and manuals), and by phone (customer service centers). In-person training by contractors is also available for some providers. Though limited by funding, CMS has initiated strategies to improve communication with providers. Initial responses have included a Web based FAQs (frequently asked questions) site, updated online reference and training guides, and open door forums directed toward specific provider types. Efforts are also underway to improve customer service responses and streamline the information overload that burdens CMS and its contractors and ultimately the providers.

First Coast Service Options, Inc. encourages providers to use our provider Web site *www.floridamedicare.com* with its links to the CMS site and the fiscal intermediary toll-free customer service number – (877) 602-8816 for information especially on coding and/or billing problems. If the problem or question addresses policy, contact the Office of the Medical Director for more options. Some questions may involve research at the contractor, and other questions may require queries to a more extensive network including a professional association or CMS regional/central office. Though it may take some time before the efficiencies of a streamlined Medicare program can be implemented, the opportunities for improvement in networks and communication exist now.

Sincerely,

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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

Payment for Air Ambulance Transportation of Deceased Beneficiary

The Centers for Medicare & Medicaid Services has established policy payment and claim processing instructions for an air ambulance service where the beneficiary is pronounced dead before the pickup. The policy is contingent on the medical necessity of the air ambulance transport.

Policy Background

The final regulation to establish an ambulance fee schedule contains a provision authorizing partial payment for an air ambulance service when an air ambulance takes off to pick up a beneficiary, but the beneficiary is pronounced dead before the pickup can be made.

Medicare has a longstanding policy to allow partial payment for an ambulance service where the ambulance begins its trip to pick up the beneficiary, but the beneficiary is pronounced dead before the pickup can be made. This policy did not explicitly state the air ambulance service was included in this policy. Implementation of an ambulance fee schedule requires clarification regarding how this policy will be implemented under the fee schedule.

Policy Guidelines

Medicare allows payment for an air ambulance service when it takes off to pick up a Medicare beneficiary, but the beneficiary is pronounced dead before being loaded onto the ambulance for transport (either before or after the ambulance arrives on the scene). This is provided the air ambulance service would otherwise have been medically necessary. In such a circumstance, the allowed amount is the appropriate air base rate, i.e., fixed wing or rotary wing. However, no amount shall be allowed for mileage or for a rural adjustment that would have been allowed had the transport of a living beneficiary or of a beneficiary not yet pronounced dead been completed.

For the purpose of this policy, a pronouncement of death is effective only when made by an individual authorized under state law to make such pronouncements.

This policy also states no amount shall be allowed if the dispatcher received pronouncement of death and had a reasonable opportunity to notify the pilot to abort the flight. Further, no amount shall be allowed if the aircraft has merely taxied but not taken off or, at a controlled airport, has been cleared to take off but not actually taken off.

Billing Requirements

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

Providers must submit documentation with the claim sufficient to show that:

a) The air ambulance was dispatched to pick up a Medicare beneficiary

b) The aircraft actually took off to make the pickup

c) The beneficiary to whom the dispatch relates was pronounced dead before being loaded onto the ambulance for transport

d) The pronouncement of death was made by an individual authorized by State law to make such pronouncements

e) The dispatcher did not receive notice of such pronouncement in sufficient time to permit the flight to be aborted before take off.

The payment amount will be based on the appropriate air base rate (fixed wing or rotary wing, as applicable) for an air ambulance service that meets the requirements of this instruction. An allowance for mileage or a rural adjustment will not be made. During the fee schedule transition, allowance amount will be based on a blended rate.

Applicable Types of Bills

The appropriate types of bills are:

12x, 13x, 22x, 23x, 32x,
33x, 34x, 83x 85x.

Coding Requirements

For claims with dates of service **on or after July 1, 2002,** when a beneficiary is pronounced dead after an ambulance (ground or air) is called but before the ambulance arrives, providers must use current ambulance billing instructions and report modifier **QL** (Patient pronounced dead after ambulance called) in form locator (FL) 44, "HCPCS/Rates" instead of the origin and destination modifier. In addition to the QL modifier, providers must continue to report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:

QM: Ambulance service provided under arrangement by a provider of services; or

QN: Ambulance service furnished directly by a provider of services.

This policy is effective for services furnished on of after July 1, 2002. ❖

Medicare Part A Appeal Documentation

Section 1866 of the Social Security Act and the Code of Federal Regulations (42 CFR 489.21(1)(2) and 489.53/9a) provide severe penalties for the provider's failure to furnish requested information. Providers are reminded of their responsibility, and the ramifications when the letters requesting submission of records are not responded timely. Therefore, effective May 1, 2002, providers will be held liable for services where they fail to provide the requested information within the appointed timeframes for all beneficiary initiated appeals. Second requests for medical records will not be made. ❖

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 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.

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 on Reason Code 30715

- Photocopy the beneficiary's red, white, and blue Medicare card.
- Verify through the direct data entry (DDE) system the 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 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 on Reason Code C7010

- 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 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 (877) 602-8816.

Tips to Avoid RTPs on Reason Code 32000

- 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 a dash in your provider number (i.e., do not key 10-xxxx, key 10xxxx).
- Verify your provider number before you send the claim to the fiscal intermediary.

Please review your office procedures to ensure that sufficient process controls exist to avoid these problems. Failure to prevent RTPs adds to your claim submission cost, delays claim payment, and generally adds unnecessary costs to the Medicare program. ❖

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 February 1, 2002, the interest rate applied to Medicare overpayments is **12.625 percent**, based on the revised PCR. The following table lists previous interest rates.

Period	Interest Rate
October 31, 2001 – January 31, 2002	13.25%
August 7, 2001 – October 30, 2001	13.25%
April 26, 2001 – August 6, 2001	13.75%
February 7, 2001 – April 25, 2001	14.125%
October 24, 2000 – February 6, 2001	13.875%
August 1, 2000 – October 23, 2000	13.875%
May 3, 2000 – July 31, 2000	13.75%
February 2, 2000 – May 2, 2000	13.50% ❖

Source: Transmittal AB-02-011; CR 1897

Electronic Medicare Provider Enrollment Forms

The electronic version of the Medicare Provider/Supplier Enrollment forms is now available through the Centers for Medicare & Medicaid (CMS) Web site at *www.hcfa.gov/medicare/enrollment/forms*. These include CMS 855A, CMS 855B, CMS 855I, CMS 855R, CMS 855S. A comprehensive user guide, providing detailed instructions on how to download these applications, is also available on the Web Site. Providers can complete the form on their computer, save it as a file, and print the completed form for final signature and submission.

At this time, providers cannot submit these forms electronically. Electronic forms may be mailed and will be handled routinely by the Medicare contractors.

For additional questions, providers may contact customer service at (877) 602-8816. ❖

Source: CMS Transmittal AB-02-029, CR 20456306

Coordination of Benefits Trading Partners

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

Trading Partner ID	Company Name	Transmission Frequency
A00031999	AFLAC	Weekly
A46254001	Anthem Insurance, Inc.	Weekly
A20904003	American Postal Workers Union	Weekly
B17177361	Capital Blue Cross	Daily
B20065001	CareFirst BCBS	Weekly
X32301999	Consultec Medicaid	Weekly
E10017303	Empire Blue Cross and Blue Shield	Daily
H68144001	Health Data Management Corp.	Weekly
	Aid Association for Lutherans	
	American Republic	
	North American	
	Celtic Life Insurance	
	Oxford Life Insurance	
	Savers Life Insurance	
	USAble Life Insurance	
	State Farm	
	Highmark Services	
	Continental General	
	Physicians Mutual	
	BCBS of Texas	
	Central Benefits	
	Mutual Protective (Medico Life)	
	Pacific Care Health Plan Administrators	
	Pyramids Life	
	Unified Life	
B60654030	Bankers Life & Casualty	Weekly
B35244001	BCBS of Alabama	Daily
DELW19899	BCBS of Delaware	Daily
BCNH03111	BCBS of New Hampshire	Weekly
M02110001	BCBS of Massachusetts	Daily
B32202001	BCBS of Florida	Daily
BSBSI4121	BCBS of Illinois	Daily
MN5512100	BCBS of Minnesota	Weekly
O98225001	Olympic Health Management	Weekly
P61101056	Pioneer Life Insurance Company	Weekly
UTAI78755	United Teachers Association	Weekly
	Humana, Inc.	
WELL50309	Wellmark, Inc.	Daily
UAIC75070	United American Insurance	Weekly
CONT37027	Continental Life Insurance	Weekly
WISC53713	Wisconsin Medicaid	Weekly
GAMD30021	Georgia Medicaid	Daily
MOIC68175	Mutual of Omaha	Weekly
TFL888888	Tricare, Inc.	Daily
GHI010001	Group Health Insurance	Weekly

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

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

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

GENERAL COVERAGE

Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes

Peripheral neuropathy is the most common factor leading to amputation in people with diabetes. In diabetes, peripheral neuropathy is an anatomically diffuse process primarily affecting sensory and autonomic fibers; however, distal motor findings may be present in advanced cases. Long nerves are affected first, with symptoms typically beginning insidiously in the toes and then advancing proximally. This leads to loss of protective sensation (LOPS), whereby a person is unable to feel minor trauma from mechanical, thermal, or chemical sources. When foot lesions are present, the reduction in autonomic nerve functions may also inhibit wound healing.

Peripheral neuropathy with LOPS, secondary to diabetes, is a localized illness of the feet and falls within the regulation's exception to the general exclusionary rule (see 42 C.F.R. section 411.15(l)(l)(i)). Foot exams for people with diabetic peripheral neuropathy with LOPS are reasonable and necessary to allow for early intervention in serious complications that typically afflict diabetics with the disease.

Effective for services furnished on or after July 1, 2002, Medicare covers, as a physician service, an evaluation (examination and treatment) of the feet no more often than every six months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS, as long as the beneficiary has not seen a foot care specialist for some other reason in the interim.

LOPS shall be diagnosed through sensory testing with the 5.07 monofilament using established guidelines, such as those developed by the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. Five sites should be tested on the plantar surface of each foot according to the Institute's guidelines. The areas must be tested randomly since the loss of protective sensation may be patchy in distribution, and the patient may get clues if the test is done rhythmically. Heavily callused areas should be avoided. As suggested by the American Podiatric Medicine Association, an absence of sensation at two or more sites out of five tested on either foot (when tested with the 5.07 Semmes-Weinstein monofilament) must be present and documented to diagnose peripheral neuropathy with loss of protective sensation.

HCPCS Codes

G0245 Initial physician evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) that must include:

1. Diagnosis of LOPS
2. Patient history
3. Physical examination that consists of at least the following elements:
   (a) visual inspection of the forefoot, hindfoot, and toe web spaces,
   (b) evaluation of a protective sensation,
   (c) evaluation of foot structure and biomechanics,
   (d) evaluation of vascular status and skin integrity, and
   (e) evaluation and recommendation of footwear
4. Patient education

G0246 Follow-up evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following:

1. Patient history
2. Physical examination that includes:
   (a) visual inspection of the forefoot, hindfoot, and toe web spaces,
   (b) evaluation of protective sensation,
   (c) evaluation of foot structure and biomechanics,
   (d) evaluation of vascular status and skin integrity, and
   (e) evaluation and recommendation of footwear
3. Patient education

G0247 Routine foot care of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include if present, at least the following:

1. Local care of superficial wounds
2. Debridement of corns and calluses
3. Trimming and debridement of nails.

Note: Code G0247 must be billed on the same date of service with either G0245 or G0246 in order to be considered for payment.

ICD-9-CM Diagnosis Codes

One of the following ICD-9-CM diagnosis codes must be reported in conjunction with this benefit:

250.60, 250.61, 250.62, 250.63, or 357.2

Payment Methodology

Payment is as follows:

- Hospital outpatient departments – Reimbursement made under the outpatient prospective payment system
- Critical access hospitals – Reimbursement made under reasonable cost for method I. For method II, reasonable cost for technical component, 115 percent of the fee schedule for professional component.
- Comprehensive outpatient rehabilitation facilities – Reimbursement made under Medicare physician fee schedule (MPFS).
- Skilled nursing facilities – Reimbursement made under MPFS.
- Rural health clinics/federally qualified health centers (RHCs/FQHCs) – Reimbursement made under all-inclusive rate.

Deductible and coinsurance apply.

Diagnosis and Treatment of Peripheral Neuropathy with LOPS ... (continued)

Applicable Bill Types

The applicable bill types are:

13x, 23x, 71x, 73x, 74x, 75x, 85x.

This service, when furnished in an RHC/FQHC by a physician or non-physician, is considered an RHC/FQHC service. RHCs/FQHCs bill under type of bill 71x or 73x with revenue code 940 and HCPCS codes G0245, G0246, and G0247.

Payment will not be made for this service unless the claim contains a related visit code (revenue code 520 or 521).

Applicable Revenue Codes

The applicable revenue code is 940, except for hospitals.

This service can be performed in other revenue centers such as a clinic (510) for hospitals.

Therefore, these services must be reported under the revenue center where they are performed. ❖

Source: CMS Transmittal AB-02-042 CR 2060

Administrative Policies for Clinical Diagnostic Laboratory Services

Section 4554(b)(1) of the Balanced Budget Act (BBA) of 1997, Public Law 105-33 mandated the use of a negotiated rulemaking committee to develop national coverage and administrative policies for clinical diagnostic laboratory services payable under Part B of Medicare. The BBA requires these national policies be designed to promote program integrity and national uniformity, and simplify administrative requirements.

The Committee for the Negotiated Rulemaking for Laboratory Services recommended several administrative procedures. These administrative policies apply to every diagnostic clinical laboratory service payable under Medicare Part B regardless of the place where the service was performed or the type of contractor that processes the claim. A service provided in a hospital laboratory, independent laboratory, physician/practitioner office laboratory, or other type of CLIA approved laboratory service is subject to these administrative policies.

The treating physician must be the physician who orders any clinical diagnostic laboratory service.

Reporting ICD-9-CM Diagnosis Codes

Provider must report diagnosis codes based on the established guidelines for reporting ICD-9-CM diagnosis codes for diagnostic laboratory services as required by the implementation of the Health Insurance Portability and Accountability Act (HIPAA). See "ICD-9-CM Coding for Diagnostic Tests" published in the First Quarter 2002 Medicare A Bulletin (pages 5-8) and "Diagnosis Coding for the UB-92 Form" published on the Second Quarter 2002 *Medicare A Bulletin* (page 12).

Diagnosis and Procedure Codes Matching

Providers billing for clinical diagnostic laboratory services must submit all services on the same day on a single claim unless the furnished services are billed using condition "20" or "21."

Multiple Services

Two CPT modifiers identify multiple services for the same beneficiary on the same day. Their specific use is:

- Modifier 59 indicates distinct procedural services. Modifier 59 is appropriate to report multiple service submissions by a clinical laboratory for the same beneficiary on the same day. These situations usually involve microbiology where samples or cultures are taken from a patient from different anatomical sites or different wounds, use the same *CPT* code, and then tested the same day.
- Modifier 91 indicates repeat clinical diagnostic laboratory services.
  If an ordering physician requests a laboratory test that requires several of the same services (same *CPT* code) to be performed for the same beneficiary on the same day, the laboratory must use modifier 91 to report that multiple clinical diagnostic laboratory tests were performed.

Example: An arterial blood sample is drawn from the patient at three different intervals on the same day, and the blood testing is performed there times the same day, the ***CPT code 82803 – Gas, blood, any combination of pH, pCO_2, pO_2, CO_2, HCO_2, (including calculated O_2 saturation.*** The laboratory must report the services as "82803 91"on the line item of claim Form UB-92 HCFA-1450 or its electronic equivalent.

These modifiers are not interchangeable. Modifier 91 is expected to be the most frequently used. Using either modifier does not relieve the laboratory of the responsibility to supply medical necessity documentation if requested by the contractor.

Ordering Practitioner

The administrative policies that relate to the individual who orders the service apply to a physician or a non-physician practitioner qualified to order diagnostic services [42CFR410.32(a)(3)].

Ordering practitioners include nonphysician practitioners such as clinical nurse specialists, clinical psychologists, clinical social workers, nurse midwives, nurse practitioners, and physician assistants who furnish services that would be physician services if furnished by a physician, who work within the scope of their authority under state law and within the scope of the Medicare statutory benefit.

Documentation Requirements

The ordering physician must maintain documentation of medical necessity in the beneficiary's medical record.

The laboratory must maintain documentation it receives from the ordering physician, and must ensure the information listed on the claim accurately reflects such documentation.

The laboratory may request additional diagnostic and other medical information from the physician to document the medical necessity and reasonableness of its services. If the laboratory requests additional documentation, it must

Administrative Policies for Clinical Diagnostic Laboratory Services (continued)

request material relevant to the medical necessity of the specific service(s), taking into consideration current rules and regulations on patient confidentiality.

If a claim selected for review by Medicare contains additional documentation attached or simultaneously submitted with the claim, Medicare must review the documentation before denying the claim. **Exception:** Medicare may deny without reviewing attached or simultaneously submitted documentation when clear policy serves as the basis for denial.

Note: The term "clear policy," means a statute, NCD, coverage provision in an interpretive manual, or local medical review policy that specifies the circumstances under which a service will always be considered noncovered or incorrectly coded.

Signature on Requisition Form

Medicare does not require the signature of the ordering physician on a laboratory service requisition. While the signature of a physician on a requisition is one way of documenting that the treating physician ordered the service, it is not the only permissible way of documenting that the service has been ordered. For example, the physician may document the ordering of specific services in the patient's medical record. ❖

Source: CMS Transmittal AB-02-030, CR 1998

New CLIA Waived Tests

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under the Clinical Laboratory Improvement Amendments (CLIA). The *Current Procedural Terminology (CPT)* codes for these new tests must be submitted with modifier QW to be recognized as a waived test.

- International Technidyne ProTime Microcoagulation System (ProTime 3 Cuvette) Prescription Home Use, effective: July 23, 2001, *CPT* code: 85610QW
- International Technidyne ProTime Microcoagulation System (ProTime 3 Cuvette) Professional Use, effective: July 23, 2001, *CPT* code: 85610QW
- Ostex International Osteomark NTX Point of Care Prescription Home Use, effective: July 30, 2001, *CPT* code: 82523QW
- Embryotech Laboratories FertilMARQ™ Home Diagnostic Screening Test for Male
- Infertility, effective; August 15, 2001, *CPT* code: 89300QW
- Metrika A1c Now™ – Professional Use, effective: August 17, 2001, CPT code: 83036QW
- Diagnostic Chemicals ImmunoDip™ Urinary Albumin Screen (Urine Dipstick), effective: August 29, 2001, *CPT* code: 82044QW
- FemTek pHEM-ALERT®, effective: October 9, 2001, *CPT* code: 83986QW
- Provalis Diagnostics Glycosal™ HbA1c Test, Effective: November 9, 2001, *CPT* code: 83036QW
- Quidel QuickVue+ Infectious Mononucleosis (Whole Blood), Effective: December 18, 2001, *CPT* code: 86308QW
- Acon® Strep A Rapid Strip Test, effective: December 18, 2001, *CPT* code: 87880QW
- Beckman Coulter Primary Care Diagnostics ICON DS Strep A, effective: December 18, 2001, *CPT* code: 87880QW.

New waived CPT codes have been assigned for the following tests:

- 82523QW for the Ostex International Osteomark NTX Point of Care Prescription Home Use test
- 89300QW for the Embryotech Laboratories FertilMARQ™ Home Diagnostic screening Test for Male Infertility.

The additional CPT code 83986QW has been added for the Beckman Coulter Primary Care Diagnostics Gastroccult® test since it detects gastric occult blood and determines the pH of gastric aspirates. This test was previously approved for waived status under CLIA and its effective date is August 30, 2001.

New CLIA Waived Test continued next page

Newly Added Test Granted Waived Status under CLIA

TEST NAME	MANUFACTURER	CPT CODE	USE
International Technidyne ProTime Microcoagulation System (ProTime 3 Cuvette) Prescription Home Use	International Technidyne Corporation	85610QW	Aid in screening for congenital deficiencies of Factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumarin or warfarin effect; screen for Vitamin K deficiency
International Technidyne ProTime Microcoagulation System (ProTime 3 Cuvette) Professional Use	International Technidyne Corporation	85610QW	Aid in screening for congenital deficiencies of Factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumarin or warfarin effect; screen for Vitamin K deficiency
Ostex International Osteomark NTX Point of Care Prescription Home Use	Ostex International Inc.	82523QW	Measures normalized cross-linked N-telopeptides of type 1 collagen in urine
Embryotech Laboratories FertilMARQ™ Home Diagnostic Screening Test for Male Infertility	Embryotech Laboratories, Inc.	89300QW	Screening test to measure sperm concentration.
Metrika A1c Now™ - Professional Use	Metrika, Inc.	83036QW	Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes
Diagnostic Chemicals ImmunoDip™ Urinary Albumin Screen (Urine Dipstick)	Diagnostic Chemicals Limited (USA)	82044QW	Semi-quantitative measurement of microablumin in urine for the detection of patients at risk for developing kidney damage
FemTek pHEM-ALERT®	FemTek, LLC	83986QW	Vaginal pH detection (acid-base balance)
Provalis Diagnostics Glycosal™ HbA1c Test	Provalis Diagnostics Ltd.	83036QW	Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes
Quidel QuickVue+ Infectious Mononucleosis (Whole Blood)	Quidel Corporation	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis
Acon® Strep A Rapid Strip Test	Acon Laboratories, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection, which typically causes strep throat, tonsillitis, and scarlet fever
Beckman Coulter Primary Care Diagnostics ICON DS Strep A	Acon Laboratories, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection, which typically causes strep throat, tonsillitis, and scarlet fever

Information on CLIA services may be found on:
Hospital Manual section 437.2
Skilled Nursing Facility Manual section 541.2
Rural Health Clinic Manual section 640
End Stage Renal Disease Manual section 322. ❖

Source: CMS Transmittal AB-02-024, CR 2033

Non-contact Normothermic Wound Therapy (NNWT)

Non-contact normothermic wound therapy (NNWT) is a device reported to promote wound healing by warming a wound to a predetermined temperature. The device consists of a noncontact wound cover where a flexible, battery powered, infrared heating card is inserted. Based on a recent national coverage decision (section 60-25 of the Coverage Issues Manual), there is insufficient scientific or clinical evidence to consider this device as reasonable and necessary for the treatment of wounds within the meaning of section 1862(a)(1)(A) of the Social Security Act. Therefore, Medicare does **not** cover this device.

Billing Guidelines

New codes were issued for NNWT effective January 1, 2002. The codes are:

E0231	Non-contact wound warming device (temperature control unit, AC adapter, and power cord) for use with warming card and wound cover.
E0232	Warming card for use with the non-contact wound warming device and non-contact wound warming wound cover.
A6000	Non-contact wound warming cover for use with the non-contact wound warming device and warming card.

Claims for NNWT for dates of service **on or after July 1, 2002** will be denied as not medically necessary. Claims for dates of service **prior to July 1, 2002,** will be handled under individual consideration. ❖

Source: CMS Transmittal AB-02-025, CR 2027

Clarification to the Billing of Sacral Nerve Stimulation

An article addressing the coverage and billing for sacral nerve stimulation was published in the First Quarter 2002 *Medicare A Bulletin* (pages 12-13). Since that publication, the Centers for Medicare & Medicaid Services has provided clarification to several billing issues.

- HCPCS code C1767, C1778, C1883 and C1897 are only applicable when billing under the hospital outpatient prospective payment system. These codes must be reported in place of HCPCS codes A4290, E0752 and E0756.
- The applicable revenue codes for device codes C1767, C1778, C1883 and C1897, provided in a hospital outpatient department are 272, 274, 275, 276, 278, 279, 280, 289, 290 or 624 as appropriate. The applicable revenue code for device codes A4290, E0752 and E0756 provided in a critical access hospital is 290.
- Only hospital outpatient departments report HCPCS codes C1767, C1778, C1883 and C1897. Payment for these services is made under the outpatient prospective payment system.
- Type of bill 22x and 23x are not appropriate for billing of the sacral nerve stimulation benefit. ❖

Source: CMS transmittal AB-01-166, CR 1936
CMS transmittal A-02-020, CR 2098

INPATIENT HOSPITAL SERVICES

Conversion of Hospital Swing Bed Facilities to the Skilled Nursing Facility Prospective Payment System (SNF PPS)

The Balanced Budget Act (BBA) of 1997 section 4432(a) specifies swing bed facilities must be incorporated into the SNF PPS by the end of the statutory transition period. **Effective with cost reporting periods beginning on or after July 1, 2002,** swing bed bills will no longer be paid based on the current cost-related method, but rather on the basis of the SNF PPS. These payment rates will cover all costs of furnishing covered swing bed extended care services (routine, ancillary, and capital-related costs), other than costs associated with operating approved educational activities as defined in 42 CFR 413.85.

The SNF PPS initiative will be phased-in based on each swing bed hospital's fiscal year. This transition period starts on the first day of the provider's next cost report year that begins **on or after July 1, 2002.** Consequently billing for all beneficiaries in a swing bed must be split at the end of the provider's current fiscal year. A new bill must be created for beneficiaries remaining in the facility at the start of the new fiscal year. The bill must be prepared under the SNF PPS claim guidelines described in this notification.

The SNF PPS initiative applies to short-term hospitals, long-term hospitals, and rehabilitation hospitals certified as swing bed hospitals. **Critical access hospitals (CAHs) with swing beds are exempt from the SNF PPS, and are not affected by these instructions.**

Medicare SNF Coverage Guidelines Under PPS

Posthospital extended care services furnished in a swing bed hospital are covered under Part A of Medicare. Beneficiaries with hospital insurance coverage are entitled to have payment made on their behalf for covered extended care services furnished by the provider, by others under arrangement with the provider, or by a hospital with which the provider has a transfer agreement.

Under SNF PPS, beneficiaries must continue to meet the established eligibility requirements for an SNF-level stay (i.e., the beneficiary must have received acute care as a hospital inpatient for a medically necessary stay of at least three consecutive calendar days). In addition, the beneficiary must have started receiving extended care services in the swing bed hospital within 30 days after discharge as an acute care patient from the swing bed facility or other hospital, unless the exception in section 3131.3b of the *Medicare Intermediary Manual* (MIM) applies. To be covered, the extended care services must be needed for a condition that was treated during the beneficiary's qualifying hospital stay, or for a condition that arose while receiving extended care services for a condition for which the beneficiary was previously treated during the acute care stay.

Under the SNF PPS, coverage determinations (i.e., level of care determination) have been significantly simplified by adopting the system for classifying residents based on resource utilization known as resource utilization groups, version 3 (RUG-III).

- Swing bed providers will assess the clinical condition of beneficiaries by preparing a minimum data set (MDS) for swing bed hospitals for each Medicare beneficiary receiving SNF level care.
- The MDS must be completed in compliance with the Medicare PPS schedule shown in the chart below.
- Each MDS record must then be encoded and electronically transmitted.
- Swing bed providers must complete the MDS assessment within 14 days of the assessment reference date. An MDS is considered complete on the day that the registered nurse coordinating the assessment signs and dates the assessment.
- The MDS records must be transmitted electronically to the Centers for Medicare & Medicaid Services (CMS), and will be considered timely if transmitted and accepted into the database within 14 days of completion. Medicare uses information from the MDS to classify residents into the RUG-III for purposes of Medicare reimbursement.

Medicare Assessment Schedule For Swing Bed Facilities

Medicare MDS Assessment Type	Reason for Assessment (MDS Item 11b code)	Assessment Reference Date* (based on start of Part A stay)	Assessment Reference Date Grace Days	Number of Days Authorized for Coverage and Payment	Applicable Medicare Payment Days
5-day	1	1 – 5**	6 – 8**	14	1 – 14
14-day	7	11 – 14	15 – 19	16	15 – 30
30-day	2	21 – 29	30 – 34	30	31 – 60
60-day	3	50 – 59	60 – 64	30	61 – 90
90-day	4	80 – 89	90 – 92	10	91 – 100

*The assessment reference date is the last date of the observation period for the clinical assessment.

Time requirements are calculated using the first day of the Medicare Part A-covered stay as "day 1."

** If a beneficiary expires or transfers to another facility before day 8, the facility will still need to prepare an MDS as completely as possible for the RUG-III classification and Medicare payment purposes. Otherwise the days will be paid at the default rate. The assessment reference date may also need to be adjusted to no later than the date of discharge.

Conversion of Hospital Swing Bed Facilities to the SNF PPS (continued)

SNF PPS is linked to the beneficiary acuity level as identified by classification into one of the 44 RUG-III. Medicare beneficiaries typically group into one of the upper 26 RUG-III, classification groups that indicate the need for skilled services.

Medicare has established an administrative presumption of Medicare Part A coverage for beneficiaries correctly assigned to one of the upper 26 RUG-III (i.e., the rehabilitation, extensive care, special care, and clinically complex categories) under the initial five-day, Medicare-required assessment and the five-day Medicare required readmission/return assessment. In these cases, the level of care requirement is considered met from the date the beneficiary is "admitted" for extended care services (even though the beneficiary may remain in the same hospital or even the same bed) up to and including the assessment reference date for that five-day assessment. Although this presumption does not apply in connection with any of the subsequent assessments, the coverage that arises from the presumption remains in effect for as long thereafter as it continues to be supported by the actual facts of the beneficiary's condition and care needs. See article on page 18 for a detailed discussion of the presumptive coverage criteria.

A beneficiary who is assigned to any of the lower 18 of the 44 RUG-III is not automatically classified as meeting or not meeting the SNF level of care definition. Instead, the beneficiary must receive an individual level of care determination using existing administrative criteria and procedures. See article on page 19 for a list of the administrative criteria used to establish coverage.

Any beneficiary who is in a covered SNF Part A stay on the date the facility comes under the SNF PPS will not have his or her coverage terminated for the duration of that covered stay. If the beneficiary was determined to be "skilled" using the level of care criteria in place prior to the transition to the SNF PPS, the beneficiary continues to be considered skilled through the earlier of the:

- Last day of the Part A benefit period,
- Date of discharge from the swing bed, or
- Date the condition/service that required skilled Care is resolved/eliminated.

CMS is developing a customized swing bed MDS software program that will permit hospitals to enter, store, and transmit data related to their swing bed MDS assessments. This software will be available to providers, at no charge, in the late Spring of 2002. Detailed information on the RUG-III classification methodology can be obtained by accessing CMS's Internet Web site at *www.hcfa.gov/medicaid/mds20*.

Payment Provisions Under SNF PPS

Swing bed services reimbursed under the SNF PPS will be paid at the full federal rate. The federal payment rates were developed by CMS using allowable costs from hospital-based and freestanding SNF cost reports from reporting periods beginning in fiscal year 1995. The data used in developing the federal rates also incorporated an estimate of the amount payable under Part B for covered SNF level services furnished during fiscal year 1995 to individuals who were residents of the facility and receiving Part A covered services.

In accordance with the formula prescribed in the BBA, federal rates were set at a level equal to the weighted mean of freestanding costs plus 50 percent of the difference between the freestanding mean and the mean of all SNF costs (hospital-based and freestanding) combined. In addition, the portion of the federal rate attributable to wage-related costs is adjusted by an appropriate wage index. Payment rates are computed and applied separately for facilities located in urban and rural areas. **All swing bed hospitals are classified as rural providers, and will be paid at the rural rate for their geographic locations.**

The federal rate incorporates adjustments to account for facility case mix from the RUG-III patient classification system used under the national PPS. RUG-III is a 44-group patient classification system that provides the basis for the case-mix payment indices (or relative payment weights). This is used to standardize the federal rates and subsequently establish case-mix adjustments to the rates for patients with different service use. Information from the MDS is used to classify residents into one of 44 RUG-III. CMS is in the process of developing a customized two-page MDS for use by swing bed hospitals. A **draft** of the MDS for swing bed hospitals is available on the CMS website at *www.hcfa.gov/medicare/snfpps.htm*. Like other providers subject to the SNF PPS, swing bed providers must complete these assessments according to an assessment schedule specifically designed for Medicare payment; i.e., on the 5th, 14th, 30th, 60th, and 90th days after admission.

For Medicare billing purposes, there is a Health Insurance PPS (HIPPS) rate code associated with each of the 44 RUG-III, and each assessment applies to specific days within a resident's swing bed stay. When assessments are performed late, the swing bed facility will be paid at a default rate equal to the payment made for the lowest RUG-III. The default rate will remain in effect for as long as the provider is not in compliance with this MDS schedule.

Under the SNF PPS, covered swing bed services will include posthospital services for which benefits are provided under Part A (the hospital insurance program). In addition, the SNF PPS rate includes all items and services for which, prior to July 1, 1998, payment had been made under Part B (the supplementary medical insurance program) but furnished to SNF residents during a Part A covered stay.

Services that are not reimbursed through the SNF PPS per diem rate include:

- Physician services
- Physician assistant services
- Nurse practitioner and clinical nurse specialist services
- Certified midwife services
- Qualified psychologist services
- Certified registered nurse anesthetist services
- Anesthesiologist assistant services.

Services of nurses and physician assistants are not separately billable when they are employees of the swing bed facility. When employed by independent physicians, these services may be billed to the carrier on Form CMS-1500. In addition, certain legislative and administrative

Conversion of Hospital Swing Bed Facilities to the SNF PPS (continued)

exclusions are also excluded from the services included under the SNF PPS rate. See article on page 20 for more detailed information on services that are separately billable for a beneficiary in a Part A stay.

Part A Billing Requirements Under SNF PPS

Providers of swing bed services reimbursed under the SNF PPS will be required to bill room and board charges using a SNF PPS revenue code 0022 and a HIPPS code on Form UB-92 CMS-1450, or its electronic equivalent, for all Part A inpatient claims type of bill (TOB) 18x.

The Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, along with the UB-92 version 6.0 are at *www.hcfa.gov/medicare/edi/edi3.htm.* These formats are effective through the implementation date of the Health Insurance Portability and Acountability Act (HIPAA) requirements. The X12N 837 version 4010 (HIPAA) to UB-92 version 6.0 mapping is at *http://www.hcfa.gov/medicare/edi/hipaadoc.htm.* The 837 version 4010 can be downloaded at *http://www.wpc-edi.com*. Revenue code 0022 will be used in conjunction with the HIPPS code to identify the beneficiary's RUG-III as of the assessment reference date. These claims must be submitted on TOB 18x.

- Revenue Code, ANSI X-12 837-institutional (SV201), record type (RT) 60 (field 5), or form locator (FL) 42, must contain revenue code 0022. This code indicates the claim is being paid under SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS code(s) or assessment periods.
- HCPCS/Rates, ANSI X-12 837-institutional (SV202-2), RT60 (field 6), or FL 44, must contain a five-digit HIPPS code (AAA00-SSC79). The first three positions of the code contain the MDS RUG-III and the last two positions of the code contain a two-digit assessment indicator that identifies the type of assessment for payment purposes.
- Service Date, ANSI X-12 837-Institutional (2400 loop DTP03), RT60 (field 13), or FL 45, must contain an assessment reference date when FL 42 contains revenue code 0022 unless FL 44 contains HIPPS code AAA00.
- Service Units, ANSI X-12 837-Institutional (SV205), RT60 (field 9), or FL46, must contain the number of covered days for each HIPPS code and, if applicable, the number of modalities/treatments for each rehabilitation therapy code.
- Total Charges, ANSI X-12 837-Institutional (SV203), RT60 (field 10), FL 47, should contain zero total charges when the revenue code is 0022. For accommodation revenue codes (010x-021x), total charges must equal the rate multiplied by the units. The SNF PRICER will calculate and return the rate for each line item with revenue code 0022, then place it in the claim record. The standard system will then sum the 0022 revenue code lines for TOB 18x and 21x, and make the appropriate payment. Payments will not be made based on the total charges shown in revenue code 0001 on the incoming claim. The actual PPS payment amount for each iteration of revenue code 0022 will be shown on the remittance advice and will be stored in the ANSI X-12 837-Institutional (SV203), RT 60 (field 10), or FL 47 on the claim in CWF.

RUG-III Classification Codes

AAA (the default code)

BA1,	BA2,	BB1,	BB2			
CA1,	CA2,	CB1,	CB2,	CC1,	CC2	
IA1,	IA2,	IB1,	IB2			
PA1,	PA2,	PB1,	PB2,	PC1,	PC2,	PD1,
PD2,	PE1,	PE2				
RHA,	RHB,	RHC,	RLA,	RLB,	RMA,	RMB,
RMC,	RUA,	RUB,	RUC,	RVA,	RVB,	RVC
SE1,	SE2,	SE3,	SSA,	SSB,	SSC	

HIPPS Modifiers/Assessment Type Indicators

Basic Assessments

01 5-day Medicare-required assessment
02 30-day Medicare-required assessment
03 60-day Medicare-required assessment
04 90-day Medicare-required assessment
05 Readmission/Return Medicare-required assessment
07 14-day Medicare-required assessment
08 Off-cycle other Medicare-required assessment (OMRA)
30 Off-cycle swing bed change in clinical status (outside assessment window)

Replacement Assessments – OMRAs

18 OMRA replacing 5-day Medicare-required assessment or 5-day Readmission/Return Assessment
28 OMRA replacing 30-day Medicare-required assessment
38 OMRA replacing 60-day Medicare-required assessment
48 OMRA replacing 90-day Medicare-required assessment
78 OMRA replacing 14-day Medicare-required assessment

Replacement Assessments – Change in Clinical Status

32 Swing bed change in clinical status replaces 30-day Medicare-required assessment
33 Swing bed change in clinical status replaces 60-day Medicare-required assessment
34 Swing bed change in clinical status replaces 90-day Medicare-required assessment
35 Swing bed change in clinical status replaces a readmission/return Medicare-required assessment
37 Swing bed change in clinical status replaces 14-day Medicare-required assessment

Note: Medicare is not providing a code for a change in clinical status replacing the initial 5-day Medicare-required assessment. If the change in clinical status occurs after the initial 5-day assessment has been completed (i.e., between days 1-8), and before the assessment window for the 14-day assessment, it will be considered an off-cycle change in clinical status, and the HIPPS code will be coded as 30.

Replacement Assessments: Combined OMRA and Change in Clinical Status

When billing for swing bed services, there is no need to differentiate between an OMRA and an OMRA that is also a change in clinical status. For any assessment that

Conversion of Hospital Swing Bed Facilities to the SNF PPS (continued)

meets both the OMRA and clinical change criteria, use the appropriate OMRA assessment indicator.

18 OMRA and change in clinical status replaces 5-day assessment
28 OMRA and change in clinical status replaces 30-day assessment
38 OMRA and change in clinical status replaces 60-day assessment
48 OMRA and change in clinical status replaces 90-day assessment
78 OMRA and change in clinical status replaces 14-day assessment

Special Payment Situations – *New Assessment Indicator Codes Effective July 1, 2002*

In some situations, beneficiaries may change payer source after admission to the swing bed, but fail to notify the provider in a timely manner; e.g., disenrollment from an HMO, disenrollment from a hospice, change in Medicare payer status from secondary to primary, etc. In those situations, the provider may not have completed the MDS assessments needed for Medicare billing. New assessment indicator codes have been established for these special payment situations. Claims processing instructions are being developed and will be issued on a later date.

19 Special payment situation 5-day assessment
29 Special payment situation 30-day assessment
39 Special payment situation 60-day assessment
49 Special payment situation 90-day assessment
79 Special payment situation 14-day assessment

Default Code – No Assessment Completed

00 Default code (No assessment completed)

When a HIPPS code of RUAxx, RUBxx and/or RUCxx is present, a minimum of two rehabilitation therapy ancillary revenue codes are required (042x and/or, 043x and/or, 044x). When a HIPPS code of RHAxx, RHBxx, RHCxx, RLAxx, RLBxx, RMAxx, RMBxx, RMCxx, RVAxx, RVBxx and/or RVCxx is present, a minimum of one rehabilitation therapy ancillary revenue code is required (042x, 043x or 044x). Generally, it is assumed that facilities will perform an OMRA assessment within 10 days from the date of the last therapy session. The OMRA assessment would be used to establish a new RUG-III that would not be in the rehabilitation category.

Therefore, allowing the 10-day grace period will allow the processing of bills that span more than one month with the therapy billed entirely on the prior month's bill. Bills that are missing the required rehabilitation therapy ancillary revenue codes for a period greater than 10 days are to be returned to the provider of swing bed services for resubmission. Current policy does not require that another assessment be performed when therapy services are reduced. Therefore, when one therapy service is discontinued at the end of the month, and the RUG-III code being used on the subsequent month's bill is edited by the provider (i.e., verifies the presence of two therapy ancillaries during the observation period for the MDS being used to support the billing), the facility may utilize a "workaround." Use **one unit** of the discontinued therapy at a charge of $0.01. Medical records must reflect that the beneficiary continued treatment in at least one therapy discipline until the next assessment was required.

Billing Requirement Summary

To ensure that swing bed claims will process correctly under the SNF PPS the following billing requirements must be present on the bill.

- Providers of swing bed services reimbursed under the SNF PPS must report revenue code 0022 on TOB 18x. The customary room and board revenue codes 010x-021x, and charges must also be included on the bill.
- A valid HIPPS code must be always present on revenue code 0022.
- All revenue code 0022 lines have total units greater than 0. Charges cannot be associated with the 0022 revenue code, and the charge field should be left blank.
- The assessment reference date of the MDS used to support the bill must be entered into the service date field for all HIPPS codes except AA000. The AA000 default code indicates that no assessment was performed so the date field will be blank.
- Revenue code total charges line 0001 must equal the sum of the individual total charges lines.
- The length of stay in the "Statement Covers Period From Through" dates equals the total days for accommodation revenue codes 010x - 021x, including revenue code 018x (leave of absence).
- The sum of revenue codes 010x - 021x units minus revenue code 018x, leave of absence units, is equal to the sum of PPS revenue code 0022 covered units.

Billing Ancillary Services Under SNF PPS

When coding PPS bills for ancillary services associated with a Part A swing bed stay, providers should continue to show the traditional revenue codes in FL 42 (e.g., 0250 - Pharmacy, 042x - Physical Therapy) in conjunction with the appropriate entries in Service Units, FL 46 and Total Charges, FL 47.

- Providers of swing bed services are required to report the number of units in FL 46 based on the procedure or service.
- Providers of swing bed services are required to report the actual charge for each line item (except for revenue code 0022), in Total Charges, FL 47.
- The accommodation revenue code 018x, leave of absence, ANSI X-12 837-Institutional (SV201) RT 50 (field 5), or FL 42, will continue to be used in the current manner including the appropriate UB92 occurrence span code, 74, noncovered days or leave of absence, ANSI X-12 837-Institutional (2300 loop HI code BI), RT 40 (fields 28-33), or FL 36, and the date range of the non-covered care.

Billing Ancillary Services under Medicare Part B

The swing bed program does not include an inpatient Part B benefit. For beneficiaries who continue to receive extended care services after the end of a Part A stay (e.g., benefits exhausted, not receiving a skilled level of care, etc.), ancillary services may be billed under the hospital provider number as inpatient Part B services.

Swing bed providers must utilize line item date of service HCPCS coding for Part B inpatient billing.

Conversion of Hospital Swing Bed Facilities to the SNF PPS (continued)

Demand Bills

Demand bills, identified by the presence of condition code 20, (ANSI X-12 837-Institutional (2300 loop HI code BG) RT 41 (fields 4 - 13), or FLs 24 - 30)) may be submitted at the request of a beneficiary or family member. All required billing information must be present, including the HIPPS codes (reflecting either the RUG-III group generated by processing the MDS through the RUG-III grouper program or the default code, AAA) and the 0022 revenue code.

Spell of Illness

To code a claim properly for a resident whose Medicare Part A coverage is ending due to a change in the skilled level of care (or benefits exhausted) when the beneficiary continues to reside in the facility, the patient status ANSI X-12 837-Institutional (CL103), RT 20 (field 21), or FL 22 must equal 30 (still patient). For the purpose of breaking a spell of illness, those residents who have changed to a nonskilled level of care must have their Part A claim coded with an occurrence code 22 ANSI X-12 837-Institutional (2300 loop HI code BH), RT 40 (fields 8 - 21), or FL 32 - 35 and must enter the date of the last medically covered day. A benefits exhausted situation does not automatically break a spell for a Medicare beneficiary; therefore, occurrence code 22 should not be coded in a benefits exhausted situation unless there is medical justification for doing so.

For a beneficiary who changes to a nonskilled level of care after Part A reimbursement ends, occurrence code 22 and the date of the last medically covered day should be coded on a claim, showing the from and through dates of the non-covered period and indicating beneficiary or provider liability (76 or 77) as ANSI X-12 837-Institutional (2300 loop HI code RH), RT 40 (fields 22 - 27), or FL 36. When using code 76 to show beneficiary liability, the provider must also use occurrence code 31 and value code 31 as is currently required for hospital inpatient claims.

When properly applied, occurrence code 22 (and the date) will set an indicator on common working file (CWF) to track the days of utilization properly for spell of illness. In addition to the SNF PPS revenue code, providers of swing bed services will also be required to bill the customary room and board revenue codes (01x - 021x) and charges on inpatient claims (TOB 18X).

If a beneficiary's Part A benefits are exhausted, TOB 18x should be coded with occurrence code A3, B3 or C3 (payer status indicators), as appropriate, ANSI X-12 837-Institutional (2300 loop HI code BH), RT 40 (fields 8-21), or FL 32 - 35.

If the beneficiary remains a resident in the swing bed facility after the end of the Part A stay, the hospital may submit a claim to the fiscal intermediary (FI) for those services covered under inpatient Part B using TOB 12x. The beneficiary would be eligible for the same benefits available to a hospital inpatient in a Part B stay. The hospital provider of SNF level swing bed services must also file a Part A nonpayment bill either monthly or at discharge using the appropriate nonpayment code. (See MIM section 3624.)

If a beneficiary is admitted to another hospital as an inpatient for services not available at the swing bed facility, the beneficiary should be discharged. If that beneficiary subsequently returns to the swing bed facility, he or she should be readmitted.

Late Charges

Bills for late charges will not be processed. Providers must file adjustments if they determine the original bill inadvertently omitted charges for services/supplies furnished to the beneficiary.

SNF PRICER Software

The SNF PRICER will be used for swing bed providers. The SNF PRICER program calculates the daily Medicare SNF PPS rate for each facility and uses the facility's provider-specific rate, the provider's Metropolitan Statistical Area, the "Statement Covers Period From Through" date on the claim, and the HIPPS code to calculate the SNF PPS rates.

Special Billing Requirements Under SNF PPS

Providers of swing bed services are eligible for additional payment for services that are excluded from the SNF Part A consolidated billing requirements. These consolidated billing exclusions are not subject to the hospital bundling requirements specified in section 1862 (a)(14) of the Act and in 42 CFR section 411.15(m). All services not specifically excluded from the SNF PPS consolidated billing requirements must be included in the Part A swing bed bill (TOB 18x).

If a swing bed hospital furnishes a service or supply to a beneficiary receiving SNF-level services that is excluded from the SNF PPS rate; the swing bed hospital may submit a separate bill to the FI for the SNF PPS-excluded service. This bill must use TOB 12x with all appropriate revenue codes, HCPCS codes, and line item date of service billing information. See page 20 for a list of services that are excluded from the SNF PPS rate.

Bills for these SNF PPS consolidated billing "exclusions" must be filed as inpatient Part B services and will be paid as inpatient Part B services under the outpatient prospective payment system (OPPS). See PM A-01-142 for a list of billable inpatient Part B services that are covered through the OPPS. Services included under the SNF PPS may not be billed separately.

Similarly, as explained above, swing bed hospitals may file bills with the FIs for Part B ancillary services furnished to Medicare beneficiaries who are not in a Part A swing bed stay. These claims will also be billed as inpatient Part B services, and payable under the OPPS.

Additional training materials, articles and other relevant information on swing bed PPS are available on the CMS' Web site at *www.hcfa.gov/medlearn/SBPPS.htm*. ❖

Source: CMS Transmittal A-02-016, CR 1666

Presumption of Coverage for Swing Bed Services

The following scenarios further clarify that a beneficiary's classification to one of the upper 26 RUG-III groups triggers the coverage presumption under the initial 5-day, Medicare-required assessment only when that assessment occurs directly following the beneficiary's hospital discharge.

1. **Routine Swing Bed Admission Directly from Qualifying Hospital Stay**
   If the beneficiary is admitted for SNF-level care immediately following a 3-day qualifying hospital stay (regardless of whether the acute care hospital stay was in the swing bed facility or not), there is a presumption that he or she meets the Medicare level of care criteria. The presumption lasts through the assessment reference date of the 5-day assessment, which must occur no later than the eighth day of the stay.

2. **Admission for SNF-level Care Does Not Immediately Follow Discharge from the Qualifying Hospital Stay, but Occurs Within 30 Days (as required under the "30 day transfer" rule)**
   If the beneficiary is discharged from the hospital to a setting other than the SNF-level services provided in the swing bed facility, the presumption of coverage does not apply, even if the beneficiary's return to the swing bed facility for SNF-level services occurs within 30 days of discharge from the qualifying hospital stay. Accordingly, coverage would be determined based on a review of the medical evidence in file.

3. **Resident is Re-hospitalized and then Returns**
   If a beneficiary who has been in a covered Part A stay requires readmission to a hospital (either the swing bed hospital or another hospital), and is transferred directly back to the swing bed to receive SNF-level services, there is a presumption that he or she meets the level of care criteria upon readmission. A new Medicare 5-day assessment is required and the presumption of coverage lasts through the assessment reference date, which must occur no later than the eighth day of the stay.

4. **Routine Swing Bed Admission Directly from Qualifying Hospital Stay, but Initial Portion of Swing Bed Stay Covered by Another Insurer (Medicare as Secondary Payer)**
   When a beneficiary goes directly from a qualifying hospital stay to the swing bed for SNF-level care, but the initial portion of the post acute stay is covered by another insurer that is primary to Medicare, Medicare coverage would not start until coverage by the insurer ends. The Medicare required schedule of assessments will not begin until the first day of Medicare coverage. If Medicare begins within the first 8 days of the stay, the presumption lasts through the assessment reference date of the 5-day assessment or, if earlier, the eighth day of the stay. Thus, if the other insurer's coverage lasts through the eighth day of the stay, there is no presumption.

5. **Beneficiary Receives a Notice of Noncoverage upon Admission and Requests a Demand Bill**
   In this situation, a Medicare 5-day assessment was not performed because the SNF's clinical staff determined upon admission that the beneficiary did not meet the level of care criteria for coverage. Since no 5-day assessment was performed, the medical review would be based on the coverage criteria. See article on page 19. If the medical review indicated that the services should have been covered, the days would be paid at the default rate since no 5-day assessment was actually performed.

6. **Readmission for Post - Acute Swing Bed Care within 30 Days after Discharge from Initial Swing Bed Stay—No Intervening Hospitalization**
   As noted in scenario 1, if a beneficiary is initially admitted to the swing bed directly following a covered Part A acute care stay, the presumption for that stay is applicable. However, if that beneficiary is discharged (NOT to an acute care facility) and then subsequently readmitted, there is no presumption applicable to the second swing bed admission. (If the beneficiary is transferred to a hospital, and returns directly to the swing bed, see scenario 3 above.)

7. **Initial, Non-Medicare Swing Bed Stay Followed by Qualifying Hospitalization and Readmission to a Swing Bed Facility for a Medicare-Covered Extended Care Stay**
   Dually eligible (Medicare/Medicaid) beneficiaries whose initial post acute swing bed stay is either Medicaid-covered or private pay, are eligible for the Medicare presumption of coverage when readmitted to the swing bed for SNF-level services following a qualifying hospitalization.

8. **Transfer from One Extended Care (i.e., SNF-level) Facility to Another**
   There is no presumption of coverage in cases involving transfer of a beneficiary from one SNF level provider to another. The presumption applies only to the SNF-level stay that immediately follows the qualifying hospital stay. Similarly, in cases involving transfer of a beneficiary from a swing-bed hospital to a SNF, the presumption applies only when the beneficiary stopped receiving inpatient acute care services and initiated the extended care portion of the stay in the swing bed hospital. The swing bed services payable under the SNF PPS are eligible for the presumption. However, the presumption does not apply to beneficiaries transferring to a SNF after receiving extended care services in a swing bed hospital.

Bear in mind, the presumption was deliberately designed to create a very high probability of identifying those situations that involve a need for skilled care. Accordingly, we do not anticipate there will be a significant number of cases in which a beneficiary qualifies for the presumption and yet does not actually require any skilled care. However, as indicated in the July 30, 1999, final rule (64 FR 41668-69), if it becomes apparent in actual practice this is not the case with regard to certain specific criteria under the RUG-III classification system (e.g., the 14-day "look-back" provision), CMS reserves the right to reassess the validity of the presumption's use of those criteria. ❖

Source: CMS Transmittal A-02-016, CR 1666

Eligibility and Coverage Changes for Swing Bed Services

With the incorporation of swing bed facilities into the skilled nursing facility prospective payment system, some of the administrative criteria used to established coverage have been modified, eliminated or remain the same. This article outlines a comparison and rationale for eligibility and coverage of these changes.

Technical Eligibility

Physician certification for the need of skilled care has been changed to:

- Physician, nurse practitioner, or clinical nurse specialist *may initially* certify to the need for skilled care *or c*orrectness of the RUG III
- *Re-certifications* are for the ongoing need of skilled services.

Coverage for the following technical eligibility activities remain the same:

- Three-day qualifying stay
- Transferred within 30 days of hospital stay of three consecutive days
- Medical predictability (continuation Rx is inappropriate from a medical perspective)
- Administered for a condition that was treated during qualified stay, *or* which arose while in a SNF for a treatment of condition for which the beneficiary previously was treated in a hospital.

Coverage Eligibility

Teaching and training activities have been redefined to require the skills of a technical/professional for the teaching of a self-maintenance program. Examples are:

- Self injection
- Newly diagnosed diabetic insulin injection/diet/ observation foot care precautions
- Gait training and prosthesis care
- Recent colostomy/ileostomy care
- Self catherization and self GT feedings care and maintenance CVP's/Hickman catheters
- Care of braces, splints, orthotics associated skin/care
- Specialized dressings or skin treatment.

Coverage for the following activities remain the same:

- Skilled nursing or skilled rehabilitation on a daily basis
- Performed by or under direct physician supervision
- Management/evaluation of the plan of care
- Observation and assessment of the plan of care.

Coverage of Direct Skilled Services

Coverage eligibility for some direct skilled services have been modified and or eliminated. These services are:

- Injections have been modified to the coverage of IV (intravenous) and IM (intramuscularly). SC (subcutaneous) injections have been eliminated.
- Hypodermoclycis, IV feedings modified to IV feedings only. Hypodermoclycis have been eliminated.
- NG (nasal gastric) tube, gastrostomy, jejunostomy modified to feeding 26 percent of QD (daily) calories and minimum of 501 ml fluid per day.
- Naso-pharyngeal tracheotomy aspiration.
- Insertion, sterile irrigation, replacement catheters/care of suprapubic catheter and insertion/ care of catheter adjunct to active Rx of a disease modified to suprapubic catheters only.

Coverage for the following direct skilled services remain the same:

- Application of dressings with prescription meds and aseptic techniques
- Treatment of decubitus ulcers. Severity of grade three or worse or widespread skin disorder
- Heat Rx's ordered by physician requiring skilled observation
- Rehabilitation nursing procedures includes related teaching adaptive aspects of nursing and part of active treatment necessitating skilled nursing; e.g., institution of bowel and bladder training programs
- Initial regimen involving administration of medical gases such as bronchodilator therapy
- Care of a colostomy/early post-operative phase with associated complications.

Skilled Rehabilitation Services

The following skilled rehabilitation services are captured within the RUG III rehabilitation groups:

Skilled Physical Therapy

- Directly related written plan of treatment
- Requires knowledge/skills/judgment of qualified professional
- Services must be considered under acceptable standards of clinical practice
- Expectation of improvement of restorative potential in a reasonable and predictable period of time, or
- Establishment of a safe and effective maintenance program.*

Applications

- Hot packs hydrocollator infra red, paraffin baths only in the presence of complicating condition; e.g., open wounds
- Gait training
- Ultrasound, short-wave, diathermy
- ROM tests
- Therapeutic exercises.

Skilled Occupational Therapy

- Ordered by a physician to improve or restore function.

Applications

- Evaluation/Reevaluation of function
- Teaching task oriented therapeutic activities
- Plan/implement/supervise individualized therapeutic activities and sensory integration functions
- Testing of compensatory techniques
- Design/fabrication and fitting orthotic or self help devices
- Vocational/pre-vocational.

Speech Therapy

- Directly related written plan of treatment
- Requires knowledge/skills/ judgment of qualified professional
- Services must be considered under acceptable standards clinical practice
- Expectation of improvement; i.e. restorative potential in a reasonable and predictable period of time, or
- Establishment of a safe and effective maintenance program
- Services necessary for diagnosis and treatment of speech and language disorders.

Eligibility and Coverage Changes for Swing Bed Services (continued)

Applications

- Restoration therapy
- Establishment of a maintenance program*****
- Diagnostic and evaluation services
- Therapeutic services
- Services for the treatment of dysphagia

*****The actual provision of maintenance therapy does not generally require the skills of a licensed therapy professional. ❖

Source: CMS Transmittal A-02-016, CR 1666

Swing Bed Responsibility for Billing Ancillary Services

Medicare SNF Consolidated Billing Responsibility

Services	Bundled Back to Swing Bed Provider	Separately Billable by Swing Bed Provider
Services Provided After Discharge From the SNF-Level Extended Care Bed		X
• To home (no return by midnight)	X	
• To home (return by midnight)		X
• To home for home health services under a plan of care • To hospital or CAH for inpatient admission		Billed by hospital or CAH
Services within the General Scope of Swing Bed Care (All services except those specifically excluded by legislation and/or by CMS)	X	
Services Excluded by the BBA • Physician services • Physician assistant services performed under supervision • Nurse practitioners and clinical nurse specialists working in collaboration with a physician • Certified nurse midwife • Qualified psychologist • Certified registered nurse anesthetist • Home dialysis supplies and equipment, self care dialysis support services, and institutional dialysis services and supplies • Erythropoietin for certain dialysis patients • Hospice care related to a beneficiary's terminal illness • Ambulance – initial admission /final discharge		X
Services Excluded by CMS from SNF PPS Financial Responsibility under Consolidated Billing[1]		X
• **Outpatient Hospital Emergency Services[2]**		X
• Magnetic resonance imaging		X
• Computerized axial tomography scans		X
• Ambulatory surgery involving the use of an operating room - (1999 PPS Final Rule provides that PEG tube procedures performed in a GI suite or an endoscopy suite are alsoexcluded from consolidated billing.)		X
• Hospital outpatient radiation therapy		X
• Hospital outpatient angiography		X
• Lymphatic and venous procedures		X
• Hospital outpatient angiography		X
• Lymphatic and venous procedures		X
Services excluded by the BBRA[3]		
• Certain Chemotherapy items and administrative services		X
• Certain Radioisotope services		X
• Certain Customized prosthetic devices		X

[1] Services must be obtained at an outpatient hospital department. Services obtained at a freestanding clinic are not exempt.
[2] Outpatient hospital emergency services are defined in 42 CFR Section 424.101 as services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.
[3] Services do not have to be obtained at an outpatient hospital department. The Part B suppliers of these services will be able to bill Medicare Part B directly, i.e., the specified chemotherapy and radioisotope services can be provided and billed by hospital outpatient departments, physicians' offices, or other appropriate suppliers, and prosthetics suppliers will be able to bill for the specified customized prosthetic devices indicated by the codes in the legislation.

Current Responsibility for Ambulance Services to Medicare Beneficiaries Receiving SNF-Level Services in a Swing Bed Hospital

Type Of Trip	Ambulance Bills Carrier	Ambulance Bills Swing Bed Facility
Initial Admission to SNF-Level Care at Swing Bed Facility[4]	X	
Final Discharge From SNF		
• To home (no return by midnight)	X	
• To home (return by midnight)		X
• To home for home health services under a plan of care	X	
• To another hospital for acute care services	X	
• To another SNF (medical necessity)[5]		X
Round-Trip to Obtain Dialysis Services (BBRA) in another facility	X	
Round-Trip to Another Hospital for Emergency Services	X	
Round-Trip to Another Hospital for Services Within the General Scope of Swing Bed Care (All services except those specifically excluded by CMS)		X
Round-Trip to Another Hospital for Services Excluded by CMS from SNF PPS Financial Responsibility Under Consolidated Billing[6]	X	
• Magnetic resonance imaging	X	
• Computerized axial tomography scans	X	
• Ambulatory surgery involving the use of an operating room – (1999 PPS Final Rule provides that PEG tube procedures performed in a GI suite or an endoscopy suite are also excluded from consolidated billing.)	X	
• Cardiac catheterization	X	
• Hospital outpatient radiation therapy	X	
• Hospital outpatient angiography	X	
• Lymphatic and venous procedures	X	
Round-Trip to Provider of Services Excluded by BBA from SNF PPS Financial Responsibility under Consolidated Billing, e. g., a round-trip to a physician's office		X
Round-Trip to Provider of Services Excluded by BBRA from SNF PPS Financial Responsibility Under Consolidated Billing[7] – Certain chemotherapy items and administrative services, radioisotope services, and customized prosthetic devices		X

[4]Applicable to swing bed providers only when the patient is being transferred from another acute care hospital to receive extended care services at a swing bed facility.
[5]Ambulance bills transferring facility.
[6]Services must be obtained at an outpatient hospital department. Ambulance payment is available only if the services required by the beneficiary are not available at the swing bed hospital. Services obtained at a freestanding clinic are not exempt.
[7]It is expected that swing bed providers perform these services within the facility. However, if the services are not available in the swing bed facility, the swing bed provider may use an independent supplier. The Part B suppliers of these services will be able to bill Medicare Part B directly; e.g., radioisotope services performed in a freestanding center, ambulance transportation to a dialysis center. ❖

Source: CMS Transmittal A-02-016, CR 1666

Clarification of New Patient Status Codes 62 and 63

Effective for services furnished on or after January 1, 2002, it is appropriate for all providers, including acute care providers, billing on the claim Form UB-92 HCFA-1450 or its electronic equivalent to bill patient status (PS) codes 62 and 63 in field locator 22.

Under the inpatient prospective payment system, PS code 62 and 63 will work like PS code 05 in the post-acute care transfer policy for the ten established diagnosis related groups. The PS code 05 continues to be valid, however, inpatient rehabilitation hospitals and units and long-term care hospitals have been pulled from that definition.

Effective immediately, the National Uniform Billing Committee has approved a change in the definition of PS code 62. The revised descriptor is:

62 Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital.

PS code 63 refers to discharges/transfers to long-term care hospitals. Long-term care hospitals are certified under Medicare as short-term acute care hospitals and have an average inpatient length of stay of greater than 25 days. Their provider number ranges are between xx2000 – xx2299. ❖

Source: CMS Transmittal A-02-022, CR 2069

HOSPITAL SERVICES

Medicare Secondary Payer (MSP) Information Collection Policies Changed for Hospitals

An article addressing the new relaxed policy associated with hospital collection of certain MSP data was published in the First Quarter 2002 Medicare A Bulletin (pages 17-18). Since then, the Centers for Medicare & Medicaid Services (CMS) has reevaluated and made changes to the associated data collection requirements as indicated in the following article. ***For hospital reference laboratories and recurring outpatient services policies only,*** *information provided in this publication supersedes data collection requirements previously published.*

Beneficiary-specific data on third-party payers obligated to be primary payers to Medicare are maintained by CMS for the purpose of ensuring the Medicare program processes claims properly. The basis for provider collection of this data is found in the law and regulations, a synopsis of which is provided below:

Background

Based on the law and regulations, providers are required to file claims with Medicare using billing information obtained from the beneficiary to whom the item or service is furnished.

Section 1862(b)(6) of the Social Security Act (the Act) (42 USC section 1395y(b)(6)) requires all entities seeking payment for any item or service furnished under Part B to complete, on the basis of information obtained from the individual to whom the item or service is furnished, the portion of the claim form relating to the availability of other health insurance.

Additionally, 42 CFR section 489.20(g) requires that all providers must agree "… to bill other primary payers before billing Medicare…." Thus, any provider that bills Medicare for services rendered to Medicare beneficiaries, including nonpatient (reference lab) services, must determine whether or not Medicare is the primary payer for those services. This must be accomplished by asking Medicare beneficiaries, or their representatives, questions concerning the beneficiary's MSP status. Hospital Manual section 301.2, "Types of Admission Questions to Ask Medicare Beneficiaries," may be used to determine the correct primary payers of claims for all beneficiary services furnished by a hospital. If providers fail to file proper claims with Medicare, the regulations at 42 CFR section 411.24 permit Medicare to recover its conditional payments from them.

In order to conform to the law and regulations, the provider must verify MSP information prior to submitting a bill to Medicare. This greatly increases the likelihood that the primary payer is billed correctly. Verifying MSP information means confirming the information previously furnished about the presence or absence of another payer that may be primary to Medicare is correct, clear, and complete, and that no changes have occurred.

CMS has recently reevaluated the paperwork burden associated with hospital collection of certain MSP data and is making changes to its associated data collection requirements, as described below. For the hospital reference labs and recurring outpatient services policies only, this Program Memorandum (PM) supersedes Intermediary Transmittal Number A-01- 116 and Hospital Manual Transmittal 777, both of which were issued on September 25, 2001.

1. Policy for Hospital Reference Laboratoies

Hospitals must collect MSP information from a beneficiary or his/her representative for hospital reference lab services. If the MSP information collected by the hospital, from the beneficiary or his/her representative and used for billing, is no older than 90 calendar days from the date the service was rendered, then that information may be used to bill Medicare for non-patient reference lab services furnished by hospitals. Hospitals must be able to demonstrate they collected MSP information from the beneficiary or his/her representative, which is no older than 90 days, when submitting bills for their Medicare patients. Acceptable documentation may be the last (dated) update of the MSP information, either electronic or hardcopy.

2. Policy for Recurring Outpatient Services

Hospitals must collect MSP information from the beneficiary or his/her representative for hospital outpatients receiving recurring services. Both the initial collection of MSP information and any subsequent verification of this information must be obtained from the beneficiary or his/her representative. Following the initial collection, the MSP information should be verified once every 90 days. If the MSP information collected by the hospital, from the beneficiary or his/her representative and used for billing, is no older than 90 calendar days from the date the service was rendered, then that information may be used to bill Medicare for recurring outpatient services furnished by hospitals.

Note: A Medicare beneficiary is considered to be receiving recurring services if he/she receives identical services and treatments on an outpatient basis more than once within a billing cycle.

Hospitals must be able to demonstrate that they collected MSP information from the beneficiary or his/her representative, which is no older than 90 days, when submitting bills for their Medicare patients. Acceptable documentation may be the last (dated) update of the MSP information, either electronic or hardcopy. ❖

Source: CMS Transmittal A-02-021, CR 2104

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 **June 24, 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**).*

22520: Percutaneous Vertebroplasty

Policy Number
22520

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Percutaneous Vertebroplasty

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
06/24/2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Percutaneous vertebroplasty is a therapeutic, interventional neurosurgical and radiological procedure that consists of the percutaneous injection of a biomaterial, methyl methacrylate, into a lesion of a cervical, thoracic, or lumbar vertebral body. The procedure is utilized for pain relief and bone strengthening of weakened vertebral bodies.

The procedure is performed under fluoroscopic guidance, although some prefer the use of computed tomography (CT) with fluoroscopy for needle positioning and injection assessment. An intraosseous venogram is sometimes performed before cement injection to determine whether the needle is positioned within a direct venous anastomosis to the central or epidural veins, to minimize extravasation into venous structures. General anesthesia or neuroleptanalgesia with additional local anesthesia (1% lidocaine) is utilized, as pain may intensify during cement injection. The methyl methacrylate is injected into the vertebral body until resistance is met or until cement reaches the posterior wall. The procedure usually lasts from 1 to 2 hours, unless cement is injected into two or more vertebral bodies. The patient must remain flat for about three hours following the procedure.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider the performance of a percutaneous vertebroplasty procedure medically reasonable and necessary for the following indications:

- Painful osteolytic vertebral metastasis;
- Painful myeloma;
- Painful and/or aggressive hemangioma; and
- Painful, debilitating, osteoporotic vertebral collapse/compression fractures that have not responded to appropriate medical treatment (e.g., 2-4 week period of immobilization such as restricted activity/bracing and analgesia/scheduled narcotic).

The decision to perform this procedure should be multidisciplinary, taking into consideration the following factors: the local and general extent of the disease, the spinal level involved, the severity of pain experienced by the patient, previous treatments and their outcomes, as well as the patient's neurological condition, general state of health and life expectancy.

Percutaneous vertebroplasty is contraindicated in coagulation disorders due to the large diameter of the needles used for injection.

Relative contraindications to performance of a percutaneous vertebroplasty are extensive vertebral destruction, significant vertebral collapse (i.e., vertebra reduced to less than one-third its original height), neurological symptoms related to compression, and when there is no neurosurgical backup for emergency decompression in the event a neurological deficit develops during the injection of methyl methacrylate.

CPT/HCPCS Section & Benefit Category
Surgery/Musculoskeletal System

Type of Bill Code
Hospital – 13x
Critical Access Hospital – 85x

Revenue Codes
360 Operating Room Services – General Classification

CPT/HCPCS Codes
22520 Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic
22521 lumbar
22522 each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

Not Otherwise Classified Codes (NOC)
N/A

22520: Percutaneous Vertebroplasty (continued)

ICD-9-CM Codes that Support Medical Necessity

170.2	Malignant neoplasm of vertebral column, excluding sacrum and coccyx
198.5	Secondary malignant neoplasm of bone and bone marrow
203.00-203.01	Multiple myeloma
228.09	Hemangioma, of other sites
238.6	Neoplasm of uncertain behavior of plasma cells
733.13	Pathologic fracture of vertebrae
805.00-805.9	Fracture of vertebral column without mention of spinal cord injury (post-traumatic compression fracture only)

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

HCPCS code 22520 and/or 22521 should only be billed one time, regardless of the number of injections to the one vertebral body.

Documentation Requirements

Medical record documentation (e.g., office/progress notes, procedure notes) maintained by the provider must indicate the medical necessity for performing this service. The documentation must also support that the service was performed.

When the service is performed for painful, debilitating, osteoporotic vertebral collapse/compression fractures, documentation must support that conservative treatment has failed.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information and Basis for Decision

Cotten, A., Dewatre, F., Cortet, B., Assaker, R., et al. (1996). Percutaneous vertebroplasty for osteolytic metastases and myeloma: Effects of the percentage of lesion filling and the leakage of methyl methacrylate at clinical follow-up. *Radiology,* 200: 525-530.

Cotten, A., Boutry, N., Cortet, B., Assaker, R., et al. (1998). Percutaneous vertebroplasty: State of the art. *Radiographics*, 18: 311-320.

Gangi, A., Kastler, B.A., & Dietmann, J.L. (1994). Percutaneous vertebroplasty guided by a combination of CT and fluoroscopy. *American Journal of Neuroradiology,* 15: 83-86.

Jensen, M.E., Evans, A.J., Mathis, J.M., Kallmes, D.F., et al. (1997). Percutaneous polymethlmethacrylate vertebroplasty in the treatment of osteoporotic vertebral body compression fracture: technical aspects. *American Journal of Neuroradiology,* 18 (10):1897-1904.

Martin, J.B., Jean, B., Sugiu, K., San Millan Ruiz, D., et al. (1999). Vertebroplasty: Clinical experience and follow-up results. *Bone*, 25 (2): 11S-15S.

Mathis, J.M., Petri, M., & Naff, N. (1998). Percutaneous vertebroplasty treatment of steroid-induced compression fractures. *Arthritis and Rheumatism,* 41: 171-175.

Weill, A., Chiras, J., Simon, J.M., Rose, M., et al. (1996). Spinal metastases: Indications for and results of percutaneous injection of acrylic surgical cement. *Radiology,* 199: 241-247.

Advisory Committee Notes

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

Start Date of Comment Period

01/18/2002

End Date of Comment Period

03/04/2002

Start Date of Notice Period

05/01/2002

Revision History

Revision Number:	Original
Start Date of Comment Period:	01/18/2002
Start Date of Notice Period:	05/01/2002
	3rd Qtr 2002 *Bulletin*
Original Effective Date	06/24/2002 ❖

66821: Yag Laser Capsulotomy

Revision Overview: "Indication and Limitations of Coverage and/or Medical Necessity" and "Utilization Guidelines" sections have been revised to define the medical necessity and reasonableness for a Yag laser capsulotomy. In addition, "Type of Bill Code" and "Revenue Code" sections of the policy have been revised.

Policy Number
66821

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Yag Laser Capsulotomy

AMA CPT Copyright Statement

CMS National Coverage Policy
Coverage Issues Manual, Section 35-52

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
07/30/1998

Original Policy Ending Date
N/A

Revision Effective Date
06/24/2002

Revision Ending Date
06/23/2002

LMRP Description
The neodymium:YAG (Nd:Yag) laser is used to treat posterior capsulotomies for posterior capsule opacification. Posterior capsule opacification generally occurs following cataract surgery. Desired outcomes of use of the Nd:Yag laser are an increase in visual acuity and/or improvement in glare and contrast sensitivity.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider the Nd:Yag laser capsulotomy medically necessary and reasonable if the following criteria are met:

- The patient complains of symptoms such as blurred vision, visual distortion and/or glare resulting in **reduced ability or inability to carry out activities of daily living** due to decreased visual acuity or an increase in glare, particularly under bright light conditions, and/or conditions of night driving.
- The eye examination confirms the diagnosis of posterior capsular opacification and excludes other ocular causes of functional impairment by one of the following methods:
  - The eye examination should demonstrate decreased light transmission (visual acuity 20/30 or 20/25 if the procedure is performed to assist in the diagnosis and treatment of retinal detachment) after other causes of loss of acuity have been ruled out, or
  - Additional testing must demonstrate 1) contrast sensitivity testing resulting in a decreased visual acuity by two (2) lines or 2) a decrease of two (2) lines of visual acuity in the glare tester**.**
- This procedure should not be routinely scheduled after cataract surgery and rarely would it be expected to see this procedure performed within four months following cataract surgery. However, if a patient develops a posterior capsular opacification within four months following cataract surgery, Yag laser capsulotomy will be considered medically reasonable and necessary when the documentation demonstrates the following: the patient is experiencing symptoms of blurred vision, visual distortion, and/or glare with associated functional impairments; decreased light transmission (visual acuity < 20/30; and/or contrast sensitivity testing or glare testing resulting in a decreased visual acuity by two (2) lines.
- Occasionally, a Yag laser capsulotomy may also be performed to assist in the diagnosis and treatment of retinal detachment; to assist in the diagnosis and treatment of macular disease; to assist in the diagnosis and treatment of diabetic retinopathy; to evaluate the optic nerve head; or to diagnose posterior pole tumors.
- Generally, the Yag laser capsulotomy is expected to be performed only once per eye per lifetime of a beneficiary.

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

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

Revenue Code
360 Operating Room Services–General Classification

CPT/HCPCS Codes
66821 Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (one or more stages)

66821: Yag Laser Capsulotomy (continued)

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

366.50	After-cataract, unspecified
366.51	Soemmering's ring
366.53	After-cataract, obscuring vision

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

- When a series of procedures is planned for the removal of a posterior dense fibrotic capsule, it will be covered as a single procedure.
- If the procedure is performed on the same patient, on the same eye and is not part of a series of posterior capsule removal, documentation must be submitted to determine the medical necessity of the subsequent procedure(s).

Documentation Requirements

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

Documentation may be requested if procedure code 66821 is billed within four months of cataract surgery.

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

Utilization Guidelines

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

Other Comments

N/A

Sources of Information and Basis for Decision

Claesson, M., Klaren, L., Beckman, C. & Sjostrand, J. (1994). Glare and contrast sensitivity before and after Nd:Yag laser capsulotomy. *Acta Ophtalmologica,* 72, 27-32.

Magno, B., Datiles, M., Maria, S., Fajardo, M., Caruso, R., & Kaiser-Kupfer, M. (1997). Evaluation of visual function following neodymium: YAG laser posterior capsulotomy. *Ophthalmology,* 104(8), 1288-1293.

Roger, J. McPherson, B., & Govan J. (1995). Posterior capsule reopacification after neodymium: YAG laser capsulotomy. *Journal of Cataract Refractory Surgery,* 21, 351-352.

Advisory Committee Notes

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

Start Date of Comment Period

01/18/2002

End Date of Comment Period

03/04/2002

Start Date of Notice Period

05/01/2002

Revision History

Revision Number:	3
Start Date of Comment Period	01/18/2002
Start Date of Notice Period	05/01/2002 3rd Qtr 2002 *Bulletin*
Revised Effective Date:	06/24/2002

Explanation of Revision: To delete type of bill 71x (Rural Health Clinic), add type of bill 85x (Critical Access Hospital) and change revenue code 361 to 360. To further define the medical necessity and reasonableness of performing a Yag laser capsulotomy within four months following cataract surgery.

Revision Number:	2
Start Date of Comment Period	N/A
Start Date of Notice Period	02/25/2000 Special Issue 2000 *Bulletin*
Revised Effective Date:	08/01/2000

Explanation of Revision: Outpatient PPS implementation.

Revision Number:	1
Start Date of Comment Period	N/A
Start Date of Notice Period	N/A
Revised Effective Date:	07/30/1998

Revision Number:	Original
Start Date of Comment Period	02/23/1998
Start Date of Notice Period	05/29/1998
Original Effective Date:	07/30/1998. ❖

93015: Cardiovascular Stress Test

Revision Overview: "Type of Bill Code" and "Coding Guidelines" sections of the policy have been revised. In addition, diagnosis range 786.50-786.09 has been corrected to 786.50-786.59.

Policy Number
93015

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Cardiovascular Stress Test

AMA CPT Copyright Statement

CMS National Coverage Policy
Coverage Issues Manual, Section 35-25
Hospital Manual, Section 443
Intermediary Manual, Sections 3627, 3631, 3925

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
01/01/2002

Revision Ending Date
12/31/2001

LMRP Description
Cardiovascular Stress Testing or Exercise Stress Test (EST) consists of the continuous monitoring of an electrocardiogram (ECG) (generally a 12-lead system) with frequent 3-lead or 12-lead recordings taken according to clinical circumstances, frequent blood pressure determinations and continuous patient observation before, during and after exercise of progressively increasing intensity (usually with a treadmill or cycle ergometer) to any of a number of test end points. Usually, the heart rate, blood pressure, and (ECG) are recorded at the end of each stage of exercise, immediately before and immediately after stopping exercise, and for each minute for at least 5-10 minutes in the recovery stage. A minimum of three leads should be displayed continuously on the cathode ray screen during the test. Arm exercise is occasionally used in selected patients, although it is seldom as satisfactory.

Exercise Stress Testing is valuable for diagnosing ischemic heart disease and in investigating physiologic mechanisms underlying cardiac symptoms, such as angina, dysrhythmias, inordinate rises in blood pressure, and functional valve incompetence. EST also measures functional capacity for work, sport, or participation in a rehabilitation program and estimates response to medical or surgical treatment. Additionally, the function of physiologic responsive pacemakers (testing for upper rate limits) can be evaluated.

Normally, the systolic blood pressure increases with exercise and the diastolic remains essentially unchanged. An exercise test is considered negative when the patient does not exhibit significant symptoms, arrthymias, or other ECG abnormalities at 85 pewrcent of maximum heart rate predicted for age and sex.

In many instances, exercise testing may be combined with other procedures, such as myocardial perfusion imaging, radionuclide ventriculography, echocardiography or other imaging procedures.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider a cardiovascular stress test medically reasonable and necessary for the following conditions:

- To evaluate the prognosis and functional capacity of patients with Coronary Artery Disease (CAD) soon after a myocardial infarction (before discharge or early after discharge and again 6-8 weeks after uncomplicated MI).
- To assess for the presence or absence of coronary disease, appropriate heart rate and/or blood pressure response for cardiac transplant patients. For optimal management of these patients, annual testing is recommended.
- Evaluation of patients after coronary artery revascularization by the following methods:
  - Coronary Artery Bypass Grafting. (CABGs) Testing is recommended in patients with suspected incomplete revascularization, technical difficulties during or after the operation, initial difficulties in being disconnected from the extra corporeal support system, enzymatic or electrocardiographic evidence of intraoperative MI, or other evidence of perioperative complications.
  - Percutaneous Transluminal Coronary Angioplasty (PTCA). Testing is performed prior to discharge (2-5 days after procedure) and again at 3 and 6 months (helps identify the 20-30% of patients who restenose in the first 6 months after the procedure).
  - Thrombolytic therapy (e.g., Streptokinase, TPA, Urokinase). Testing is usually performed prior to discharge.

93015: Cardiovascular Stress Test (continued)

- To evaluate functional capacity serially in the course of an exercise cardiac rehabilitation program (prior to starting rehab and at 12 weeks).
- **Initial** evaluation of patients with symptoms consistent with recurrent, exercise-induced cardiac arrthymias (e.g., SOB on exertion, syncope, palpitations, etc.).
- **Initial** evaluation of exercise capacity of selected patients with valvular heart disease **with** related symptomatology.
- **Initial** diagnostic workup for a patient that presents with abnormal signs and symptoms such as chest pain, palpitations, dyspnea, etc., which may suggest a cardiac origin.
- **Initial** evaluation of patients with **new** onset of arrthymias.
- **Initial** evaluation of a patient with an old Myocardial Infarction in which a workup has not been previously performed.
- Evaluation of a patient presenting with recent changes in an ECG.
- Evaluation of a patient with known CAD that presents with new symptoms such as increasing shortness of breath (SOB), palpitations, change in (ECG), etc.
- Evaluate patient's response to a newly established therapy for angina, palpitations, arrthymias, SOB or any other cardiopulmonary disease process.
- Evaluation of other symptomatology which may indicate a cardiac origin especially in those patients who have a history of a MI, CABG surgery or PTCA **or** patients who are being treated medically after a positive stress test or cardiac catheterization.

General contraindications to exercise testing include*:

- Very recent acute myocardial infarction (generally < 6 days)
- Unstable angina
- Severe symptomatic left ventricular dysfunction
- Untreated life-threatening cardiac dysrhythmias (e.g., Ventricular Tachycardia/Fibrillation)
- Acute pericarditis, myocarditis or endocarditis
- Severe aortic stenosis (calculated effective orifice less than .75 cm^2 /m^2 BSA or a peak systolic pressure gradient exceeding 50 mg Hg in presence of normal cardiac output
- Severe arterial hypertension (generally > 200 mmHg systolic or 120 mmHg diastolic)
- Acute pulmonary embolus or infarction
- Acute thrombophlebitis or deep vein thrombosis
- Acute or serious noncardiac disorder
- Neuromuscular, musculoskeletal or arthritic condition that precludes exercise
- Uncontrolled metabolic disease, such as diabetes, thyrotoxicosis or myxedema

*In selected cases, testing may be performed by a skilled cardiologist, generally in a referral center.

CPT/HCPCS Section & Benefit Category

Medicine/Cardiovascular

Type of Bill Code

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

Revenue Codes

482 Stress Test

CPT/HCPCS Codes

93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
93016	physician supervision only, without interpretation and report
93017	tracing only, without interpretation and report
93018	interpretation and report only

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

391.0-391.9	Rheumatic fever with heart involvement
392.0	Rheumatic chorea with heart involvement
394.0-394.9	Diseases of mitral valve
395.0-395.9	Diseases of aortic valve
396.0-396.9	Diseases of mitral and aortic valves
398.0-398.99	Other rheumatic heart disease
402.00-402.91	Hypertensive heart disease
404.00-404.93	Hypertensive heart and renal disease
410.00-410.92	Acute myocardial infarction
411.0-411.89	Other acute and subacute forms of ischemic heart disease
412	Old myocardial infarction
413.0-413.9	Angina pectoris
414.00-414.9	Other forms of chronic ischemic heart disease
415.0-415.19	Acute pulmonary heart disease
416.0-416.9	Chronic pulmonary heart disease
424.0	Mitral valve disorders
424.1	Aortic valve disorders
426.0-426.9	Conduction disorders
427.0-427.9	Cardiac dysrhythmias
428.0-428.9	Heart failure
780.2	Syncope and collapse
780.4	Dizziness and giddiness
785.0-785.3	Symptoms involving cardiovascular system
786.00-786.09	Dyspnea and respiratory abnormalities
786.50-786.59	Chest pain
794.31	Abnormal electrocardiogram [ECG] [EKG]
E942.0-E942.9	Agents primarily affecting the cardiovascular system
V42.1	Organ or tissue replaced by transplant, heart
V45.81	Postsurgical aortacoronary bypass status
V67.00	Follow-up examination following surgery, unspecified

93015: Cardiovascular Stress Test (continued)

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

Florida Medicare does not cover cardiovascular stress testing as a screening test for coronary artery disease.

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

Based on a review of this service, it has been determined that this procedure requires constant supervision, monitoring, and emergency backup equipment. Therefore, it is generally expected that this service will be performed only in locations where emergency backup equipment is available.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the test. In addition, the results of the stress test must be available in the patient's medical record. This information is normally found in the office/progress notes, hospital notes, and/or test results.

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

ACP/ACC/AHA Task Force Statement. Clinical Competence in Exercise Testing: A statement for physicians from the ACP/ACC/AHA Task Force on Clinical Priveleges in Cardiology (1990). *Journal of American College of Cardiology,* 16 (5), 1061-1065.

American College of Cardiology/American Heart Association Task Force on Assessment of Cardiovascular Procedures. (Subcommittee on Exercise Stress Testing). Guidelines for exercise testing (1986). *Journal of American College of Cardiology*, 8(3), 725-38.

Braunwald, E., (1992). *Heart Disease: A Textbook of Cardiovascular Medicine* (4th ed.). Philadelphia: W.B. Saunders Company.

Fischback, F., (1996). *A Manual of Laboratory and Diagnostic Tests* (5th ed.). Philadelphia: J.B. Lippincott Company.

Schlant, R., and Alexander, R. (eds.). (1994). *The Heart: Arteries and Veins* (8th ed.). New York: McGraw-Hill Inc.

Advisory Committee Notes

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

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

05/01/2002

Revision History

Revision Number	2
Start Date of Comment Period	N/A
Start Date of Notice Period	05/01/2002 3rd Qtr 2002 *Bulletin*
Revised Effective Date	01/01/2002

Explanation of Revision: Effective 8/1/2000, procedure codes 93015, 93016, and 93018 were removed from the list of non-reportable procedures based on change request 1967 (transmittal A-01-134). This transmittal was effective 1/1/2002.

Revision Number	1
Start Date of Comment Period	N/A
Start Date of Notice Period	10/01/2000 Oct/Nov 2000 *Bulletin*
Revised Effective Date	10/01/2000

Explanation of Revision: Annual ICD-9-CM Update

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

J0635: Vitamin D Analogs in Chronic Renal Disease

Policy Number
J0635

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Vitamin D Analogs in Chronic Renal Disease

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
06/24/2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Vitamin D is a fat-soluble vitamin derived from natural sources (fish, liver oils) or from conversion of provitamins (7-dehydrocholesterol and ergosterol). In humans, natural supplies of vitamin D depend on ultraviolet light for conversion of 7-dehydrocholesterol to vitamin D_3 or ergosterol to vitamin D_2. Following exposure to ultraviolet light, vitamin D_3 must then be converted to the active form of vitamin D (calcitriol) by the liver and kidneys. Vitamin D is considered a hormone. Although not a natural human hormone, vitamin D_2 can substitute for D_3 in every metabolic step. Biologically active vitamin D metabolites control the intestinal absorption of dietary calcium, the tubular reabsorption of calcium by the kidney, and, in conjunction with parathyroid hormone (PTH), the mobilization of calcium from the skeleton. They act directly on bone cells to stimulate skeletal growth and on the parathyroid glands to suppress PTH synthesis and secretion. Vitamin D is also involved in magnesium metabolism.

In patients with renal failure, the decreased capacity to synthesize 1, 25-$(OH)_2D$ and to excrete phosphate causes secondary hyperparathyroidism. This results from the lowering of serum calcium by phosphate, the impairment of calcium absorption in the intestine, and the loss of the feedback inhibitory effect of 1, 25-$(OH)_2D$ on PTH production. Hyperparathyroidism is categorized by the severity of disease as determined by the PTH level: mild to moderate (200-600 pg/mL); moderate to severe (>600-1200 pg/mL), and overt severe (> 1200 pg/mL). Management of secondary hyperparathyroidism of chronic renal failure requires both prevention and treatment. The initial preventive focus is directed at maintaining serum calcium and phosphate levels within the normal range. Treatment involves the administration of calcium salts or that of active vitamin D derivatives. Prolonged treatment with active vitamin D derivatives requires regular monitoring to avoid the occurrence of complications such as deterioration of chronic renal failure, adynamic bone disease, and extraskeletal calcifications.

This policy addresses the parenteral forms of vitamin D that include Calcitriol (Calcijex®), Paricalcitol (Zemplar®), and Doxercalciferol (Hectorol®).

Indications and Limitations of Coverage and/or Medical Necessity

Calcitriol (Calcijex®) – J0635

Florida Medicare will consider parenteral Calcitriol medically reasonable and necessary for the following indications:

- Management of hypocalcemia in patients undergoing chronic renal dialysis. It is recommended that patients receive the oral form of a vitamin D analog prior to initiation of parenteral vitamin D. Reimbursement is not dependent on whether the patient has attempted oral vitamin D therapy.
- Management of hypocalcemia in patients undergoing chronic renal dialysis who develop hypercalcemia on the oral form of the drug. Hypercalcemia is defined as a serum calcium level greater than 11.2 mg/dL.
- Management of secondary hyperparathyroidism and resultant metabolic bone disease in patients with moderate to severe chronic renal failure (Ccr 15 to 55 ml/min) not yet on dialysis. It is recommended that patients receive the oral form of a vitamin D analog prior to initiation of parenteral vitamin D. Reimbursement is not dependent on whether the patient has attempted oral vitamin D therapy.
- Management of secondary hyperparathyroidism and resultant metabolic bone disease in patients with moderate to severe chronic renal failure (Ccr 15 to 15 ml/min) not yet on dialysis who develop hypercalcemia on the oral form of the drug. Hypercalcemia is defined as a serum calcium level greater than 11.2 mg/dL.

The recommended initial dose of parenteral Calcitriol is 1-2 mcg 3 times weekly approximately every other day. The dose may be increased by 0.5-1 mcg at 2 to 4 week intervals. Calcitriol should be discontinued if hypercalce-

J0635: Vitamin D Analogs in Chronic Renal Disease(continued)

mia or serum calcium times phosphate (Ca x P) produce totals > 70. Reinitiate at a lower dose. Doses may need to be reduced as the PTH levels decrease in response to therapy (see titration table in Facts and Comparisons).

Note: It is expected that patients taking oral Calcitriol received the recommended dosage as indicated in Facts and Comparisons (i.e., 0.25 mcg/day initially with titration of 0.25 mcg/day at 4-8 week intervals if needed).

Doxercalciferol (Hectorol®) – J1270

Florida Medicare will consider parenteral Doxercalciferol medically reasonable and necessary for the following indications:

- Reduction of elevated iPTH levels in the management of secondary hyperparathyroidism in patients undergoing chronic renal dialysis. It is recommended that patients receive the oral form of a vitamin D analog prior to initiation of parenteral vitamin D. Reimbursement is not dependent on whether the patient has attempted oral vitamin D therapy**.**
- Reduction of elevated iPTH levels in the management of secondary hyperparathyroidism in patients undergoing chronic renal dialysis who develop hypercalcemis on the oral form of the drug. Hypercalcemia is defined as a serum calcium level greater than 11.2 mg/dL.

The recommended initial dose of parenteral Doxercalciferol is 4.0 mcg three times a week or every other day for PTH levels >400. Dose titration is based on the following PTH levels:

PTH LEVEL	DOSE
Decreased by <50% & above 300	Increase by 1.0-2.0 mcg at 8 week intervals
150-300	Maintain current dose
< 100	Suspend times 1 week; resume at least 1.0 mcg lower

Note: It is expected that patients taking oral Doxercalciferol receive the recommended dosage as indicated in Facts and Comparisons (i.e., 10 mcgs three times a week with titration to lower blood iPTH levels into the range of 150-300 pg/ml).

Paricalcitol (Zemplar®) – J2500 and J3490

Florida Medicare will consider parenteral Paricalcitol medically reasonable and necessary for the following indications:

- Prevention and treatment of patients with secondary hyperparathyroidism associated with chronic renal failure. It is recommended that patients receive the oral form of a vitamin D analog prior to initiation of parenteral vitamin D. Reimbursement is not dependent on whether the patient has attempted oral vitamin D therapy.
- Prevention and treatment of patients with secondary hyperparathyroidism associated with chronic renal failure who develop hypercalcemia on the oral form of the drug. Hypercalcemia is defined as a serum calcium level greater than 11.2 mg/dL.

The currently accepted target range for intact parathyroid hormone (iPTH) levels of CRF patients is 1.5 to 3 times the non-uremic upper limit of normal. The recommended initial dose of parenteral Paricalcitol is 0.04-0.1 mcg/kg (2.8-7 mcg) administered as a bolus dose no more frequently than every other day at any time during dialysis. If a satisfactory response is not observed, the dose may be increased by 2 to 4 mcgs at 2 to 4 week intervals. If an elevated calcium level or a Ca x P product > 75 is noted, immediately reduce or interrupt the drug dosage until parameters are normalized and reinitiate at a lower dose. Doses may need to be reduced as the PTH levels decrease in response to therapy (see titration table in Facts and Comparisons).

Note: It is expected that patients taking an oral vitamin D analog receive the recommended dosage as indicated in Facts and Comparisons.

All three vitamin D derivatives treat the patient with secondary hyperparathyroidism associated with chronic renal failure by directly suppressing the synthesis and secretion of PTH. Because calcitriol, paricalcitol, and doxercalciferol produce the same clinical effects, reimbursement will be based on the drug that is the least costly when given for patients with secondary hyperparathyroidism (diagnosis code 588.8).

CPT/HCPCS Section & Benefit Category

Drugs Administered Other Than Oral Method

Type of Bill Code

Hospital – 13x
End Stage Renal Disease – 72x
Critical Access Hospital – 85x

Revenue Codes

250 Pharmacy, General Classification
636 Drugs Requiring Detailed Coding

CPT/HCPCS Codes

J0635 Injection, calcitriol, 1 mcg ampule
J1270 Injection, doxercalciferol, 1 mcg
J2500 Injection, paricalcitol, 5 mcg

Not Otherwise Classified Codes (NOC)

J3490 Injection, paricalcitol, 2 mcg

ICD-9-CM Codes that Support Medical Necessity

Calcitriol (Calcijex) – J0635

275.41 Hypocalcemia
588.8 Other specified disorders resulting from impaired renal function (secondary hyperparathyroidism [of renal origin])

Doxercalciferol (Hectorol®) – J1270 and Paricalcitol (Zemplar®) – J2500 and J3490

588.8 Other specified disorders resulting from impaired renal function (secondary hyperparathyroidism [of renal origin])

Diagnoses that Support Medical Necessity

N/A

J0635: Vitamin D Analogs in Chronic Renal Disease(continued)

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

Outpatient hospitals affected by outpatient prospective payment system (OPPPS) should bill the drugs identified in this policy with revenue code 250. All three vitamin D derivatives included in this policy are packaged into the APC rate; therefore, no additional payment will be made.

ESRD facilities must bill the drugs with the applicable HCPCS code under revenue code 636.

Documentation Requirements

Medical record documentation maintained by the performing provider must substantiate the medical necessity for the use of parenteral vitamin D analogs. The documentation must support the criteria as set forth in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy. This information is normally found in the office/progress notes, facility/hospital records, and/or laboratory results.

Utilization Guidelines

N/A

Other Comments

The information provided in the Facts and Comparisons identifies titration and administration of the vitamin D analogues based on the patient's calcium, phosphorus, Ca x P product, and PTH levels. The elevated serum phosphorus, calcium/phosphorus product and secondary hyperparathyroidism in patients substantially increase the incidence of cardiac, visceral, and peripheral vascular calcification seen in this population. The current management of the upper limit of Ca x P of 70 or 75 may no longer be acceptable. The following revised treatment goals in dialysis patients have been proposed: Ca x P < 55 mg^2/dL^2, phosphorus 2.5 – 5.5 mg/dL, calcium 9.2 – 9.6 mg/dL, and PTH 100 – 200 pg/mL.

The Facts and Comparisons also indicates that dosing is calculated based on the patient's weight. Newer studies are being conducted to determine whether titration of the analogues demonstrate a more desirable clinical response using a formula (e.g., PTH level/80) rather than the patient's weight.

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 Nephrologists.

Start Date of Comment Period

06/18/2001

End Date of Comment Period

08/02/2001

Start Date of Notice Period

05/01/2002

Revision History

Revision Number:	Original
Start Date of Comment Period:	06/18/2001
Start Date of Notice Period:	05/01/2002
	3rd Qtr 2002 *Bulletin*
Original Effective Date	06/24/2002 ❖

J1561: Intravenous Immune Globulin

Revision Overview: "Indication and Limitations of Coverage and/or Medical Necessity," "Type of Bill Code," and "Documentation Requirements" sections of the policy have been revised. In addition, the "Coding Guidelines" section has been revised to reflect changes in the outpatient prospective payment system.

Policy Number
J1561

Contractor Name
First Coast Service Options, Inc.

Contractor Number
090

Contractor Type
Intermediary

LMRP Title
Intravenous Immune Globulin

AMA CPT Copyright Statement

CMS National Coverage Policy
Medicare Intermediary Manual, Sections 3101.3 and 3112.4

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
01/19/1995

Original Policy Ending Date
N/A

Revision Effective Date
09/28/2001

Revision Ending Date
09/27/2001

LMRP Description
Intravenous Immune Globulin (IVIG) is a solution of human immunoglobulins specifically prepared for intravenous infusion. Immunoglobulin contains a broad range of antibodies that specifically act against bacterial and viral antigens.

Indications and Limitations of Coverage and/or Medical Necessity
The use of intravenous immune globulin should be reserved for patients with serious defects of antibody function. The goal is to provide immunoglobulin G (IgG) antibodies to those who lack them. Florida Medicare will provide coverage for intravenous immune globulin when it is used in treatment of the following conditions:

1. Immunodeficiency Disorders

a) Primary Humoral Immunodeficiency Syndromes

IVIG is indicated for the treatment of patients with primary immunodeficiency syndromes such as common variable immunodeficiency (CVID), congenital agammaglobulinemia (X-linked agammaglobulinemia), severe combined immunodeficiency (SCID), X-linked immunodeficiency with hyperimmunoglobulin M (IgM), and Wiskott-Aldrich syndrome to replace or boost immunoglobulin G (IgG).

- Common variable immunodeficiency (CVID) (also known as acquired hypogammaglobulinemia, adult-onset hypogammaglobulinemia, and dysgammaglobulinemia) is characterized by reduced serum immunoglobulins, impaired antibody responses, and heterogenous clinical features. It is a rare syndrome, affecting one in 50,000 to one in 200,000 people. In most patients, the onset is in the second or third decade of life. The most common clinical presentation of CVID is an increased susceptibility to infection. Most patients experience severe recurrent and/or chronic sinopulmonary infections such as bronchitis, pneumonia, or bronchiectasis. Patients with CVID can also develop a variety of autoimmune and inflammatory disorders and are also at risk for inflammatory bowel disease. Once the diagnosis of CVID is suspected based on clinical presentation, laboratory confirmation should be made. A low serum IgG level is the most consistent laboratory abnormality in CVID, with most patients having concurrent deficiencies of IgA and IgM. However, there are rare instances when a patient will have normal IgG levels. Therefore, the serum immunoglobulin measurement alone does not establish a diagnosis of CVID. A definitive diagnosis of CVID is established when a patient does not demonstrate an antibody response to immunization with protein antigens (e.g., tetanus) or carbohydrate antigens (e.g., pneumococcal capsular polysaccharides such as pneumovax).

Therefore, Florida Medicare requires the following diagnostic evidence to support a diagnosis of CVID:

– Laboratory reports demonstrating a normal to low IgG level for the assay utilized; and
– Laboratory reports demonstrating a lack of ability to produce an antibody response to protein or carbohydrate antigens (e.g., tetanus, pneumococcal capsular polysaccharides such as pneumovax).

Florida Medicare will not provide reimbursement for the initiation or continuation of intravenous immune globulin therapy based solely on a low IgG value, or for patients with mild sinopulmonary disease, or for those that do not demonstrate a

J1561: Intravenous Immune Globulin (continued)

lack of ability to produce an antibody to protein or carbohydrate antigens. IVIG therapy for patients with normal humoral immunity but recurrent infections, particularly upper respiratory infections, has no scientific rationale.
The dosing regimen for patients with CVID is not standardized, but is based primarily on the clinical response. Trough levels of IgG and functional antibody levels should also be taken into consideration in the management of the IVIG therapy. A patient will generally receive initial IVIG doses of 200-400 mg/kg/3 to 4 weeks. IVIG replacement in these patients is usually life-long.

- Congenital agammaglobulinemia (X-linked agammaglobulinemia) is an inherited deficiency that appears in the first 3 years of life and occurs in one out of 10,000 people. Quantitative immunoglobulins show marked deficits or absence of all five immunoglobulin classes. Peripheral blood B-lymphocytes are usually absent.
- Severe combined immunodeficiency (SCID) is a rare and fatal inherited syndrome that has an incidence of approximately one in 1,000,000 people. The typical case involves an infant less than one year of age. The lymphocyte counts are significantly below normal, the levels of B- and T-lymphocytes are absent or below normal, the lymphocyte response to mitogen is absent or below normal, and the quantitative measurements of IgG, IgA, and IgM show marked deficits.
- X-linked immunodeficiency with hyperimmunoglobulin M (IgM) is similar to X-linked agammaglobulinemia, however, these patients sometimes have lymphoid hyperplasia. The concentrations of serum IgG, IgA, and IgE are very low, whereas the serum IgM concentration is either normal or, more frequently, greatly elevated and polyclonal.
- Wiskott-Aldrich syndrome is an X-linked recessive syndrome characterized by eczema, thrombocytopenia purpura with normal-appearing megakaryocytes but small defective platelets, and undue susceptibility to infection. Patients usually present during infancy. Survival beyond the teens is rare.

b) Idiopathic Thrombocytopenic Purpura (ITP)
Idiopathic thrombocytopenic purpura (ITP) is a decrease in the circulating number of platelets in absence of toxic exposure or other disease associated with a low platelet count. It occurs as an effect of peripheral platelet destruction. Acute ITP is a disease of childhood, which usually follows an acute infection and has spontaneous resolution within 2 months. Chronic ITP is a disease, which persists after 6 months without a specific cause. It is usually seen in adults and persists for months to years.
Patients with platelet counts >50,000 should not be given IVIG. IVIG is also inappropriate for patients with platelet counts >30,000 who are asymptomatic or have only minor purpura.

IVIG is indicated for ITP under the following circumstances:

- When administered preoperatively for patients undergoing elective splenectomy, who have platelet counts <20,000.
- For patients with platelet counts <30,000 who have active bleeding.
- For pregnant women with platelet counts <10,000 in the third trimester.
- For pregnant women with platelet counts 10,000-30,000 who are bleeding.

The duration of treatment is generally a short course of 3 to 5 days.

c) Pediatric Human Immunodeficiency Virus (HIV) Infection
IVIG is indicated for use in HIV-infected children (less than 13 years of age) with a CD-4 lymphocyte count of greater than or equal to 200/mm3 to reduce the risk of serious bacterial infections. Laboratory reports must demonstrate an IgG level that is below the normal age-related ranges for the assay utilized. There must also be evidence of a lack of ability to produce an antibody response to immunization with protein antigens (e.g., tetanus) or carbohydrate antigens (e.g., pneumococcal capsular polysaccharides such as pheumovax). IVIG is *not* indicated for use in adult HIV patients (13 years of age and older).

2. Neurological Disorders

IVIG is indicated for the treatment of patients with neurological disorders such as Guillain-Barre' syndrome, relapsing-remitting multiple sclerosis, chronic inflammatory demyelinating polyneuropathy, myasthenia gravis, refractory polymyositis and refractory dermatomyositis. However, it is noted that not all patients with these diagnoses require treatment with IVIG.

For each of these diseases, the diagnosis of the disorder must be unequivocal. There must be clinical (history, quantitative examination), electrophysiological motor-sensory nerve conductions, electromyography (EMG), cerebrospinal fluid (CSF), and when necessary biopsy (muscle-nerve) data to support the diagnosis.

IVIG therapy will only be considered medically reasonable and necessary for the following neurological diseases when there is evidence of rapid progression of the disease or relapse.

Once treatment is initiated, we expect meticulous documentation of progress. If there is initial improvement, and continued treatment is necessary, then some type of quantitative assessment to monitor the progress is required (e.g., ADL measurements). Changes in these measures must be clearly documented. Subjective or experiential improvement alone is insufficient to either continue IVIG or to expect coverage.

There must be an attempt made to wean the dosage when improvement has occurred. There must be an attempt to stop the IVIG infusion if improvement is sustained with

J1561: Intravenous Immune Globulin (continued)

dosage reduction. If improvement does not occur with IVIG, then infusion should not continue.

- Guillain-Barre' syndrome is an acute, frequently severe, and fulminant polyneuropathy that occurs at a rate of approximately one case in a million per month. An infection generally precedes the onset of neuropathy by 1 to 3 weeks. A small proportion occur within 1 to 4 weeks of a surgical procedure. The clinical features include ascending paralysis, areflexia (absence of reflexes), possibly ascending sensory loss, and high spinal fluid protein levels. Intravenous administration of high-dose immunoglobulin given over 5 days has been proven effective.
- Multiple Sclerosis that is relapsing-remitting is characterized by unpredictable recurrent attacks of neurological dysfunction. Attacks generally evolve over days to weeks and may be followed by complete, partial, or no recovery. Patients with a relapsing-remitting course experience no progression of neurological impairment between attacks. The age of onset is generally between 15 and 60 years.
- Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) includes a group of chronic progressive or relapsing, inflammatory demyelinating peripheral neuropathies that are manifested by physiological abnormalities such as slowed nerve conduction velocities or dispersion of compound muscle action potentials. Clinical features include chronic progressive or relapsing weakness with sensory loss and high spinal fluid protein levels.
- Myasthenia gravis is a disorder of neuromuscular transmission characterized by fluctuating weakness and fatigability. It is attributed to blockage of the acetylcholine receptor at the neuromuscular end-plates by anti-acetylcholine receptor autoantibodies.

  The diagnosis of myasthenia gravis is confirmed by a positive Tensilon test. Anticholinesterase drugs or thymectomy are generally the first treatments for this condition.

  IVIG is indicated in those patients with myasthenia gravis who are either **refractory** to corticosteroids over a 6 week period; have been unable to successfully taper corticosteroids below moderately high doses; or develop **severe** side effects due to steroid therapy; **and** have also failed at least one immunosuppressive agent (e.g., azathiprime, Methotrexate, cyclophosphamide, cyclosperine). Length of treatment with IVIG will vary due to the remittent and recurrent nature of this condition.
- Polymyositis and dermatomyositis are conditions in which the skeletal muscle is damaged by a nonsuppurative inflammatory process dominated by lymphocytic infiltration. Polymyositis begins acutely or insidiously with muscle weakness, tenderness, and discomfort. It affects proximal muscles more often than distal muscles. Dermatomyositis involves characteristic skin changes that may precede or follow the muscle syndrome and include a localized or diffuse erythema, maculopapular eruption, scaling eczematoid dermatitis, or rarely, an exfoliative dermatitis. The classic lilac-colored (heliotrope) rash is on the eyelids, bridge of the nose, cheeks (butterfly distribution), forehead, chest, elbows, knees and knuckles, and around the nailbeds. Periorbital edema is frequent.

  Diagnostic studies to support a diagnosis of polymyositis or dermatomyositis include an elevated creatine phosphokivase (CPK), an abnormal electromyography (EMG), and/or an abnormal muscle biopsy.

  IVIG is indicated in those patients with polymyositis or dermatomyositis who are either **refractory** to corticosteroids over a 6 week period; have been unable to successfully taper corticosteroids below moderately high doses; or develop **severe** side effects due to steroid therapy; **and** have also failed at least one immunosuppressive agent (e.g., azathioprime, Methotrexate, cyclophosphamide, cyclosperine). Length of treatment with IVIG will vary due to the remittent and recurrent nature of these conditions. The need for continuation of IVIG must be documented and would be demonstrated by continued decreased muscle strength, elevated CPKs, and/or EMG abnormalities.

  Note: For patients who are unable to tolerate corticosteroid or immunosuppressive agents, or in the rare instance that these agents are contraindicated for the patient, treatment for polymyositis or dermatomyositis will be covered only if documentation is maintained in the patient's medical record that clearly indicates the reason that the patient cannot take the corticosteroid or immunosuppressive agent.

3. Other Disorders

a) Chronic Lymphocytic Leukemia
Chronic lymphocytic leukemia is a disorder of accumulation of mature-appearing lymphocytes in blood marrow and other organs. The symptoms usually develop gradually and include fatigue, shortness of breath with activity, weight loss, or frequent infections of the skin, lungs, kidneys, or other sites. Recurrent infections are a frequent complication.
IVIG is indicated for the prevention of recurrent bacterial infections in patients with hypogammaglobulinemia associated with B-cell chronic lymphocytic leukemia (CLL) in order to help correct the patient's immunity deficiency.

b) Bone Marrow Transplantation (BMT)
IVIG is indicated to prevent the risk of acute graft-versus-host disease, associated interstitial pneumonia

J1561: Intravenous Immune Globulin (continued)

(infectious or idiopathic) and infections (e.g., cytomegalovirus infections [CMV], varicella-zoster virus infection, and recurrent bacterial infection) after BMT in patients 20 years of age or older in the first 100 days after transplantation. It is not indicated in BMT patients younger than 20 years of age, nor is it recommended for autologous transplants.

c) Kawasaki Disease (mucocutaneous Lymph Node Syndrome)
Kawasaki disease is an acute childhood vasculitis, the diagnosis of which is made based on clinical criteria. These criteria include fever of at least 5 days duration and at least 4 of the following: (1) polymorphic exanthem, (2) changes in the oropharynx such as fissured lips and strawberry tongue without discrete lesions, (3) changes in the extremities such as edema of the hands and feet and erythema of the palms and soles, (4) bilateral conjunctival infection without exudate, and (5) cervical lymphadenopathy, often singular and unilateral. IVIG is indicated for the treatment of Kawasaki disease when used in conjunction with aspirin.

d) Autoimmune Hemolytic Anemia
Autoimmune hemolytic anemia is an acquired anemia induced by binding of autoantibodies and/or complement to the red cells. Signs and symptoms may include, but are not limited to, weakness, fatigue, exertional dyspnea, pallor, jaundice, tachycardia, splenomegaly, hepatomegaly, and anemia. In the majority of patients, this disease is controlled by steroid therapy alone, by splenectomy, or by a combination.

Intravenous immune globulin is indicated only for those patients who have failed to respond to other forms of therapy and/or require rapid cessation of hemolysis due to severe or life threatening manifestatons of this condition. Duration of treatment is generally a short course of 3-5 weeks.

e) Autoimmune Neutropenia
Autoimune neutropenia is a hematologic disorder in which there is a decreased number of neutrophilic leukocytes in the blood due to an autoimmune mechanism. The disease is usually benign and self-limiting, and does not require treatment with IVIG. Occasionally, however, it is marked by repeated infection. IVIG may be recommended for the treatment of an absolute neutrophil count less than 800mm; with recurrent bacterial infections.

CPT/HCPCS Section & Benefit Category
Drugs and Biologicals

Type of Bill Code
Hospital – 12x, 13x
Skilled Nursing Facility – 21x, 22x, 23x
End Stage Renal Disease – 72x
Comprehensive Outpatient Rehabilitation Facility – 75x
Critical Access Hospital – 85x

Revenue Codes
Drugs Requiring Detailed Coding – 636

CPT/HCPCS Codes
J1561 Injection, immune globulin, intravenous, 500 mg
J1563 Injection, immune globulin, intravenous, 1g

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

042	Human immunodeficiency virus (HIV) disease (in children)
204.10-204.11	Chronic lymphoid leukemia (with associated hypogammaglobulinemia)
279.04	Congenital hypogammaglobulinemia (X-linked agammaglobulinemia)
279.05	Immunodeficiency with increased IgM (X-linked with hyper IgM)
279.06	Common variable immunodeficiency (CVID)
279.12	Wiskott-Aldrich syndrome
279.2	Combined immunity deficiency (SCID)
283.0	Autoimmune hemolytic anemias
287.3	Primary thrombocytopenia (Idiopathic Thrombocytopenic Purpura (ITP)
288.0	Agranulocytosis (Autoimmune neutropenia)
340	Multiple sclerosis (relapsing-remitting)
357.0	Acute infective polyneuritis (Guillian-Barre' syndrome)
357.8	Inflammatory and toxic neuropathy, other (Chronic inflammatory demyelinating polyneuritis [CIDP])
358.0	Myasthenia gravis
446.1	Acute febrile mucocutaneous lymph node syndrome (MCLS, Kawasaki disease)
710.3	Dermatomyositis (refractory)
710.4	Polymyositis (refractory)
996.85	Complications of transplanted organ, bone marrow

Diagnosis that Support Medical Necessity
N/A

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

Diagnosis that DO NOT Support Medical Necessity
N/A

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

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

Noncovered Diagnosis
N/A

J1561: Intravenous Immune Globulin (continued)

Coding Guidelines

All hospital, skilled nursing facility, ESRD facility and critical access hospital providers of service must bill Intravenous Immune Globulin under Revenue Code 636 - Drugs requiring detailed coding. In addition, HCPC J1561 or J1563 must be included to identify which product was administered. However, effective April 1, 2002, under outpatient prospective payment system (OPPS) only HCPC J1561 is to be used, instead of HCPC J1563. ESRD facility providers must bill procedure code X0051 for gamimune N 5% - 500 mg. Comprehensive outpatient rehabilitation facility (CORF) providers may bill this service if it is directly related to the skilled rehabilitation services required by the beneficiary.

IV immune globulin may be billed by an ESRD facility only if it is actually administered in the facility by the facility staff. Staff time used is covered under the composite rate and may not be billed separately. However, the supplies used to administer this drug may be billed in addition to the composite rate.

Documentation Requirements

Medical record documentation maintained by the treating physician/facility must clearly document the medical necessity to initiate intravenous immune globulin therapy and the continued need thereof. Required documentation of medical necessity should include:

- history and physical;
- office/progress note(s);
- applicable test results with written interpretation;
- an accurate weight in kilograms should be documented prior to the infusion since the dosage is based mg/kg/ dosage; and
- prior treatment therapies (where appropriate or referenced by this policy).

In addition, medical record documentation maintained by the treating physician/facility for claims billed with a diagnosis of CVID must include the following: the initial presenting IgG levels and evidence that the patient has been vaccinated with pneumovax and has had pre-and post-vaccine pneumococcal antibody titers performed to demonstrate the lack of ability to produce an antibody response to protein or carbohydrate antigens.

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

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information and Basis for Decision

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

Advisory Committee Notes

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

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

05/01/2002

Revision History

Revision Number	9
Start Date of Comment Period	N/A
Start Date of Notice Period	05/01/2002 3rd Qtr 2002 *Bulletin*
Revised Effective Date	04/01/2002

Explanation of Revision: Change Request 2102 (Transmittal A-02-026) dated March 28, 2002 indicates that under the outpatient prospective payment system, HCPC J1561 is to be used instead of HCPC J1563 effective April 1, 2002. The "Coding Guidelines" section of the policy has been revised to reflect this change.

Revision Number	8
Start Date of Comment Period	N/A
Start Date of Notice Period	05/01/2002 3rd Qtr 2002 *Bulletin*
Revised Effective Date	09/28/2001

Explanation of Revision: Deletion of requirement for a radiological or CT report as diagnostic evidence to support a diagnosis of CVID. The addition of language allowing treatment of polymyositis and dermatomyositis with IVIG when the patient cannot tolerate corticosteroids or immunosuppressive agents or when these agents are contraindicated for the patient as long as the medical record indicates the reason the patient cannot take the agent(s). These changes are effective for claims processed on or after 09/28/2001.

Revision Number	7
Start Date of Comment Period	06/01/2000
Start Date of Notice Period	08/01/2001 4th Qtr 2001 *Bulletin*
Revised Effective Date	09/28/2001

Explanation of Revision: Policy revised to provide clarification regarding diagnostic criteria for conditions, as well as to revise the list of approved indications for IVIG.

Revision Number	6
Start Date of Comment Period	N/A
Start Date of Notice Period	05/01/2001 3rd Qtr 2001 *Bulletin*
Revised Effective Date	02/20/2001

Explanation of Revision: Explanation of Revision: Addition of ICD-9-CM code 340 (Multiple sclerosis) to the policy as a covered indication.

Revision Number	5
Start Date of Comment Period	12/22/2000
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. ❖

72192: Computerized Tomography of the Pelvis—Correction to Article

An article to communicate an addition to the local medical review policy for Computerized Tomography of the Pelvis – 72192 was published in the First Quarter 2002 *Medicare A Bulletin* (page 78). In that article, the diagnosis for abdominal pain, unspecified site was printed incorrectly as 789.0. The correct diagnosis code to be added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy is 789.00 – Abdominal pain, unspecified site. ❖

84436: Thyroid Function Tests—Addition to Policy

The local medical review policy for Thyroid Function Tests – 84436 was published in the December 1999 Special Issue *Medicare A Bulletin* (pages 29-31). Since that time, the following diagnosis codes have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy:

354.0	Carpal tunnel syndrome
E942.0	Agents primarily affecting the cardiovascular system, cardiac rhythm regulators

ICD-9-CM diagnosis code 783.4 – Lack of expected normal physiological development in childhood was expanded to specificity 783.40 - 783.43.

In addition, revisions to the "Type of Bill Code" section of the policy were made: rural health clinic–71x was deleted and critical access hospital – 85x was added to the policy.

This revision is effective for claims processed **on or after March 15, 2002.** ❖

94010: Spirometry—Addition to Policy

The local medical review policy for Spirometry – 94010 was published in the First Quarter 2002 *Medicare A Bulletin* (pages 56-59). Since that time, the following diagnosis codes have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy:

500, 501, 502, 503, 504, 505, 506.4, 506.9.

This addition is effective for services processed **on or after April 24, 2002.** ❖

In addition, critical access hospital – 85x has been added to the " Type of Bill Code" section of the policy. ❖

84100: Serum Phosphorus—Addition to Policy

The local medical review policy for Serum Phosphorus – 84100 was published in the First Quarter 2001 *Medicare A Bulletin* (pages 25-27). Since that time, diagnosis code 275.3 for disorders of phosphorus metabolism has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy effective for claims processed **on or after February 8, 2002**

Effective for claims processed **on or after April 18, 2002,** the following diagnosis codes have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy:

403.01, 403.11, 404.02,
404.03, 404.12, 404.13. ❖

85651 Sedimentation Rate, Erythrocyte—Addition to policy

The local medical review policy for Sedimentation Rate, Erythrocyte – 85651 was published in the February 25, 1997 *Medicare A Bulletin* (pages 1-6). Since that time, the ICD-9-CM diagnosis code 783.21 – loss of weight has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy.

This revision is effective for claims processed **on or after April 4, 2002.** ❖

87086: Urine Bacterial Culture—Revision to Policy

The local medical review policy for Urine Bacterial Culture – 87086 was published in the December 1999/ January 2000 *Medicare A Bulletin* (pages 22-23). Since that time, revenue code 28x has been removed from the policy.

This revision is effective for claims processed **on or after March 29, 2002.** ❖

94240: Functional Residual Capacity or Residual Volume—Addition to Policy

The local medical review policy for Functional Residual Capacity or Residual Volume – 94240 was published in the First Quarter 2002 *Medicare A Bulletin* (pages 60-62). Since that time, the following diagnosis codes have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy:

500, 501, 502, 503, 504, 505, 506.4, 506.9.

This addition is effective for services processed **on or after April 24, 2002.**

In addition, critical access hospital – 85x has been added to the " Type of Bill Code" section of the policy. ❖

97003: Occupational Therapy Policy for Rehabilitation Services—Addition to Policy

The local medical review policy Occupational Therapy Policy for Rehabilitation Services – 97003 was published in the Second Quarter 2002 *Medicare A Bulletin* (pages 38-46). Since that time, there have been a few revisions made to the policy.

The following statement was added to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy:

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 section regarding "plans of care" was revised as follows:

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.

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. ❖

J9999: Antineoplastic Drugs—Addition to Policy

The complete local medical review policy (LMRP) for Antineoplastic Drugs – J9999 was published in the First Quarter 2002 *Medicare A Bulletin* (pages 70-77). Since that time, Rituximab – J9310 has received an additional indication, chronic lymphoid (lymphocytic) leukemia. **Effective for services processed on or after April 17, 2002,** ICD-9-CM codes 204.10-204.11 have been added to the policy for J9310.

In addition, critical access hospital – 85x has been added to the " Type of Bill Code" section of the policy. ❖

Delay in Implementation of Outpatient Pulmonary Rehabilitation Services in Chronic Respiratory Disease Policy

The local medical review policy (LMRP) for Pulmonary Rehabilitation Services was published in the February 2002 *Medicare A Bulletin Special Issue* (pages 3-10). Implementation of the policy was to be April 22, 2002; however, due to additional comments received from the provider community, implementation is delayed until further notice. Please continue to refer to our provider Web site - *www.floridamedicare.com* – and the *Medicare A Bulletin* for future information regarding the Pulmonary Rehabilitation Services LMRP. Florida Medicare apologizes for any inconvenience this delay may cause. ❖

Revision to Local Medical Review Policies

The following policy revisions are related to the implementation of outpatient prospective payment system and skilled nursing facility prospective payment system as well as the establishment of critical access hospitals in Florida.

Colonoscopy – A44388

Added type of bill code 85x

Ocular Photodynamic Therapy (OPT) with Verteporfin – A67221

Deleted revenue code 361 and replaced it with revenue code 360
Added type of bill code 85x

Bone Mineral Density Studies – A76075

Deleted type of bill codes 71x and 72x
Added type of bill codes 21x and 85x
Added type of bill information to the "Coding Guidelines" section of the policy

Diagnostic Mammography – A76090

Added type of bill codes 12x, 13x, and 85x

Screening Mammograms – A76092

Added type of bill codes 12x, 13x, and 85x
Type of bill information was deleted from the "Coding Guidelines" section of the policy

Fecal Occult Blood Testing – A82270

Deleted type of bill codes 71x and 72x
Added type of bill code 85x

Cardiac Output by Electrical Bioimpedance – A93701

Deleted type of bill code 71x
Added type of bill codes 12x and 85x
Type of bill information was deleted from the "Coding Guidelines" section of the policy

Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator – A93724

Added type of bill codes 12x, 14x, 21x, and 85x

Allergen Immunotherapy – A95115

Added type of bill codes 21x and 85x

Occupational Therapy Policy for Rehabilitation Services – A97003

Type of bill information was deleted from the "Coding Guidelines" section of the policy

Complex Decongestive Physiotherapy – A97110

Type of bill information was deleted from the "Coding Guidelines" section of the policy

Dysphagia/Swallowing Diagnosis and Therapy – ADYSPHRT

Deleted type of bill code 71x
Added type of bill code 85x
Added statement (only applicable for G0195 and G0196) next to type of bill code 74x
Changes were made to the "Reasons for Denials" section of the policy

Self-Administered Drugs – AJ0001

Deleted type of bill codes 12x, 14x, 22x, 71x, and 72x
Added type of bill code 85x

Thyrotropin Alfa (Thyrogen®) – AJ3240

Deleted type of bill code 71x
Added type of bill code 85x

Hemophilia Clotting Factors – AJ7190

Deleted type of bill codes 22x and 71x
Added type of bill code 85x

This revisions are effective for services processed **on or after March 29, 2002.** ❖

FRAUD AND ABUSE

Four "Rights" Can't Be Wrong

The federal government, its agencies and contractors are not embarked on a "witch hunt" to arbitrarily prosecute health care providers for suspected wrongdoing. As a contractor for the federal government, First Coast Service Options, Inc. (FCSO) is responsible for ensuring the integrity of the Medicare program. Our mission is clear: "Pay the right amounts to the right providers for the right services on behalf of the right beneficiaries."

FCSO believes the majority of our customers, that is, health care providers and people with Medicare, are honest and do not abuse the Medicare program. Therefore, the actions FCSO takes as a Medicare contractor when improper payments are identified must be fair and appropriate. FCSO employs a number of processes, both proactive and reactive, to help the contractor identify and address improper payments. For example:

- There are numerous "edits" within the claim processing system and medical policies that help the contractor identify and prevent inappropriate payments. Some "edits" are designed to automatically deny payment based on the information on the claim and others prompt to review the claim to ensure the services are appropriate for the patient.
- FCSO receives numerous complaints of alleged fraudulent activities on a regular basis. Before any punitive measures are considered, the obvious—billing errors, payment errors, or misunderstandings of information is ruled out. The findings of the research will determine the course of action to take: correcting claims information, collecting monies paid in error, and/or providing clarification to our customers. If fraud is suspected, further research is conducted to substantiate or negate the allegations.
- FCSO analyzes claim submissions for aberrancies or unusual billing patterns. The identification of such occurrences does not automatically indicate potential fraud. Rather, it provides the basis for researching why a particular aberrancy or billing pattern is occurring. Again, the results of the research will determine the course of action whether it is education, review of claims for medical necessity, collection of overpaid funds, investigation of suspected fraudulent activities, or nothing at all.

The work FCSO does to protect the Medicare program is considered by some to be less than effective. To the contrary, FCSO's collective efforts during fiscal year 2001 resulted in $523.2 million in savings to the Medicare program. In terms of efficiency, for every tax dollar spent on safeguards activities, $18 was returned to the Medicare program. In addition, the work contributed toward the prosecution of health care fraud cases in 2001 resulted in over $165 million in fines, restitution, penalties, and settlements.

FCSO is proud of the contributions to protecting the Medicare program and the contractor is committed to ensuring that taxpayer dollars are used as they should be—to care for those who need it. ❖

Medicare Fraud Alert: Inappropriate Billing of Free Samples or Items

Federal regulations do not prohibit sales representatives from a pharmaceutical company or durable medical equipment supply company, to furnish free samples or items to physician practices, hospitals, or other health care providers and suppliers for their use. Regulations also do not prohibit health care providers from furnishing these free samples or items to their patients as part of their care. However, it is *not* appropriate for the health care provider to submit claims for payment to Medicare for furnishing such free samples or items. Such an activity may constitute a violation of the False Claims Act, as the provider is claiming payment for items for which no expenses are incurred. In addition, this activity may be considered a violation of the Anti-Kickback Statutes, as the sales representatives' intent for furnishing free samples or items appears questionable. That is, it gives the appearance sales representatives are expecting the provider to purchase or endorse their products, in return for billing for the free samples or items.

It is understood that receiving free samples and items from sales representatives is a common business practice. However, regardless of the circumstances, health care providers may not request payment for these free samples and items from the Medicare program. ❖

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

2002 Update of the Hospital Outpatient Prospective Payment System

In the December 2001 *Medicare A Bulletin* Special Issue (page 23), hospitals and community mental health centers (CMHCs) were notified of the delay in the implementation of the 2002 outpatient prospective payment system (OPPS) rate update. As a result of the delay, hospitals and CMHCs were not to submit claims for OPPS services using new 2002 HCPCS codes (which includes new 2002 HCPCS modifiers) during the period of the delay. Instead, because of the delay, hospitals and CMHCs were to use 2001 HCPCS codes and modifiers to bill for OPPS services.

The 2002 outpatient prospective payment system rate update was implemented for services furnished **on or after April 1, 2002.** Unless otherwise noted, all the changes describe in this notification are effective for services furnished **on or after April 1, 2002.**

Coding and Billing for Services Furnished on or after January 1, 2002 through March 31, 2002 Payable under the OPPS

As a result of the delay in the 2002 OPPS update, special billing requirements apply for services furnished on or after January 1, 2002 through March 31, 2002.

- For services furnished on or after January 1, 2002 through March 31, 2002, payable under the OPPS, hospitals are to use the same HCPCS codes and modifiers that they used during 2001. For services that were not covered under the OPPS in 2001, but that are covered in 2002, hospitals must use 2001 HCPCS codes and modifiers that most closely describe the services furnished in order to receive payment for this period.
- Hospitals and CMHCs are not to use 2002 HCPCS codes or modifiers to bill for services furnished on or after January 1, 2002 through March 31, 2002, that are paid under the OPPS.
- Claims that contain any new 2002 HCPCS codes or modifiers for dates of service preceding April 1, 2002, were returned unprocessed to the provider. Provider must resubmit the claim within the timeframes specified in section 3307 of the *Medicare Intermediary Manual* (MIM) utilizing a 2001 HCPCS code(s) and/or modifiers(s) that most closely describe the service(s) furnished.
- Coverage and billing instructions issued prior to December 21, 2001, that reflect a January 1, 2002 effective date for new 2002 codes payable under the OPPS, are effective April 1, 2002, for hospitals and CMHCs.

Beneficiary Copayment Changes

For calendar year 2002, the national unadjusted copayment amount for an ambulatory payment classification (APC) is limited to 55 percent of the APC payment rate established for a procedure or service. In addition the wage-adjusted copayment amount for a procedure or service cannot exceed the inpatient hospital deductible amount for 2002 of $812. These changes were implemented by changes to the OPPS PRICER effective for services furnished on or after January 1, 2002.

Extension of Election Period for Elections to Reduce Beneficiary Copayments

Generally, hospitals are required to notify their fiscal intermediaries (FI) of their elections to reduce beneficiary copayments by no later than the December 1st preceding the calendar year for which the election is effective. Because the final rule on OPPS payment rates for 2002 was not published until March 1, 2002, providers were unable to make election decisions for 2002 by December 1 preceding the year the payment rates become effective, the typical deadline for making such elections. The deadline for providers to make elections to reduce beneficiary copayments for 2002 was extended until April 1, 2002. The elections will be effective for services furnished on or after April 1, 2002.

Transitional Corridor Payments for Children's Hospitals

Children's hospitals that are excluded from the inpatient hospital prospective payment system will receive the same transitional corridor hold-harmless protection as cancer hospitals under the OPPS.

The recently published regulations were updated to reflect this change, however, this change was effective retroactively to August 1, 2000. Implementing instructions for this change were included in PM A-01-15 issued on January 29, 2001, to address a number of changes to the OPPS required under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

Change in Services Covered within the Scope of the OPPS

Medicare excludes from payment under the OPPS, covered Part B-only services furnished to inpatients when they are furnished by a hospital that does no other Medicare billing for hospital outpatient services under Part B. The Part B-only services, which are payable for hospital inpatients who have either exhausted their Part A benefits or who are not entitled to Part A benefits are specified in section 3110 Part A of the MIM, and in section 228 of the *Medicare Hospital Manual*. These services include, but are not limited to, diagnostic tests; X-ray and radioactive isotope therapy; surgical dressings; limb braces and trusses, and artificial limbs and eyes. Medicare payment for excluded Part B-only services furnished by these hospitals will be determined using the method under which the hospital was paid prior to OPPS.

2002 Update of the Hospital Outpatient PPS (continued)

Hospitals must notify their FI if they do not submit claims for outpatient Part B services, so that their claims can be excluded from the OPPS. Once a hospital notifies their FI that they furnish only inpatient Part B services, the hospital must also notify the FI in the future if their situation changes and they begin to furnish Part B outpatient services.

Change in Hospitals Excluded from the OPPS

The OPPS final rule for 2002 clarified that Medicare excludes from the OPPS, hospitals that are located outside the 50 States or the District of Columbia or Puerto Rico; that is, hospitals in Guam, Saipan, American Samoa, and the Virgin Islands. This policy is consistent with their current exclusion from the inpatient PPS and will also save these hospitals from billing system revisions.

Although Medicare discussed exclusion of hospitals located in Guam, Saipan and American Samoa in Program Memorandum A-00-36 issued in June 2000, Medicare failed to discuss the exclusion of hospitals located in the Virgin Islands. These hospitals are to be excluded from OPPS effective January 1, 2002.

Outlier Payments Calculated on a Service-by Service Basis

Since the beginning of the OPPS on August 1, 2000, Medicare have calculated outlier payments in the aggregate for all OPPS services that appear on a claim. However, beginning April 1, 2002, the OPPS PRICER will calculate outlier payments based on each individual OPPS service. In calculating outlier payments, billed charges will continue to be converted to costs using a single overall hospital-specific cost-to-charge ratio. The costs attributable to all packaged items and services that appear on a claim will be allocated to all the OPPS services that appear on the claim.

The amount allocated to each OPPS service is based on the percent the ambulatory payment classification (APC) payment rate for that service bears to the total APC rates for all OPPS services on the claim. To illustrate, assume the cost of all packaged services on the claim is $100, and the three APC payment amounts paid for OPPS services on the claim are $200, $300 and $500 (total APC payments of $1000). The first OPPS service or line item will be allocated $20 or 20 percent of the costs of packaged services, because the APC payment for that services represents 20 percent ($200/$10000) of total APC payments on the claim. The second OPPS service will be allocated $30 or 30 percent of the costs of packaged services and the third OPPS service will be allocated $50 or 50 percent of the cost of packaged services.

When a hospital performs several surgical procedures during the same operative session, it is an acceptable billing practice to show the entire charge for use of the operating room or treatment room on the line with one of the surgical HCPCS codes and from zero up to $1.00 in charges on the lines with the remaining surgical HCPCS codes. Medicare does not intend to require that hospitals change this practice. Hospitals will continue to have the option of splitting out the charges for the operating room or treatment room among the individual surgical procedures based on the resources that are attributable to each procedure or they may show a single combined operating room or treatment room charge with one of the surgical HCPCS codes and from zero up to $1.00 in charges with the remaining surgical HCPCS codes. If the hospital chooses the latter option in calculating outliers on a service–by-service basis, the OPPS PRICER will allocate the combined operating or treatment room charge among all of the surgical procedures on the claim. This charge will be allocated to each surgical procedure based on the proportion that the APC payment for the procedure bears to the total APC payments for all surgical procedures performed on that claim.

In addition to calculating outlier payments on a service-by-service basis, beginning April 1, 2002, the outlier threshold is increased from 2.5 to 3.5 and the outlier payment percentage is decreased from 75 percent to 50 percent. Outlier payments will be made if the cost of providing a service exceeds 3.5 times the OPPS payments for the service and the amount of the outlier payment will be 50 percent of the amount by which the provider's costs exceed 3.5 times the OPPS payments.

Billing for Intensity Modulated Radiation Therapy (IMRT) and Stereotactic Radiosurgery (SR)

Billing for IMRT Planning and Delivery

Effective for services furnished on or after April 1, 2002, codes G0174 and G0178 are no longer valid codes. Hospitals must use *CPT* code 77301 for IMRT planning and *CPT* code 77418 for IMRT delivery. Any of the *CPT* codes 77401 through 77416 or 77418 may be reported on the same day as long as the services are furnished at a separate treatment sessions. In these cases, modifier 59 must be appended to the appropriate codes.

Billing for Multi-source Photon Stereotatic Radiosurgery (SR) Planning and Delivery

Effective for services furnished on or after April 1, 2002, hospitals must bill for multi-source photon SR planning and delivery using HCPCS codes G0242 for planning and G0243 for delivery. Services represented by *CPT* codes 77401 through 77416 should never be reported on the same day as code G0243, unless the services were furnished at a separate treatment session.

G0242 Multi-source photon stereotactic radiosurgery (cobalt 60 multi-source converging beams) plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment.

G0243 Multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions.

Billing for Linear Accelerator (gantry or image directed) SR Planning and Delivery

Effective for services furnished on or after April 1, 2002, hospitals must bill for gantry or image directed linear accelerator SR using G0242 for planning. Hospitals must bill G0173 for delivery if the delivery occurs in one session, and G0251 for delivery per session (not to exceed five sessions) if delivery occurs during multiple sessions.

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G0173 Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment in one session, all lesions.

G0251 Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment.

Note: Although code G0251 is effective on April 1, 2002, the Outpatient Code Editor or the OPPS PRICER systems will not recognize the code until July 1, 2002. Therefore, hospitals may either hold all bills that contain this code and submit the bills after July 1, 2002, or submit bills but omit this code and submit an adjustment bill reflecting this service after July 1, 2002.

Additional Billing Instructions

Payment for the services identified by *CPT* codes 77280 through 77295, 77300, and 77305 through 77321, 77336 and 77370 are included in the APC payment for IMRT and SR planning. These codes should not be billed in addition to 77301 and G0242.

Payment for IMRT and SR planning does not include payment for services described by *CPT* codes 77332 through 77334. When provided, these services should be billed in addition to the IMRT and SR planning codes 77301 and G0242.

Payment for *CPT* code 20660 is included in G0243; therefore, hospitals should not report 20660 separately.

Changes to Pass-Through Drugs and Biologicals from the March 1, 2002 Final Rule

The OPPS Proposed Rule dated August 24, 2001indicated that the payment rates for the pass-through drugs and biologicals will be updated annually. For calendar year 2002 Medicare used the July 2001 Redbook. The following represents substantive changes that have been made in the March 1, 2002 Final Rule. This list does not negate the need to read the March 1, 2002 Final Rule for all changes.

HCPCS Codes Replacements

The HCPCS codes listed in the column titled "Old Code" have been retired effective December 31, 2001, however, because of the delay in using new 2002 codes, these codes are in effect for hospital outpatient billing for drugs furnished through March 31, 2002. Beginning April 1, 2002, these codes are no longer reportable under the hospital OPPS. These codes have been replaced with new HCPCS codes indicated in the column titled "New HCPCS Code" effective April 01, 2002, and will be reportable under the hospital OPPS.

The latest payment rates associated with each APC number listed below may be found in the OPPS PRICER file available on our website, as well as in Addendum A and B of OPPS Final Rule.

Old Code	APC	New HCPCS Code	APC
A4642	0704	C1066	1066
C9001	9001	J2020	9001
C9002	9002	J3100	9002
C9004	9004	J9300	9004
C9011	9011	J0706	9011
C9012	9012	J9017	9012
C9018	9018	J0587	9018
C9104	9104	J7511	9104
J7315	7315	J7316	7316
Q0160	931	J7193	931
Q0161	932	J7195	932
Q2015	7033	J2940	7052
Q2016	7034	J2941	7034

Codes Not Reportable Under the Hospital OPPS

Effective April 1, 2002, the following HCPCS codes are no longer reportable under the hospital OPPS. These codes were either assigned to a status indicator of "D" or "E" in the OPPS Final Rule that was published on March 1, 2002.

HCPCS Code C1090 APC 1090

Based on consultation with a nuclear pharmaceutical expert, it has been determined that this radiopharmaceutical agent is never administered in isolation. It is always combined with another agent. Therefore, this code will no longer be reportable under the hospital OPPS.

HCPCS Code J1810 APC 7047

Review of this specific drug indicates that it is no longer manufactured. Therefore, this code will no longer be reportable under the hospital OPPS.

HCPCS Code J9266 APC 843

Review of this specific drug indicates that it is no longer manufactured. Therefore, this code will no longer be reportable under the hospital OPPS.

HCPCS Code Q2020 APC 1616

Review of this specific drug indicates that it is no longer manufactured. Therefore, this code will no longer be reportable under the hospital OPPS.

Additional Drugs Eligible for Pass-Through Payments

The following drugs were inadvertently omitted in the OPPS Final Rule dated November 30, 2001. These drugs are reflected in the March 1, 2002 final rule and payment will be made for these drugs effective April 1, 2002. Although the OCE and OPPS PRICER currently contain these codes, fiscal intermediaries must ensure that these codes are reflected in the HCPCS files in their internal claims processing systems.

HCPCS Code	APC
C1774	734
C1775	1775

Changes to Payment Rates and Co-Pay from the March 1, 2002 OPPS Final Rule

The information below supercedes what was published in the March 1, 2002 Final Rule, and has been updated in the latest OPPS PRICER that will be effective April 1, 2002. Only applicable changes are noted below.

HCPCS Code	APC
C9010	9010
J1190	726
J1327	1607
J7330	1059
J7505	7038
Q3007	1624

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Additional Corrections

The information below identifies additional information or changes to the November 30, 2001 and/or March 1, 2002 Final Rule. These changes are effective April 1, 2002.

HCPCS Code	APC
A4642	0704

Status indicator changed to "E"

J1561	0905

To be used instead of HCPC J1563

Q0081	0120

Still a valid code, not discontinued

Additional Billing and Reporting Information Related to Pass-Through Drugs Effective April 1, 2002

Below is additional information for the HCPCS codes listed in the November 30, 2001, and/or March 1, 2002 Final Rule.

HCPCS Code A9504 APC 1602

Payment rate for this radiopharmaceutical is based on "per vial."

HCPCS Code C1064 APC 1064

This code should be reported after the first initial 1-5 mCi. This dosage is to be used for 6 or more capsules and is used in conjunction with C1188. For example, for a patient that received 7 mCi of I-131 capsules, the following codes should be reported:

C1188 initial 1-5 mCi Units of service: 1
C1064 each add'l mCi Units of service: 2

HCPCS Code C1065 APC 1065

This code should be reported after the first initial 1-6 mCi. For example, for a patient that received 7 mCi of I-131 solution, the following codes should be reported:

C1348 initial 1-6 mCi Units of service: 1
C1065 each add'l mCi Units of service: 2

HCPCS Code C1066 APC 1066

Under OPPS, A4642 will no longer be reportable effective 04/01/2002. This radiopharmaceutical has been replaced with C1066.

HCPCS Code C1188 APC 1188

This code should be reported for only the initial 1-5 mCi dose of I-131 capsules.

HCPCS Code C1305 APC 1305

Only HCPCS code C1305 is reportable under the hospital OPPS. HCPCS J7340 should NOT be reported for Apligraf under the hospital OPPS.

HCPCS Code C1348 APC 1348

This code should be reported for only the initial 1-6 mCi dose of I-131 solution.

HCPCS Code C9003 APC 9003

The payment rate for this drug was based on a pediatric dose.

HCPCS Code C9019 APC 9019

The dosage for this code has been changed from 50 mg to 5 mg.

HCPCS Code C9020 APC 9020

The descriptor for this code has been changed from Sirolimus tablet, 1 mg to Sirolimus solution 1 mg.

HCPCS Code J1565 APC 906

The payment rate for this drug was based on a pediatric dose.

HCPCS Code Q2008 APC 7027

The dosage for this code has been changed from 1.5 mg to 15 mg.

Typographical Errors from the March 1, 2002 OPPS Final Rule

The dosage descriptors and short descriptors for the following HCPCS codes were incorrectly listed in Addendum A and B of the March 1, 2002, Final Rule. The information below corrects the information published in the Final Rule.

HCPCS Code	APC	Corrected Information
C1079	1079	**Co 57/58 0.5 uCi**
C1094	1094	**TC 99M albumin aggr, 1.0 mCi**
C9110	9110	**Alemtuzumab, per 10mg/ml**
J1626	764	**Granisetron HCL injection 100 mcg**
Q0187	1409	**Factor viia recombinant**
Q3004	1621	**Xenon xe 133**

Correction to 2002 HCPCS Code Books

In reviewing the 2002 Level II HCPCS code books, the following errors in transcription for drugs, biologicals and radiopharmaceuticals were noted. Providers must ensure that units of service on claims reflect the **CORRECT** descriptor dosages.

Note: mCi or MCI is standard abbreviation for millicurie; uCi is standard abbreviation for microcurie.

For the latest 2002 Level II HCPCS short and long descriptors, refer to the 2002 HCPCS file which can be downloaded from the CMS Web site at *www.hcfa.gov/stats/pufiles.htm#alphanu.*

HCPCS Code	Correct Descriptor
A9503	Technetium TC 99m medronate, **up to 30 MCI**
A9504	Technetium TC 99m apcitide, **per vial**
A9505	Thallous chloride TL-201, **per MCI**
A9508	Iobenguane sulfate I-131, **per 0.5 MCI**
A9511	Technetium Tc 99m Depreotide, **per MCI**
A9600	Strontium-89 chloride, **per MCI**
A9605	Samarium sm 153 lexidronanim, **per 50 MCI**
C1064	I-131 cap, **each additional MCI (6+ MCI)**
C1065	I-131 sol, **each additional MCI (7+ MCI)**
C1188	I-131 cap, **per initial 1-5 MCI**
C1348	I-131 sol, **per initial 1-6 MCI**
C9000	Na chromatecr51, **per 0.25 MCI**
C9013	Co 57 cobaltous chloride, **per 10 uCi**
C9100	Iodinated I-131 Albumin, **per MCI**
C9102	51 Na Chromate, **per 50 MCI**
Q2008	Fomepizole, **15 mg**
Q3002	Gallium ga 67, **per MCI**
Q3004	Xenon xe 133, **per 10 MCI**
Q3005	Technetium tc 99m mertiotide, **per MCI**
Q3006	Technetium tc 99m glucepatate, **per 5 MCI**
Q3007	Sodium phosphate P32, per microcurie **per MCI**
Q3008	Indium 111-in pentetreotide, **per 3 MCI**
Q3009	Technetium tc99m oxidronate, **per MCI**
Q3010	Technetium tc99mlabeledrbcs, **per MCI**
Q3011	Chromic phosphate p32, **per MCI**
Q3012	Co 57, **per 0.5 MCI**

2002 Update of the Hospital Outpatient PPS (continued)

Pro-rata Reduction in Drug and Device Pass-through Payments

The final rule published in the **Federal Register** on March 1, 2002, announced a uniform reduction of 63.6 percent to be applied to each of the transitional pass-through payments for drug and devices furnished on or after April 1, 2002. See the **Federal Registers** published on November 1, 2001, November 30, 2001, and March 1, 2002, for a full discussion of these reductions. The reductions will be implemented in the OPPS PRICER program for drugs and devices furnished on or after April 1, 2002.

Payment for Observation Services

Since the beginning of OPPS, observation services have been packaged services. No separate payment was made for observation services, as the payment for observation was included in the APC payment for the procedure or visit with which it was furnished. Although observation services will continue to be packaged in most situations, the final rule for 2002 provides a separate APC payment for observation that is provided under certain specific conditions. The APC for observation services is effective for services furnished on or after April 1, 2002. The instructions contained in PM A-01-91 dated July 31, 2001, remain in effect for all observation services provided prior to April 1, 2002, and continue to be in effect for observation services that do not qualify for separate APC payment on or after April 1, 2002. A hospital may receive a separate APC payment for observation services for patients having diagnoses of chest pain, asthma, or congestive heart failure, when certain additional criteria are met. More than one nonoverlapping observation meeting the observation criteria is allowed on a single claim and each observation is paid separately. Hospitals must use the new code G0244 for observation services that meet the criteria for separate payment and must submit the claim using type of bill (TOB) 13x. Observation is not separately paid if a surgical procedure or any service that has a status indicator of "T" under the OPPS occurs on the day before or the day that the patient is admitted to observation.

Required Diagnoses for Separate Observation APC Payment

One of the following ICD-9-CM diagnoses must be present on the bill as the principal or secondary diagnosis:

Note: Admitting Diagnosis is not a required field for Medicare outpatient claims. Admitting diagnosis will not be taken into account to determine that a patient has a qualifying diagnosis for purposes of paying an APC for observation.

1. For Chest Pain:

411.0 Postmyocardial infarction syndrome
411.1 Intermediate coronary syndrome
411.81 Coronary occlusion without myocardial infarction
411.89 Other acute ischemic heart disease
413.0 Angina decubitus
413.1 Prinzmetal angina
413.9 Other and unspecified angina pectoris
786.05 Shortness of breath
786.50 Chest pain, unspecified
786.51 Precordial pain
786.52 Painful respiration
786.59 Other chest pain

2. For Asthma:

493.01 Extrinsic asthma with status asthmaticus
493.02 Extrinsic asthma with acute exacerbation
493.11 Intrinsic asthma with status asthmaticus
493.12 Intrinsic asthma with acute exacerbation
493.21 Chronic obstructive asthma with status asthmaticus
493.22 Chronic obstructive asthma with acute exacerbation
493.91 Asthma, unspecified with status asthmaticus
92.92 Asthma, unspecified with acute exacerbation

3. For Congestive Heart Failure:

391.8 Other acute rheumatic heart disease
398.91 Rheumatic heart failure (congestive)
402.01 Malignant hypertensive heart disease with congestive heart failure
402.11 Benign hypertensive heart disease with congestive heart failure
402.91 Unspecified hypertensive heart disease with congestive heart failure
404.01 Malignant hypertensive heart and renal disease with congestive heart failure
404.03 Malignant hypertensive heart and renal disease with congestive heart and renal failure
404.11 Benign hypertensive heart and renal disease with congestive heart failure
404.13 Benign hypertensive heart and renal disease with congestive heart and renal failure
404.91 Unspecified hypertensive heart and renal disease with congestive heart failure
404.93 Unspecified hypertensive heart and renal disease with congestive heart and renal failure
428.0 Congestive heart failure
428.1 Left heart failure
428.9 Heart failure, unspecified

Additional Requirements for Separate Observation APC Payment:

In addition to having one of the above diagnoses on the bill the following requirements must also be met in order to receive a separate APC payment for observation services:

1. An emergency department visit (APC 0610, 0611, or 0612), a clinic visit (APC 0600, 0601,or 0602) or critical care (APC 620) is billed in conjunction with each bill for observation services. An emergency evaluation and management (E/M) code for the emergency room, clinic visit or critical care is required to be billed on the day before or the day that the patient is admitted to observation. Both the associated E/M code and the observation are paid separately if the observation criteria are met. Observation services are packaged into the E/M visit if all observation criteria are not met. More than one period of observation is allowed to be billed on a single claim however each observation period must be paired with a separate E/M visit. The E/M code associated with observation must be billed on the same claim as the observation service.

Note: An E/M visit must be billed with a modifier 25 if it has the same date of service as the observation code G0244.

2. The hospital must furnish certain other diagnostic services along with observation services to ensure that

2002 Update of the Hospital Outpatient PPS (continued)

separate payment is made only for those beneficiaries truly requiring observation care. Medicare believes these tests are typically performed on beneficiaries requiring observation care for the three specified conditions. The tests are medically necessary to determine whether a beneficiary will benefit from being admitted to observation care and the appropriate disposition of a patient in observation care. The specified diagnostic services must be performed within the dates of the E/M visit plus the first 24 hours of observation and must be billed on the same claim as the observation services to which they are related. The diagnostic tests are as follows:

- For chest pain, at least two sets of cardiac enzymes two CPK (82550, 82552, or 82553) or two troponin (84484 or 84512)] and two sequential electrocardiograms (93005)
- For asthma, a peak expiratory flow rate (94010) or pulse oximetry (94760 or 94761)
- For congestive heart failure, a chest X-ray (71010, 71020 or 71030) and an electrocardiogram (93005) and pulse oximetry (94760 or 94761).

Note: Pulse oximetry codes 94760 and 94761 are treated as packaged services under the OPPS. Although as packaged codes no separate payment is made for these codes, hospitals must separately report the HCPCS code and a charge for pulse oximetry in order to establish that observation services for congestive heart failure and asthma diagnoses meet the criteria for separate APC payment.

Multiple observation periods on a claim may be paid separately if the required criteria are met for each observation. If there are multiple observation periods for the same diagnoses, each of the required tests must be performed multiple times, that is, the tests must be rerun for each period of observation. Therefore, if a claim contains two separate periods of observation related to chest pain, four EKGs and four cardiac enzyme tests must be performed. If multiple observations are for different diagnoses, the re-use of tests will be permitted. For example, if there are 2 periods of observation on a claim, one for chest pain and one for congestive heart failure, 2 EKGs, not 3, are needed. The EKGs that are performed to meet the diagnostic test requirements for observation related to chest pain may also be used for the observation related to congestive heart failure.

3. Observation services must be billed hourly for a minimum of eight hours up to a maximum of 48 hours. In billing for observation services, the units of services represent the number of hours the patient spends in observation. Medicare will not pay separately for any hours a beneficiary spends in observation over 24 hours, but all costs beyond 24 hours will be included in the APC payment for observation services. Observation services of less than eight hours do not qualify for an APC payment. If a period of observation spans more than one calendar day, all of the hours for the entire period of observation must be included on a single line and the date of service for that line is the date the patient is admitted to observation.
    - Observation time begins at the clock time appearing on the nurse's observation admission note. (This coincides with the initiation of observation care or with the time of the patient's arrival in the observation unit.)
    - Observation time ends at the clock time documented in the physician's discharge orders, or, in the absence of such a documented time, the clock time when the nurse or other appropriate person signs off on the physician's discharge order. (This time coincides with the end of the patient's period of monitoring or treatment in observation.)
    - The beneficiary must be under the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes, timed, written, and signed by the physician.
    - The medical record must include documentation that the physician used risk stratification criteria to determine that the beneficiary would benefit from observation care.

      (These criteria may be either published generally accepted medical standards or established hospital-specific standards.)
4. Only observation services that are billed on a TOB 13x maybe considered for a separate APC payment.
5. To receive an APC payment for observation services that qualify for separate payment a hospital must bill using HCPCS code G0244. HCPCS code G0244 is to be used only when billing for observation services that meet the requirements for separate APC payment as outlined above. If the observation services furnished by a hospital do not meet the requirements for separate APC payment, the hospital must bill observation services using revenue code 762 only or using revenue code 762 with one of the HCPCS codes for packaged observation services i.e., 99218 – 99220 or 99234 – 99236**.**
6. Note that because the status indicator on HCPCS G0244 is an "S", any claim with an E/M visit on the same day as the observation will be subject to OPPS OCE edit 21 (medical visit on same day as type T or S procedure without modifier 25). Therefore, the E/M code for the visit must be billed with modifier 25 in order for the observation to be paid.

Modifier Issues Under the Hospital OPPS

Below is a listing of all the modifiers that are reported under the OPPS as of April 1, 2002:

Level I (*CPT*)		Level II (HCPCS)			
25	74	E1	F5	RT	T6
27	76	E2	F6	QM	T7
50	77	E3	F7	QN	T8
52	78	E4	F8	TA	T9
58	79	FA	F9	T1	
		GG	GH		
59	91	F1	LC	T2	
73		F2	LD	T3	
		F3	LT	T4	
		F4	RC	T5	

2002 Update of the Hospital Outpatient PPS (continued)

Modifier 50 must be used to report bilateral procedures that are performed at the same operative session as a single line item. Modifiers RT and LT must not be used when modifier 50 applies. Providers must not submit two line items to report a bilateral procedure using modifier 50. Modifier 50 applies to any bilateral procedure performed on both sides at the same session. See section 442.9 of the *Hospital Manual.*

Wage Index Changes

Medicare adjusts payments to hospitals for geographic wage differences, as required by the statute, using the fiscal year 2002 hospital inpatient PPS wage index. Medicare is using the same annual rates as the inpatient PPS, based on their final regulations published August 2001 and as revised in PM A-01-144, issued on December 20, 2001. See CMS Web site *www.hcfa.gov/medicare/hopsmain.htm* for more detailed information.

Routing of Claims

Claims containing the following TOBs, other than 32x and 33x, with services that span beyond April 1, 2001, must be split prior to their submittal. For example, if a claim contains services prior to and after April 1, 2002, the provider must submit two separate claims. One for the services prior to April 1, 2002, which will be routed to the non-OPPS OCE and another claim for the services April and later which will be routed to the OPPS OCE. If a claim is received containing pre and post April 1, 2002 dates of service, it will be returned to the provider requesting that the claim be split as indicated above.

22x – Skilled nursing facility (SNF) inpatient Part B
23x – SNF/outpatient
24x – SNF Part B
32x – Home health agency (HHA) visits under a Part B plan of treatment (POT)
33x – HHA visits under a Part A (POT)
34x – HHA visits not under a POT
71x – Rural Health Clinic
72x – Hospital based or independent renal dialysis center
73x –Federally qualified health center
74x –Other rehabilitation facilities
75x – Comprehensive outpatient rehabilitation facility
81x –Hospice (nonhospital based)
82x – Hospice (hospital based)

Claims containing the above TOBs with dates of service January 1, 2002 through March 31, 2002, should continue to be routed through the nonOPPS OCE.

Note: TOBs (12x, 13x, 14x and 85x) from critical access hospitals, Maryland hospitals, Indian health service hospitals, U.S.Virgin Island hospitals, and those hospitals located in the Pacific (American Samoa, Guam, and Saipan) do not have to be rerouted since they are sent through the nonOPPS OCE.

Medical Nutrition Therapy Services

Providers must bill for these service the same way they bill for services of practitioners such as nurse practitioners or physicians. Hospitals should submit claims for the following *CPT* codes to their local carriers:

97802, 97803, 97804. ❖

Source: CMS Transmittal A-02-026, CR 2102

Discontinue Usage of Edit 15

The Centers for Medicare & Medicaid has issued a notification to discontinue the application of the outpatient prospective payment system Outpatient Code Editor (OCE) edit 15 – Service Unit Out of Range for Procedure. The correct implementation of this edit is scheduled for the October 2002 OCE release.

Action Required

Providers are requested to resubmit any claim that has been returned for reason code W7015. ❖

Source: CMS Notification dated April 19, 2002.

ELECTRONIC DATA INTERCHANGE

CMS Issues Model Plan to Extend Deadline for Compliance with Electronic Transactions Rule

The following is a release from the CMS Public Affairs Office dated March 29, 2002

The Centers for Medicare & Medicaid Services (CMS) has issued a model compliance plan that will allow health plans, health care clearinghouses and health care providers to receive a one-year extension to comply with the new rule governing electronic health care transactions.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required the Department of Health and Human Services (HHS) to adopt national standards for conducting health care transactions electronically. By ensuring consistency throughout the industry, these national standards will make it easier for health plans and for doctors, hospitals and other health care providers to process claims electronically.

The original deadline for compliance with the electronic transactions rule was October 16, 2002 for all covered entities except small health plans, which by law had an additional year. Last year, in the Administrative Simplification Compliance Act, Congress authorized a one-year extension – to October 16, 2003 – for those covered entities required to comply in 2002. To obtain the extension, a covered entity must submit a compliance plan on or before October 15, 2002. Covered entities can use the model plan for this purpose.

"This model plan will help healthcare businesses prepare to meet these transaction standards while giving them until October 2003 to finish the job," HHS Tommy G. Thompson said. "Once adopted, these national standards will make it less costly to process claims, reducing administrative costs nationwide."

Today, different insurers require a wide variety of electronic and paper forms from health care providers filing claims. With the national standards, all health care providers—including physicians and other practitioners, hospitals and nursing facilities—will be able to use the new standards, and all health plans will be required to accept these standard electronic transactions.

"Implementing the electronic health care transactions standard is critical," CMS Administrator Tom Scully said. "This extension will allow providers time to assess their compliance needs, thoroughly test their systems and be ready under the new standards."

A covered entity will be able to submit its extension plan electronically through the CMS Web site, *www.cms.hhs.gov/hipaa*, and CMS will provide an electronic confirmation of receipt of the plan. Covered entities also have the option of submitting its own version of an extension plan that provides equivalent information and can submit a plan on paper. Instructions for filing a plan are available on the Web site.

Covered entities (except for small health plans) that do not submit a compliance plan must comply with the HIPAA electronic transactions rule by October 16, 2002. Small health plans with less than $5 million in receipts already have until October 2003 to comply and do not need to submit a compliance plan.

Under the Administrative Simplification Compliance Act, health care plans and providers must submit information on their compliance activities, including budget, assessment of compliance concerns, whether a contractor or vendor might be used to help achieve compliance, and a schedule for testing to begin no later than April 16, 2003.

The model compliance plan, and instructions on how to complete it, is available at *www.cms.hhs.gov/hipaa***.** Electronic submission capability will be available soon on the Web site. The model compliance plan and instructions also will be published in the *Federal Register* in the near future.

The electronic transactions standards are one of a series of national "administrative simplification" provisions included in HIPAA. More information on other standards, including health information privacy standards, is available at *http://aspe.hhs.gov/admnsimp*.

Source: CMS Press Release, March 29, 2002

Implementation of HIPAA-AS Standard Health Care Eligibility Transaction

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes provisions for Administrative Simplification. The Administrative Simplification provisions direct the Secretary of Health and Human Services to adopt national standards for electronic transactions and for code sets to be used in these transactions. These standards must be fully implemented by **October 16, 2002,** unless providers have filed for a one-year extension (until October 16, 2003) as provided by the Administrative Simplification Compliance Act. As stated in the Transaction and Code Set Final Rule, the Secretary adopted the ANSI ASC X12N 270/271 version 4010 as the electronic standard for Health Care Eligibility Benefit Inquiry and Response.

The ASC X12N 270/271 Eligibility Benefit Inquiry and Response Transaction

Electronic Data Interchange (EDI) requests for eligibility data must be submitted via a 270 version 4010 query effective October 2003(if the provider has filed for an extension), and each valid 270 will be issued a 271 version 4010 response. Prior eligibility formats will be discontinued effective October 2003, although the content/information will still be available via Direct Data Entry and the Automated Response Unit.

The 270/271 is a "paired" transaction (270 is an inbound eligibility inquiry and 271 is an outbound eligibility response). The 271-response time will be similar to the current response time supported for HUQA transactions submitted via LU6.2.

The version 4010 ASC X12N 270/271 Implementation Guide can be downloaded without charge from *www.wpc-edi.com/HIPAA*.

A provider that prefers to obtain eligibility data in an EDI format but who does not want to use a 270/271 may contract with a clearinghouse to translate the information on its behalf; however, that provider would be liable for those clearinghouse costs.

Entities wanting to send and receive the 270/271 must contact the EDI department of First Coast Service Options, Inc.

Providers who want to test to assure system compatibility of version 4010 of the 270/271 must schedule testing with First Coast Service Options, Inc. This testing is scheduled to begin on or about September 1, 2002. There is no charge for this system testing.

The current HUQA transaction will run parallel with the 270/271 through October 2003.

Although Medicare will furnish providers with basic information on the HIPAA-AS standard transaction requirements to enable providers to make educated and timely decisions to plan for use of a HIPAA-AS standard, Medicare will not furnish in-depth training on the use and interpretation of the standards' implementation guides. Providers who feel they have a need to obtain such in-depth training for their staff are expected to obtain training of that nature from commercial vendors, their clearinghouse, or through standards development organizations.

Direct Data Entry (DDE) Users

DDE format is specifically permitted to continue pursuant to the Transaction Final Rule (45 CFR 162.923), with stipulation that direct data entry is subject to "…the applicable data content and data condition requirements of the standard when conducting the transaction. The health care provider is not required to use the format requirements of the standard."

Data content conformity means the same information permitted or required by the 270/271 version 4010 Implementation Guide must be captured in the DDE eligibility screens.

Medicare is currently comparing the 270/271 version 4010 Implementation Guide to current DDE eligibility data elements to determine if the DDE eligibility data elements meet the standard data content and conformity requirements. If this comparison reveals that DDE screen changes are needed for data content and conformity requirements, this information will be shared with providers in future publications of the DDE Insider.

Watch for future Medicare EDI and DDE Insider publications for additional information regarding the implementation of the version 4010 270/271 eligibility transaction. ❖

Source: CMS Transmittal A-02-013, CR 2009

Clarifications on HIPAA-AS Institutional 837 Health Care Claim Implementation Updates

The Centers for Medicare & Medicaid Services (CMS) has been receiving HIPAA 837 claim implementation questions and requests for clarification on an ongoing basis. The following information is being provided to ensure an accurate HIPAA implementation.

Q1: Since the HIPAA 837 institutional implementation guide (IG) allows for only one investigational device exemptions (IDEs) per claim, how should HIPAA test claims containing multiple IDEs received via direct data entry (DDE) be tested since DDE currently allows for multiple IDEs?

A1: HIPAA 837 transaction allows for only one IDE per claim (the HIPAA free billing software should already only accept one IDE per claim) and providers should **not** submit HIPAA test claims containing multiple IDEs via DDE.

Q2: Since the HIPAA 837 Institutional IG allows for only one IDE per claim, how should HIPAA production claims containing multiple IDEs received via DDE be processed since DDE currently allows for multiple IDEs?

A2: Any production claim containing multiple IDEs must **not** be submitted via DDE. This should not be a hardship since CMS has determined that from January 2001 through June 2001 Medicare processed less than five claims with multiple IDEs.

Clarifications on HIPAA-AS Institutional 837 Health Care Claim... (continued)

Q3: How should the standard system maintainers process HIPAA test claims containing a nonnumeric revenue code?

A3: Any HIPAA test claim containing a non-numeric revenue code will be returned to the provider (RTPd) with an appropriate error message.

Q4: How should the standard system maintainers process HIPAA production claims containing a non-numeric revenue code?

A4: Any HIPAA production claim containing a nonnumeric revenue code will be RTPd with an appropriate error message.

Q5: Can providers/submitters use HCPCS codes to bill for drugs on HIPAA test inpatient claims?

A5: Yes. Claims using HCPCS can continue to be tested. CMS will determine at a later time when to accept national drug codes (NDCs).

Q6: Can providers/submitters use HCPCS to bill for drugs on HIPAA production inpatient claims?

A6: Yes. CMS will determine at a later time when to accept NDCs.

Q7: Realizing there is no employment status code, employer name, or employer address in the HIPAA 837 institutional IG, how should the standard system maintainers process HIPAA test claims when currently the standard system maintainers' internal software requires this information for certain claims?

A7: CMS has determined that this information is no longer needed. Test claims containing this information are **not** to be submitted via DDE.

Q8: Realizing there is no employment status code, employer name, or employer address in the HIPAA 837 institutional IG, how should the standard system maintainers process HIPAA production claims when currently the standard system maintainers' internal software requires this information status code for certain claims?

A8: CMS has determined that this information is no longer needed. Production claims containing this information are **not** to be submitted via DDE.

Q9: How should HIPAA test claims that require subscriber demographic information (DMG) be processed since Medicare has never required this information?

A9: The DMG segment is for other insured. This is information on the gender and date of birth for the holder of a supplementary insurance policy, if not the beneficiary. Medicare providers do not need to submit claims requiring this segment via DDE.

Q10: How should HIPAA production claims that require DMG be processed since Medicare has never required this information?

A10: The DMG segment is for other insured. This is information on the gender and date of birth for the holder of a supplementary insurance policy, if not the beneficiary. Medicare providers do **not** need to submit claims requiring this segment via DDE.

Q11: Where should the start of care date for hospice outpatient claims be reported?

A11: The HIPAA 837 institutional IG does not have a place to report the start of care date for hospice outpatient test claims. No outpatient HIPAA hospice claims will be tested while CMS awaits the results of CMS's request to the National Uniform Billing Committee to establish a new occurrence code to be used for the hospice start of care date.

Q12: Is the Medicare requirement for providers/submitters to enter a 0001 revenue code line that contains the sum of charges billed being deleted?

A12: No. There is nothing in the HIPAA 837 institutional IG to prohibit this information on the claim (even though the total charges will also be contained in CLM02). Providers must continue sending a 0001 revenue line on the claims.

Q13: How should HIPAA test claims that require discharge hour information be processed since Medicare has never required this information?

A13: Discharge hour information is required on all final inpatient claims/encounters. Medicare providers do **not** need to submit claims requiring this segment via DDE.

Q14: How should HIPAA production claims that require discharge hour information be processed since Medicare has never required this information?

A14: Discharge hour information is required on all final inpatient claims/encounters. Medicare providers do **not** need to submit claims requiring this segment via DDE.

Q15: How should HIPAA test claims that require a unique physicians identifier number (UPIN) be processed in the 2310A (attending physician information) loop?

A15: Medicare providers should **not** submit claims requiring this loop via DDE.

Q16: How should HIPAA production claims that require a UPIN be processed in the 2310A loop?

A16: Medicare providers should **not** submit claims requiring this loop via DDE.

Q17: How should the date of receipt be established?

A17: The date-of-receipt will be translator generated and mapped to the Medicare Part A Claim/COB flat file. ❖

Source: CMS Transmittal A-02-014, CR 2028

Administration Simplification Compliance Act (ASCA)—Questions and Answers

On December 27, 2001, President Bush signed the *Administrative Simplification Compliance Act* (Public Law 107-105). This law provides for a one-year extension of the date for complying with the Health Insurance Portability and Accountability Act–Administration Simplification (HIPAA-AS) standard transactions and code set requirements (until October 16, 2003) for any covered entity that submits to the Secretary of Health and Human Services, prior to October 16, 2002, a plan of how the entity will come into compliance with the HIPAA-AS requirements by October 16, 2003. This law can be viewed at the following Web site: *www.access.gpo.gov/nara/publaw/107publ.html.* Below are questions and answers regarding the ASCA from the Centers for Medicare & Medicaid Services (CMS) Web site: *www.cms.hhs.gov.* The "we" referenced in this article refers to CMS.

Q1: What will be the impact of the one-year extension?

A1: The delay will give covered entities more time to build, test, and successfully implement the new Final Electronic Transactions and Code Sets required by HIPAA.

Q2: Does the extension affect the compliance date for the HIPAA privacy standards?

A2: No, the compliance date for the privacy standards is still April 2003 or, for small health plans, April 2004.

Q3: Can small health plans get an extension to their current compliance date of October 2003?

A3: No, the compliance date for small plans does not change.

Q4: Do all covered entities automatically get an extension?

A4: No. Covered entities must submit a compliance extension plan to the Department of Health and Human Services (HHS) before October 16, 2002 to get an extension.

Q5: Why didn't Congress just give everyone an extension?

A5: The requirement to submit a compliance extension plan provides assurance that covered entities have plans in place that will allow them to be compliant by the new deadline of October 16, 2003.

Q6: Is HHS going to actually review and approve all these compliance extension plans? Will some be denied?

A6: The law does not require approval or disapproval of plans. Submission of an extension plan is sufficient to secure the one-year extension.

Q7: When will the model compliance extension form be available?

A7: The form will be available by March 31, 2002.

Q8: Where can I get a copy of the form? Do I have to use the form, or can I submit a compliance plan in another format?

A8: We will publish the form in the *Federal Register* and will also make it available on several Web sites. The compliance extension form we are developing is a model. While we strongly recommend its use, covered entities may submit plans using other formats.

Q9: How extensive will the model compliance extension form be?

A9: We are still working on the form, but we intend to make it as simple and easy to complete as possible. The ASCA requires the plans to contain summary information regarding compliance activities, including: 1) budget, schedule, work plan and implementation strategy for achieving compliance; 2) planned use of contractors or vendors; 3) assessment of compliance problems; and 4) a timeframe for testing to begin no later than April 16, 2003.

Q10: My organization has a very detailed, voluminous compliance plan – are we supposed to submit the whole thing?

A10: No. The compliance extension form will ask only for summary information from your detailed plan. You do not need to send other information.

Q11: Can I file the compliance extension form electronically?

A11: Yes, we will encourage electronic filing of compliance extension plans, although we will also accept plans submitted on paper.

Q12: What will be the application deadline for a delay?

A12: Covered entities must submit their compliance extension plans by October15, 2002.

Q13: Where should I send my completed compliance extension form?

A13: Please do not submit requests at this time. Instructions will be issued that will explain how to submit compliance extension plans.

Q14: How will one covered entity know whether another covered entity with which it does business has submitted a plan?

A14: Each covered entity should communicate directly with its own trading partners to determine which ones have submitted plans. This information could be included in establishing schedules for the testing activities that are to begin by April 16, 2003, culminating in a migration to the new standards that meets the needs of all trading partners.

Q15: I believe I will be fully compliant by October 2002. However, I know that some of my trading partners are requesting extensions and will continue to use nonstandard formats after that date. Do I need to submit a compliance extension plan so that I can continue to communicate with these partners using nonstandard transactions?

Administration Simplification Compliance Act (ASCA)—Questions and Answers (continued)

A15: No. A covered entity will be considered compliant if it can send and receive compliant transactions, and therefore would not need to submit an extension plan.

Q16: Can a plan require its network providers to move to standard transactions before October 16, 2003?

A16: This is a business decision between the plan and its provider network. Neither HIPAA nor ASCA preclude plans from requiring that their providers use standard transactions in advance of the compliance deadline, but HIPAA non-compliance penalties would not apply to a provider that has submitted a plan until 2003.

Q17: What will be done with the information I provide?

A17: ASCA requires that a sample of the plans will be provided to the National Committee on Vital and Health Statistics (NCVHS), an advisory committee to the Secretary of Health and Human Services. The NCVHS will review the sample to identify common problems that are complicating compliance activities, and will periodically publish recommendations for solving the problems.

Q18: Will the information I provide be made public?

A18: Under the Freedom of Information Act (FOIA), information held by the federal government is available to the public on request, unless it falls within one of several exemptions. The model form will be designed to avoid collection of any information that would be subject to exemption, such as confidential personal or proprietary information. If such information is submitted, both the FOIA and the ASCA require that it be redacted before the files are released either to the NCVHS or to the public.

Q19: How does the delay affect Medicare implementation activities?

A19: Medicare will continue to implement the HIPAA transaction standards on a sequenced basis, and that schedule will not change significantly. We expect to be ready to test the claim and several other transactions by Spring 2002, but implementation of several transactions (such as the referral/authorization transaction) will be in early FY 2003. Once a provider has successfully tested a transaction with us, it will be able to use the standard in our production environment.

Q20: When will Medicaid Agencies begin testing compliant transactions with their trading partners?

A20: Each Medicaid State Agency has its own project plan for achieving HIPAA compliance, and will decide whether to submit a compliance extension plan. If you are a trading partner, you will receive notice of testing directly from the Medicaid State Agency(s) with whom you do business.

Q21: Do software vendors need to file for an extension?

A21: No. Only covered entities – plans, clearinghouses and providers – must file. In fact, vendors will need to maintain their current delivery schedules for compliant software in order for covered entities to make use of the additional implementation time.

Q22: Should covered entities discontinue testing until 2003?

A22: ASCA requires that compliance plans include a testing phase that would begin no later than April 16, 2003. We recommend that all covered entities begin to test as soon as they are ready in order to allow adequate time to address and correct problems. CMS will soon send out an instruction with dates by which Medicare contractors must begin testing with providers.

Q23: ASCA allows the Secretary of HHS to exclude covered entities from the Medicare program if they do not submit a compliance extension plan or achieve compliance by October 2002. Will every such covered entity be excluded?

A23: HHS will be publishing proposed regulations to address this new exclusion authority.

Q24: Doesn't the law also require Medicare claims to be submitted electronically after October 2003?

A24: ASCA prohibits HHS from paying Medicare claims that are not submitted electronically after October 16, 2003, unless the Secretary grants a waiver from this requirement. It further provides that the Secretary must grant such a waiver if there is no method available for the submission of claims in electronic form or if the entity submitting the claim is a small provider of services or supplies. Beneficiaries will also be able to continue to file paper claims if they need to file a claim on their own behalf. The Secretary may grant such a waiver in other circumstances. We will publish proposed regulations to implement this new authority. ❖

Source: http://www.hcfa.gov/medicaid/hipaa/adminsim/hascaq&a.htm

Medicare HIPAA-AS Related News

Based on transmittal AB-02-020 received from the Centers for Medicare & Medicaid Services (CMS) and effective February 8, 2002, testing dates have changed for the ASC X12N version 4010 electronic transactions listed below. The testing dates provided in this instruction replace those that have been communicated previously.

Transaction Number	Transaction Description	Available for Trading Partner Testing
837	Health Care Claim	May 1, 2002
835	Health Care Claim Payment (Remittance) Advice	May 16, 2002
276/277	Health Care Claim Status Request & Response	July 16, 2002

Note: The 2003 dates indicated below are only applicable if the providers have filed for an extension as provided by the Administrative Simplification Compliance Act (for information on this law, refer to the article on page 53. In the absence of filing an extension, compliance must be obtained by October 16, 2002, as specified by the Transaction and Code Set Final Rule.

837-Electronic Claim Submission

As of October 2003, Medicare will switch to exclusive use of the ANSI X12N 837 Version 4010 for submission of inbound claims. Beginning on or about May 1, 2002, Medicare will be able to receive test files in the ANSI X12N 837 Version 4010 format. EDI (Electronic Data Interchange) submitters are required to pass specified levels of testing on this transaction prior to acceptance of production files.

835-Electronic Remittance Advice

General testing, while not required but recommended, will begin on or around May 16, 2002, and is scheduled to continue through October 2003. Testing will occur on a first-come, first-serve basis. Due to the large number of senders who will be testing, Medicare EDI encourages senders to begin their testing early. Senders who wait until the last few months of testing may not have enough time to prepare for the 4010 migration. Medicare will switch to exclusive use of the ANSI X12N 835 Version 4010 as of October 2003.

276/277-Electronic Claim Status Request/Response

Providers, agents, and clearinghouses are not required, in most cases, to test the 276/277 transactions prior to production submission of a 276-claim status request or for receipt of a 277-claim status response. Providers are required to notify Medicare when they plan to begin submitting 276 version 4010 queries. The X12N 276/277 Version 004010X093 transaction will become available for testing on or about July 16, 2002. Medicare will switch to exclusive use of the ANSI X12N 276/277 Version 4010 as of October 2003.

First Coast Service Options, Inc, (FCSO) strongly encourages new EDI submitters to begin with HIPAA formats, rather than test and submit production transactions in pre-HIPAA formats. FCSO will not enroll any new EDI submitters on pre-HIPAA formats after October 1, 2002.

PC-ACE Pro32® software users are not required to test the software. PC-ACE Pro32® software in the ANSI ASC X12N Version 4010 format required for Medicare claims will become available on or near July 15, 2002. ❖

Sources: CMS Transmittal AB-02-020 CR 2039

PATIENT FRIENDLY ADVISORY

Easy-to-Access Help Available at Medicare.gov

More and more, people with Medicare and those who will soon be eligible for Medicare, including your patients, use the Internet. Research shows that Internet use is growing among people age 50 and older. Findings from the Medicare Current Beneficiary Survey, sponsored by the Centers for Medicare & Medicaid Services (CMS), indicate that the percentage of people with Medicare reporting access to the Internet climbed from 6.8 percent in 1997 to 31 percent in 2001.

Established by CMS, *www.medicare.gov,* the official U.S. government Web site for people with Medicare, has useful information for your patients and those who help them make health care decisions. By accessing this Web site, your patients can:

- Search for information on health plans, nursing homes, dialysis facilities, Medigap policies, participating physicians and suppliers, telephone contacts, and Medicare activities in their area.
- Get information on coverage, eligibility, enrollment, their Medicare card, address changes, and help with health care costs.
- Learn about the Original Medicare Plan, Medicare+Choice Plans (managed care plans and Private Fee-for-Service plans), and Medigap policies, and compare health plans available in their area.
- Get information on payment, patient rights, and alternatives to nursing homes, and compare nursing homes in their area.
- Find telephone numbers and Web sites to help answer their questions.
- Look at, order, or download Medicare and health-related publications.
- Learn how to recognize and prevent fraud and abuse.
- Get important information and links to health Web sites to help them stay healthy.

Medicare.gov is designed with the needs of the diverse Medicare population in mind. First, the Medicare information is available in Spanish and Chinese. Second, "Screen Reader" technology allows people with low vision or blindness to have quick, reliable access to the information they need. Third, easy print format allows visitors to print all pages within each section without links and extra text. Last, the "Frequently Asked Questions" section allows visitors to search by category or phrase to quickly find answers to their questions. If visitors are unable to find answers, they can submit questions. This section also includes a subscription service that notifies users when questions are updated.

You may find this Web site useful for you and your staff, as well as for your patients. For example, free publications may be ordered on a variety of topics for display and distribution in your facility. To order Medicare publications in quantities of greater than 25, please use the order form on *www.medicare.gov* and fax the order to 1-410-786-1905, or call 1-800-MEDI-CARE to order the publications. A list of Medicare publications for people with Medicare can be found in the Publications Catalog on *www.medicare.gov.* In addition, the Web site is helpful for identifying prescription drug assistance programs for low-income patients. Information about local educational events for your patients can also be found on the Web site. *Medicare.gov* has answers you may need for you and your patients. Check it out! ❖

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.*

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EDUCATIONAL RESOURCES

Medicare Education and Outreach—Calendar of Upcoming Events

Below and on the following page are three months of calendars for upcoming Medicare Education and Outreach events. This will become a regular feature in the *Medicare B Update!* enabling you to plan your attendance at least a quarter at a time. Please refer to the symbol legend below to determine the type of event listed. Please note: any event with the legend (T) does not have a city listed because it is a teleconference and you are required to call. When you find a listing you are interested in, please refer to our Web site or fax a request for more information to (904) 791-6035.

Legend:

(W) **Workshop**: Cost-based event that includes interaction, exercises, in depth information

(E) **Expo**: Cost-based multi-specialty event that includes concurrent classes, workshops, and interactive sessions

(T) **Teleconference**: *Free* telephone session that deals with limited issues of a predetermined subject, and questions and answers

(SS) **Specialty Seminar**: Cost-based seminar providing in-depth material about a specific specialty

(BB) **Building Blocks**: *Free* seminar that gives overviews and general information on chosen subjects. *Note: These sessions do not include exercises and in-depth information*

For further information, including subject matter and registration, please see our Web site *www.floridamedicare.com*, call our registration hotline at (904) 791-8103, check your *Medicare A Bulletin* or fax questions to (904) 791-6035. *Customized on-site sessions are available for a fee. Call: (904) 791-8114*

July 2002

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4	5	6
7	8	9	10	11	**12 (SS)** Part A: Ambulance/ABN Part B: Ambulance/ MSP/Cardiology West Palm Beach	13
14	15	**16 (W)** Part A: UB92/DDE Jacksonville	17	18	19	20
21	22	23	**24 (BB)** Part B:E/M Coding/ E/M Doc Pensacola	25	26	27
28	29	30	31			

August 2002

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5	**6 (SS)** Part A:HOPPS Part B: Mental Health/ Chiropractic Miami	7	8	**9 (B)** Part B: CMS-1500 Jacksonville	10
11	12	**13 (W)** Part A: Modifiers Jacksonville	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

September 2002

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5	6	7
8	9	**10 (E)** Ultimate Medicare Expo for A & B: Miami	**11 (E)** Ultimate Medicare Expo for A & B: Miami	12	13	14
15	16	17	18	**19 (SS)** Part A: Rehab Jacksonville	**20 (T)** Part B: ARNP/PA	21
22	23	**24 (SS)** Part A: Hospital Swing Bed/PPS Part B: Radiology/ Med Oncology Ft. Lauderdale	25	26	**27 (T)** Part A Critical Access Hosp	28
29	30					

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 **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: ▪ *Payable to* **First Coast Service Options, Inc. #756241** ▪ *Mail to* **Medicare Education and Outreach, Attn: Phyllis Brooks, 11 Tower, P.O. Box 2078, Jacksonville, FL 32231** 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***
Focused Medical Review*	**Medicare Secondary Payer***	**SNF/Consolidated Billing**
Fraud and Abuse*	**Partial Hospitalization Program**	**UB-92 Claims Filing***
HIPAA-AS*		

QUANTITY	TITLE	PRICE (EA.)	TOTAL
		$35.00	
	.	**Sub-Total**	$
		Add 7% Tax	
		Total	$

3. PLEASE SUBMIT YOUR PAYMENT

☛ **SEND YOUR PAYMENT**	Submit the completed form with your check or money order: ▪ *Payable to* **First Coast Service Options, Inc. Account #756241** ▪ *Mail to* **Medicare Education and Outreach, Attn: Phyllis Brooks, 11 Tower, P.O. Box 2078, Jacksonville, FL 32231** Your order will be shipped within four to six weeks.

FCSO Medicare *eNews* Now Available to Web Site Visitors

Join our ***eNews*** mailing list and receive urgent or other critical information issued by your Florida Medicare carrier & intermediary, First Coast Service Options, Inc. (FCSO). By signing up, you will receive periodic messages advising you of updates to the provider Web site (**www.floridamedicare.com**) and/or: key program alerts, seminar schedules, publications availability, educational tips, critical program changes, etc. On the Web site, click on the ***eNews*** link and select the desired interest group to sign up.

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

The following outlines the types of information that is available on the First Coast Service Options, Inc. (FCSO) Florida Medicare provider Web site.

What's New

Provides a brief introduction to recent additions to specific areas of the site. Also provides items of immediate interest to providers.

Part A

- ***System & Claim Issues*** - This communication provides a status of the most commonly reported Medicare Part A claim and system issues.
- ***PPS*** - (Prospective Payment System)
- ***Fraud & Abuse*** - Articles of interest concerning fraud, abuse, and waste in the Medicare program.
- ***Publications*** - *Medicare A Bulletins* from 1997 through the present.
- ***Reason Codes*** - A listing of codes used by Part A to explain actions taken on line items/claims.
- ***Draft and Final LMRPs*** - Florida Medicare's final and draft Part A Local Medical Review Policies (LMRPs).

Part B

- ***MCS (Multi-Carrier System) Transition*** - Includes publications outlining how the conversion affects your practice and trading partners. Newsletters, Post-Transition Issues matrix, FAQs, EDI format changes, Medigap/Crossover changes and more.
- ***Publications*** - *Medicare B Updates!* from 1997 through the present.
- ***Draft and Final LMRPs*** - Florida Medicare's final and draft Part B Local Medical Review Policies (LMRPs).
- ***Fraud & Abuse*** - Articles of interest concerning fraud, abuse and waste in the Medicare program.
- ***MEDIGAP Insurer Listing*** - Information about claim crossovers (e.g., list of auto-crossovers, etc.).

Shared (information shared by Part A and Part B)

- ***Medicare Enrollment*** - Provides access to downloadable copies of the new Form CMS-855 (effective November 1, 2001) as well as various help files to assist with choosing and completing the appropriate forms.
- ***General Information***
- ***Education & Training*** - Medicare Educational resources and a Calendar of Events.
- ***UPIN Directory***
- ***Fee Schedules***
- ***MEDPARD Directory***
- ***Forms***
- ***FAQs/Q&As***
- ***Coordination Of Benefits (COB) / Medicare Secondary Payer (MSP)***

EDI (Electronic Data Interchange)

- ***HIPAA*** - Information regarding the Health Insurance Portability and Accountability Act.
- ***News*** - Important notices to EDI trading partners.
- ***Forms*** - Various EDI applications' enrollment forms such as EMC, ERN, electronic claims status, PC-Ace Pro32® software, etc.
- ***Specs*** - Format specification manuals for programmers.
- ***Other*** - EDI Vendor List, Tips to prevent EMC Error Report rejects with a complete Error Message listing, and other important news and information.

Extra

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

Search

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

Note: Web sire content changes frequently as information is added or updated.

A

B

C

C (continued)

D

E

F

G

H

I

I (continued)

L

M

M (continued)

N

O

P

Procedure Codes

CPT Codes

Anesthesia/Surgery, 00100-69979

Diagnostic Tests, 70010-89399

Diagnostic Tests, 70010-89399 (continued)

Diagnostic Tests, 70010-89399 (continued)

Medicine, 90281-99199

Medicine, 90281-99189 Codes (continued)

HCPCS Codes

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

PROVIDER EDUCATION

Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32231

Seminar Registration Hotline

(904) 791-8103

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

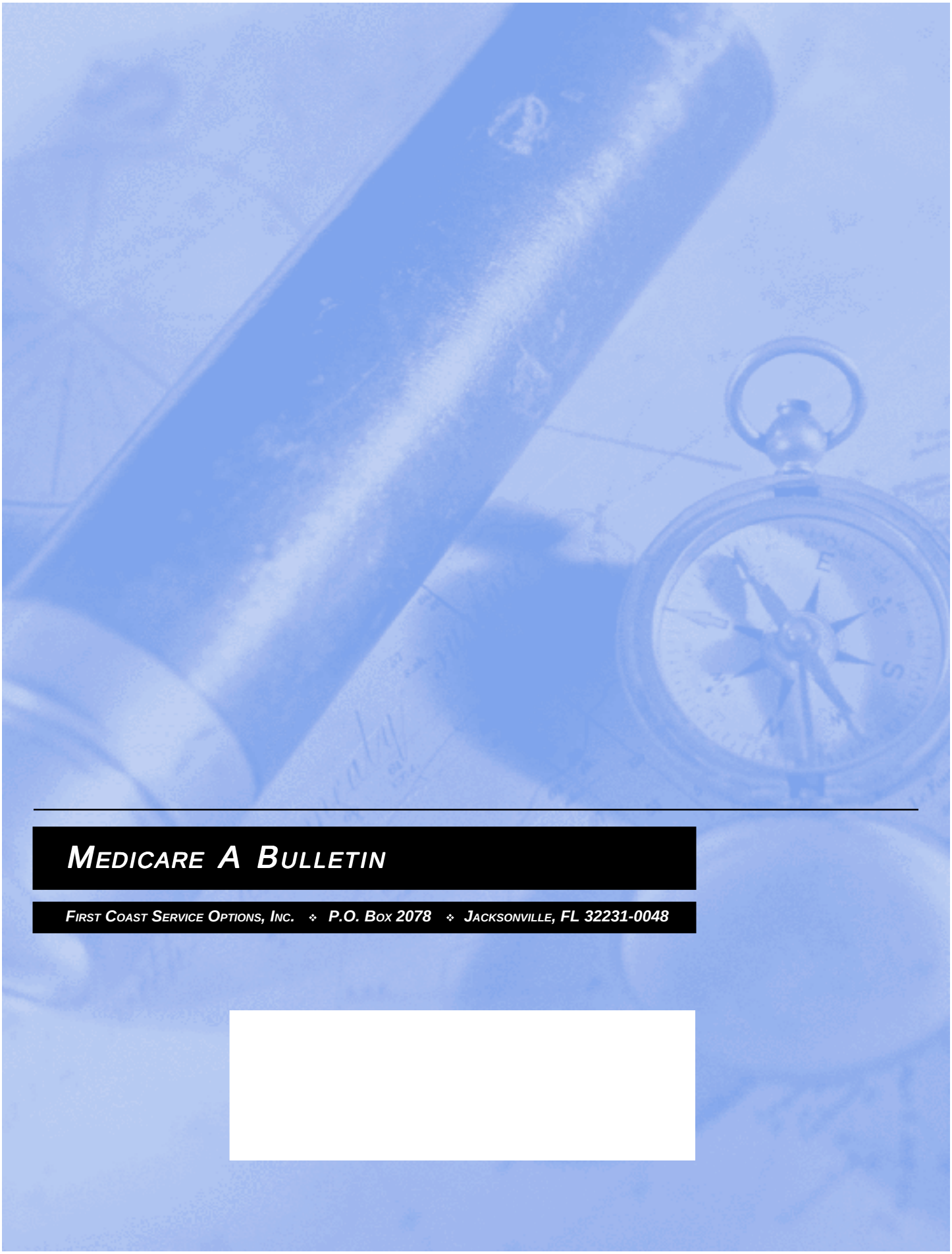
Medicare Web Sites

PROVIDERS

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

BENEFICIARIES

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



MEDICARE A BULLETIN

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