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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
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Vol. 4, No. 3
Third Quarter 2002

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P.O. Box 2078
Jacksonville, FL 32231-0048

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The Florida Medicare A Bulletin
Third Quarter 2002
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with Physicians Can Be Improved stated that information given to physicians by contractors is often difficult to use, out of date, inaccurate, and incomplete.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,

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

<table>
<thead>
<tr>
<th>Publication Name</th>
<th>Publication Date</th>
<th>Effective Date of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Quarter 2002</td>
<td>Mid-November 2001</td>
<td>January 1, 2002</td>
</tr>
<tr>
<td>Second Quarter 2002</td>
<td>Mid-February 2002</td>
<td>April 1, 2002</td>
</tr>
<tr>
<td>Third Quarter 2002</td>
<td>Mid-May 2002</td>
<td>July 1, 2002</td>
</tr>
<tr>
<td>Fourth Quarter 2002</td>
<td>Mid August 2002</td>
<td>October 1, 2002</td>
</tr>
</tbody>
</table>

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
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 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:

Q: Ambulance service provided under arrangement by a provider of services; or
Q: Ambulance service furnished directly by a provider of services.

This policy is effective for services furnished on or 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.

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.

<table>
<thead>
<tr>
<th>Period</th>
<th>Interest Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 31, 2001 – January 31, 2002</td>
<td>13.25%</td>
</tr>
<tr>
<td>August 7, 2001 – October 30, 2001</td>
<td>13.25%</td>
</tr>
<tr>
<td>April 26, 2001 – August 6, 2001</td>
<td>13.75%</td>
</tr>
<tr>
<td>February 7, 2001 – April 25, 2001</td>
<td>14.125%</td>
</tr>
<tr>
<td>October 24, 2000 – February 6, 2001</td>
<td>13.875%</td>
</tr>
<tr>
<td>August 1, 2000 – October 23, 2000</td>
<td>13.875%</td>
</tr>
<tr>
<td>May 3, 2000 – July 31, 2000</td>
<td>13.75%</td>
</tr>
<tr>
<td>February 2, 2000 – May 2, 2000</td>
<td>13.50%</td>
</tr>
</tbody>
</table>

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.hcf.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
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).

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

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.
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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0245</td>
<td>Initial physician evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) that must include:</td>
</tr>
<tr>
<td></td>
<td>(a) visual inspection of the forefoot, hindfoot, and toe web spaces,</td>
</tr>
<tr>
<td></td>
<td>(b) evaluation of a protective sensation,</td>
</tr>
<tr>
<td></td>
<td>(c) evaluation of foot structure and biomechanics,</td>
</tr>
<tr>
<td></td>
<td>(d) evaluation of vascular status and skin integrity, and</td>
</tr>
<tr>
<td></td>
<td>(e) evaluation and recommendation of footwear</td>
</tr>
<tr>
<td></td>
<td>4. Patient education</td>
</tr>
<tr>
<td>G0246</td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>1. Patient history</td>
</tr>
<tr>
<td></td>
<td>2. Physical examination that includes:</td>
</tr>
<tr>
<td></td>
<td>(a) visual inspection of the forefoot, hindfoot, and toe web spaces,</td>
</tr>
<tr>
<td></td>
<td>(b) evaluation of protective sensation,</td>
</tr>
<tr>
<td></td>
<td>(c) evaluation of foot structure and biomechanics,</td>
</tr>
<tr>
<td></td>
<td>(d) evaluation of vascular status and skin integrity, and</td>
</tr>
<tr>
<td></td>
<td>(e) evaluation and recommendation of footwear</td>
</tr>
<tr>
<td></td>
<td>3. Patient education</td>
</tr>
<tr>
<td>G0247</td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>1. Local care of superficial wounds</td>
</tr>
<tr>
<td></td>
<td>2. Debridement of corns and calluses</td>
</tr>
<tr>
<td></td>
<td>3. Trimming and debridement of nails</td>
</tr>
</tbody>
</table>

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.
Modifier 59 indicates distinct procedural services. The same beneficiary on the same day. Their specific use is:

### 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.

### 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 to 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


### 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 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, pCO₂, pO₂, CO₂, HCO₃ (including calculated O₂ 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
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.

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) 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 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.
### Newly Added Test Granted Waived Status under CLIA

<table>
<thead>
<tr>
<th>TEST NAME</th>
<th>MANUFACTURER</th>
<th>CPT CODE</th>
<th>USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Technidyne ProTime Microcoagulation System (ProTime 3 Cuvette) Prescription Home Use</td>
<td>International Technidyne Corporation</td>
<td>85610QW</td>
<td>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</td>
</tr>
<tr>
<td>International Technidyne ProTime Microcoagulation System (ProTime 3 Cuvette) Professional Use</td>
<td>International Technidyne Corporation</td>
<td>85610QW</td>
<td>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</td>
</tr>
<tr>
<td>Ostex International Osteomark NTX Point of Care Prescription Home Use</td>
<td>Ostex International Inc.</td>
<td>82523QW</td>
<td>Measures normalized cross-linked N-telopeptides of type 1 collagen in urine</td>
</tr>
<tr>
<td>Embryotech Laboratories FertilMARQ™ Home Diagnostic Screening Test for Male Infertility</td>
<td>Embryotech Laboratories, Inc.</td>
<td>89300QW</td>
<td>Screening test to measure sperm concentration.</td>
</tr>
<tr>
<td>Metrika A1c Now™ - Professional Use</td>
<td>Metrika, Inc.</td>
<td>83036QW</td>
<td>Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes</td>
</tr>
<tr>
<td>Diagnostic Chemicals ImmunoDip™ Urinary Albumin Screen (Urine Dipstick)</td>
<td>Diagnostic Chemicals Limited (USA)</td>
<td>82044QW</td>
<td>Semi-quantitative measurement of microalbumin in urine for the detection of patients at risk for developing kidney damage</td>
</tr>
<tr>
<td>FemTek pH EM-ALERT®</td>
<td>FemTek, LLC</td>
<td>83986QW</td>
<td>Vaginal pH detection (acid-base balance)</td>
</tr>
<tr>
<td>Provalis Diagnostics Glycosal™ HbA1c Test</td>
<td>Provalis Diagnostics Ltd.</td>
<td>83036QW</td>
<td>Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes</td>
</tr>
<tr>
<td>Quidel QuickVue+ Infectious Mononucleosis (Whole Blood)</td>
<td>Quidel Corporation</td>
<td>86308QW</td>
<td>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</td>
</tr>
<tr>
<td>Acon® Strep A Rapid Strip Test</td>
<td>Acon Laboratories, Inc.</td>
<td>87880QW</td>
<td>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</td>
</tr>
<tr>
<td>Beckman Coulter Primary Care Diagnostics ICON DS Strep A</td>
<td>Acon Laboratories, Inc.</td>
<td>87880QW</td>
<td>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</td>
</tr>
</tbody>
</table>

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
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 will 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

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

*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 list 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
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 Accountability Act (HIPAA) requirements. The X12N 837 version 4010 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.wpe-edl.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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA</td>
<td>(the default code)</td>
</tr>
<tr>
<td>BA1, BA2, BB1, BB2</td>
<td></td>
</tr>
<tr>
<td>CA1, CA2, CB1, CB2, CC1, CC2</td>
<td></td>
</tr>
<tr>
<td>IA1, IA2, IB1, IB2</td>
<td></td>
</tr>
<tr>
<td>PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2</td>
<td></td>
</tr>
<tr>
<td>RHA, RHB, RHC, RLA, RLB, RMA, RMB, RMC, RUA, RUB, RUC, RVA, RVB, RVC</td>
<td></td>
</tr>
<tr>
<td>SE1, SE2, SE3, SSA, SSB, SSC</td>
<td></td>
</tr>
</tbody>
</table>

**HIPPS Modifiers/Assessment Type Indicators**

**Basic Assessments**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>5-day Medicare-required assessment</td>
</tr>
<tr>
<td>02</td>
<td>30-day Medicare-required assessment</td>
</tr>
<tr>
<td>03</td>
<td>60-day Medicare-required assessment</td>
</tr>
<tr>
<td>04</td>
<td>90-day Medicare-required assessment</td>
</tr>
<tr>
<td>05</td>
<td>Readmission/Return Medicare-required assessment</td>
</tr>
<tr>
<td>07</td>
<td>14-day Medicare-required assessment</td>
</tr>
<tr>
<td>08</td>
<td>Off-cycle other Medicare-required assessment (OMRA)</td>
</tr>
<tr>
<td>30</td>
<td>Off-cycle swing bed change in clinical status (outside assessment window)</td>
</tr>
</tbody>
</table>

**Replacement Assessments – OMRAs**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>OMRA replacing 5-day Medicare-required assessment or 5-day Readmission/Return Assessment</td>
</tr>
<tr>
<td>28</td>
<td>OMRA replacing 30-day Medicare-required assessment</td>
</tr>
<tr>
<td>38</td>
<td>OMRA replacing 60-day Medicare-required assessment</td>
</tr>
<tr>
<td>48</td>
<td>OMRA replacing 90-day Medicare-required assessment</td>
</tr>
<tr>
<td>78</td>
<td>OMRA replacing 14-day Medicare-required assessment</td>
</tr>
</tbody>
</table>

**Replacement Assessments – Change in Clinical Status**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>Swing bed change in clinical status replaces 30-day Medicare-required assessment</td>
</tr>
<tr>
<td>33</td>
<td>Swing bed change in clinical status replaces 60-day Medicare-required assessment</td>
</tr>
<tr>
<td>34</td>
<td>Swing bed change in clinical status replaces 90-day Medicare-required assessment</td>
</tr>
<tr>
<td>35</td>
<td>Swing bed change in clinical status replaces a readmission/return Medicare-required assessment</td>
</tr>
<tr>
<td>37</td>
<td>Swing bed change in clinical status replaces 14-day Medicare-required assessment</td>
</tr>
</tbody>
</table>

**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 RUAx, 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 RHAx, RRHxx, 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-012x, 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 establish 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 correctness 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 catheterization 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.
- Hypodermoclysis, IV feedings modified to IV feedings only. Hypodermoclysis 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

<table>
<thead>
<tr>
<th>Services Provided After Discharge From the SNF-Level Extended Care Bed</th>
<th>Bundled Back to Swing Bed Provider</th>
<th>Separately Billable by Swing Bed Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To home (no return by midnight)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• To home (return by midnight)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• To home for home health services under a plan of care</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• To hospital or CAH for inpatient admission</td>
<td>Billed by hospital or CAH</td>
<td></td>
</tr>
</tbody>
</table>

| Services within the General Scope of Swing Bed Care (All services except those specifically excluded by legislation and/or by CMS) | X |

<table>
<thead>
<tr>
<th>Services Excluded by the BBA</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physician services</td>
<td></td>
</tr>
<tr>
<td>• Physician assistant services performed under supervision</td>
<td></td>
</tr>
<tr>
<td>• Nurse practitioners and clinical nurse specialists working in collaboration with a physician</td>
<td></td>
</tr>
<tr>
<td>• Certified nurse midwife</td>
<td></td>
</tr>
<tr>
<td>• Qualified psychologist</td>
<td></td>
</tr>
<tr>
<td>• Certified registered nurse anesthetist</td>
<td></td>
</tr>
<tr>
<td>• Home dialysis supplies and equipment, self care dialysis support services, and institutional dialysis services and supplies</td>
<td></td>
</tr>
<tr>
<td>• Erythropoietin for certain dialysis patients</td>
<td></td>
</tr>
<tr>
<td>• Hospice care related to a beneficiary’s terminal illness</td>
<td></td>
</tr>
<tr>
<td>• Ambulance – initial admission /final discharge</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services Excluded by CMS from SNF PPS Financial Responsibility under Consolidated Billing¹</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Outpatient Hospital Emergency Services²</td>
<td>X</td>
</tr>
<tr>
<td>• Magnetic resonance imaging</td>
<td>X</td>
</tr>
<tr>
<td>• Computerized axial tomography scans</td>
<td>X</td>
</tr>
<tr>
<td>• 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.)</td>
<td>X</td>
</tr>
<tr>
<td>• Hospital outpatient radiation therapy</td>
<td>X</td>
</tr>
<tr>
<td>• Hospital outpatient angiography</td>
<td>X</td>
</tr>
<tr>
<td>• Lymphatic and venous procedures</td>
<td>X</td>
</tr>
<tr>
<td>• Hospital outpatient angiography</td>
<td>X</td>
</tr>
<tr>
<td>• Lymphatic and venous procedures</td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services excluded by the BBRA³</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Certain Chemotherapy items and administrative services</td>
<td>X</td>
</tr>
<tr>
<td>• Certain Radiosotope services</td>
<td>X</td>
</tr>
<tr>
<td>• Certain Customized prosthetic devices</td>
<td>X</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Type Of Trip</th>
<th>Ambulance Bills Carrier</th>
<th>Ambulance Bills Swing Bed Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Admission to SNF-Level Care at Swing Bed Facility&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Final Discharge From SNF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• To home (no return by midnight)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>• To home (return by midnight)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• To home for home health services under a plan of care</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• To another hospital for acute care services</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• To another SNF (medical necessity)&lt;sup&gt;5&lt;/sup&gt;</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Round-Trip to Obtain Dialysis Services (BBRA) in another facility</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Round-Trip to Another Hospital for Emergency Services</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Round-Trip to Another Hospital for Services Within the General Scope of Swing Bed Care (All services except those specifically excluded by CMS)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Round-Trip to Another Hospital for Services Excluded by CMS from SNF PPS Financial Responsibility Under Consolidated Billing&lt;sup&gt;6&lt;/sup&gt;</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Magnetic resonance imaging</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Computerized axial tomography scans</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• 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.)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Cardiac catheterization</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Hospital outpatient radiation therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital outpatient angiography</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Lymphatic and venous procedures</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Round-Trip to Provider of Services Excluded by BBRA from SNF PPS Financial Responsibility Under Consolidated Billing&lt;sup&gt;7&lt;/sup&gt; – Certain chemotherapy items and administrative services, radioisotope services, and customized prosthetic devices</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

<sup>4</sup>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.

<sup>5</sup>Ambulance bills transferring facility.

<sup>6</sup>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.

<sup>7</sup>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

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**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
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 Laboratories

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
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 post-payment 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.

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

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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

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

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


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

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

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

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
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
Revised Effective Date: 08/01/2000
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: 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.

66821: Yag Laser Capsulotomy (continued)
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

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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, arrhythmias, or other ECG abnormalities at 85 percent 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 arrhythmias (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 arrhythmias.
- **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, arrhythmias, 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 cm² /m² 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**

**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
- 410.0-410.92 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 Cardiovascular 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 Post surgical aortocoronary 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

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
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
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

3rd Qtr 2002 Bulletin
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

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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 D3 or ergosterol to vitamin D2. Following exposure to ultraviolet light, vitamin D3 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 D2 can substitute for D3 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)

mía 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 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 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:

<table>
<thead>
<tr>
<th>PTH LEVEL</th>
<th>DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased by &lt;50% &amp; above 300</td>
<td>Increase by 1.0-2.0 mcg at 8 week intervals</td>
</tr>
<tr>
<td>150-300</td>
<td>Maintain current dose</td>
</tr>
<tr>
<td>&lt; 100</td>
<td>Suspend times 1 week; resume at least 1.0 mcg lower</td>
</tr>
</tbody>
</table>

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 mg²/dL², 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
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

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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, 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
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 pneumovax). 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 conduction, 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., azathioprine, Methotrexate, cyclophosphamide, cyclosporine). 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.
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**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 conjunctivitis, and (5) cervical lymphadenopathy, often 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 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 manifestations of this condition. Duration of treatment is generally a short course of 3-5 weeks.

e) Autoimmune Neutropenia
Autoimmune 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 800/mm³ 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/dose; 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.
72192: Computerized Tomography of the Pelvis—Correction to Article

A n 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

T he 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

T he 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

T he 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

T he 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

T he 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

T he 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.
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.

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.
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 ISSUES

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.
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 described 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/$1000) 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 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 dosimetry 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.
2002 Update of the Hospital Outpatient PPS (continued)

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, 2001 indicated 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.

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<th>New HCPCS Code</th>
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Old Code  APC  New HCPCS Code  APC
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
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/putfiles.htm#alphanu.

HCPCS Correct Descriptor
Code
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 Te 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 Na chromatecr51, 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 tc99m labeledrbcs, per MCI
Q3011 Chromic phosphate p32, per MCI
Q3012 Na chromatecr51, 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 Register 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
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 two 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:

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

Medicare 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.

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 Transmittal A-02-026, CR 2102

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.
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

This material provides a basic overview of the consumer privacy protection rules adopted by the United States Department of Health and Human Services in conformance with the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996. This material does not interpret these rules or attempt to apply the rules to your particular circumstances. The information provided is (1) for your information only, (2) subject to change without notice, and (3) provided “as is” without warranty of any kind, expressed or implied. FIRST COAST SERVICE OPTIONS, INC. DISCLAIMS RESPONSIBILITY FOR ANY CONSEQUENCES OR LIABILITY ATTRIBUTABLE TO OR RELATED TO ANY USE, NON-USE, OR INTERPRETATION OF INFORMATION CONTAINED OR NOT CONTAINED IN THIS MATERIAL. FIRST COAST SERVICE OPTIONS, INC. DISCLAIMS ANY LIABILITY FOR ANY DIRECT, SPECIAL, INDIRECT, INCIDENTAL, OR CONSEQUENTIAL LOSSES OR DAMAGES RELATED TO THE ACCURACY OR COMPLETENESS OF THIS MATERIAL. The information provided is no substitute for your own review and analysis of the relevant law.

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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 an 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.

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.

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.
ELECTRONIC DATA INTERCHANGE

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 October 15, 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?
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.

<table>
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<tr>
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<th>Transaction Description</th>
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<tr>
<td>837</td>
<td>Health Care Claim</td>
<td>May 1, 2002</td>
</tr>
<tr>
<td>835</td>
<td>Health Care Claim Payment (Remittance) Advice</td>
<td>May 16, 2002</td>
</tr>
<tr>
<td>276/277</td>
<td>Health Care Claim Status Request &amp; Response</td>
<td>July 16, 2002</td>
</tr>
</tbody>
</table>

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
EDUCATIONAL RESOURCES

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-MEDICARE 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! 

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.

Please continue to look for “The Patient Friendly Advisory” in future issues of the Medicare A Bulletin
ORDER FORM - PART A MATERIALS
The following materials are available for purchase. To order, please complete and submit this form along with your check/money order (PAYABLE TO: BCBSFL-FCSO, account number 756134).

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<td>Medicare A Bulletin Subscriptions - One subscription of the Medicare A Bulletin is sent free of charge to all providers with an active status with the Medicare Part A program. Non-providers (e.g., billing agencies, consultants, software vendors, etc.) or providers who need additional copies at other office facility locations may purchase an annual subscription. This subscription includes all Medicare bulletins published during calendar year 2002 (back issues sent upon receipt of the order). Please check here if this will be a:</td>
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Subtotal $_________

Tax (7%) $_________

Total $_________

Mail this form with payment to:

First Coast Service Options, Inc.
P.O. Box 45280
Jacksonville, FL 32232-5280

Facility Name:________________________________________________________________________

Mailing Address:_______________________________________________________________________

City:___________________________________    State:_______    Zip Code:_______________________

Attention:__________________________________      Area Code/Telephone Number:_______________

Please make check/money order payable to: BCBSFL- FCSO Account #756134

(CHECKS MADE TO “PURCHASE ORDERS” NOT ACCEPTED)

ALL ORDERS MUST BE PREPAID -
DO NOT FAX - PLEASE PRINT

NOTE: The Medicare A Bulletin is available free of charge online at www.floridamedicare.com.
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

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**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**

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### 2. PLEASE INDICATE THE MATERIALS YOU WOULD LIKE TO PURCHASE.

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| 1        | **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**

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### 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)

|-----------------------------|-----------------------|-------------|--------------------------|-------------------------------|-------------------------------|-------------------------|---------------------|----------|----------------------------------------|------------------|-------------------------------|-------------------------|---------------------|------------------|------------------------|-------------------------------|------------------|----------------------|--------------------------|--------------------------------|-------------------------|--------------------------------|----------------------|------------------------|

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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 site content changes frequently as information is added or updated.
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