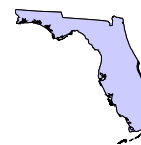


# Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers



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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](http://www.floridamedicare.com).

#### Routing Suggestions:

- Medicare Manager
- Reimbursement Director
- Chief Financial Officer
- Compliance Officer
- DRG Coordinator
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



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

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

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32231-0048**

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## A PHYSICIAN'S FOCUS

### Medicare Payment of Drugs and Biologicals Furnished Incident to a Physician's Service

The current political season features proposed Medicare reforms with much focus on new prescription drug benefits. While new bills make their way through the political process, the Centers for Medicare & Medicaid Services (CMS) has given instructions to its contractors on how to implement the provisions of the Benefits Improvement and Protection Act (BIPA) of 2000 that amended aspects of the current limited coverage of outpatient drugs. These instructions (published in change request 2200), with an effective date of August 1, 2002, are undergoing review by the appropriate contractors.

#### Brief Background

The Social Security Act does not provide a comprehensive drug benefit for Medicare beneficiaries. For Part A (inpatient services), drugs provided during acute inpatient stays and qualified skilled nursing facility stays are generally covered if requirements are met. For Part B (outpatient services including outpatient hospital such as emergency room), drugs and biologicals coverage is generally limited to the type of drugs that

- cannot be self-administered,
- are medically necessary and reasonable,
- are approved by the Food and Drug Administration, and
- are incident to the services of physicians in the treatment of patients as defined in the Medicare Carrier, Intermediary, and Hospital manuals.

The Medicare definition of the type of drugs that *cannot be self-administered* was redefined by Congress with passage of BIPA to *usually not self-administered*. As a result of this benefit structure, self-administered drugs and biologicals (pill form or injection form) in the outpatient setting are usually not covered except where Congress has provided for additional coverage.

#### How Will This Impact Part A Providers and Their Patients?

The change request instructs contractors to define *usually not self-administered* as more than 50 percent of the time for all Medicare beneficiaries who use the drug. A drug self-administered by more than 50 percent of Medicare beneficiaries is excluded from coverage. This definition and other criteria in the change request will necessitate a reevaluation process by carriers and intermediaries in applying the exclusion. Though the Medicare exclusion seems clear for oral drugs, suppositories, topical medications and coverage seems clear for intravenous drugs and most drugs given intramuscularly if other requirements are met, there are issues with exclusion vs. coverage of some drugs given subcutaneously. Per current instructions, Medicare contractors will post on their Web sites the process used to determine which drugs are self-administered. The determination will be made on a drug-by-drug basis and not on a beneficiary-by-beneficiary basis. First Coast Service Options, Inc. current list of self-administered drugs will not change until each drug is evaluated. Though each drug will not be subject to local medical review policy development, the process will include the opportunity for comment by interested parties before final decisions are reached. Providers will be given 45 days notice if a previously covered drug is noncovered. Also, providers and beneficiaries will have appeal rights for denied coverage.

Given the short time frame of the change request and its implications, providers are encouraged to monitor our Web site ([www.floridamedicare.com](http://www.floridamedicare.com)) for the posting of our process, the list of drugs impacted, and any new changes in instructions from CMS.



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

## About *The Medicare A Bulletin*

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

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

Important notifications that require communication in between these dates will be posted to the First Coast Service Options, Inc. (FCSO) Florida provider Web site [www.floridamedicare.com](http://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 Florida. FCSO, 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 (LMRP) section contains finalized medical policies and additions, revisions, and corrections to previously published LMRPs. Whenever possible, the LMRP 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 seminar 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 (FCSO) 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.

**Note:** Because this issue for the *Medicare A Bulletin* is not available in hard copy format, the date it is posted to the Web site is considered the notice date. Please see articles on pages 8 and 27 for more information.

### **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 45270 – 11T  
Jacksonville, FL 32232-5270



## GENERAL INFORMATION

### Sulzer Inter-Op Acetabular Shell Recall Settlement

The Centers for Medicare & Medicaid Services (CMS) and Sulzer Orthopedics have resolved a dispute concerning the application of the Medicare Secondary Payer (MSP) laws to a Sulzer recall of certain Inter-Op acetabular shells for hip implants. This article summarizes the dispute and its resolution and provides guidance to providers on the actions providers need to take as a result.

In December 2000, Sulzer Orthopedics recalled approximately 17,500 Inter-Op acetabular shells used in connection with hip implant procedures. Sulzer advised providers, physicians and recipients that it would cover the cost of “unreimbursed medical expenses” related to the monitoring and possible replacement of the hip implants and related services. The MSP laws preclude Medicare payment for services when payment has been made, or can reasonably be expected to be made, under a liability insurance policy or plan (including a plan of self-insurance). CMS considered Sulzer’s initial assurance of payment for “unreimbursed medical expenses” to constitute a “reasonable expectation of payment under a liability insurance policy or plan” and held that Sulzer (and its insurers) were the primary payers for these services. Sulzer disagreed and takes the position that it is not subject to recovery under the MSP provisions.

CMS and Sulzer agreed to try to resolve the dispute through negotiation. CMS asked its Medicare contractors to advise providers and suppliers to hold claims while it determined whether the claims should be sent to Sulzer or the appropriate Medicare contractor for processing. If a provider or supplier did not wish to await such guidance from CMS, it could submit a paper claim with the annotation that the claim was related to the Sulzer recall. Such claims were to be held by Medicare contractors until CMS determined whether Medicare should process the claims.

CMS and Sulzer have reached a final settlement regarding the processing of claims related to medical services provided to Medicare beneficiaries in conjunction with a revision of a recalled Inter-Op acetabular shell. Under the settlement, Medicare will process any claims for such services and shall not look to Sulzer, its liability insurance plans, the Sulzer Class Action Settlement, or the Medicare beneficiaries for repayment of any claims in connection with the hip implant devices. Other Medicare payment and coverage rules for these services will be applied.

Providers are encouraged to submit claims related to the Sulzer recall as soon as possible. If a provider submits an initial claim to Medicare for primary payment and receives such primary payment; under the terms of the settlement, providers may bill Sulzer for Medicare deductibles, Medicare coinsurance and services not covered by Medicare under applicable Medicare coverage guidelines. If a provider receives a payment from Sulzer, its liability insurance plans or the Sulzer Class Action Settlement, it may not bill Medicare on a secondary payer basis.

Providers billing claims to Florida Medicare Part A need to indicate “Sulzer Settlement” on the Form UB-96 CMS-1450, or electronic equivalent, in form locator 84 (Remarks). Send claims to:

Medicare Part A  
Attention: Sulzer Settlement  
P.O. Box 2711  
Jacksonville, FL 32231-0021. ❖

Source: CMS Notification dated May 20, 2002

### 2003 Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification

The 2003 update to the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* diagnosis coding structure is effective **October 1, 2002**. Providers are required to use the 2003-updated ICD-9-CM coding effective for all hospital discharges and outpatient services occurring **on or after October 1, 2002**. Due to the direct relationship between coding and reimbursement, it is particularly important that providers reimbursed under the prospective payment system (PPS) used the appropriate ICD-9-CM coding. Other providers that code diagnoses and procedures (non-OPPS providers) are also affected. In addition, the new diagnosis coding is used in hospital outpatient billing.

Information regarding the 2003 ICD-9-CM coding update is available on the Centers for Medicare & Medicaid Services (CMS) Web site – [www.cms.hhs.gov/medlearn/icd9code.asp](http://www.cms.hhs.gov/medlearn/icd9code.asp). Changes to local medical review policies affected by the 2003 ICD-9-CM update will be published in future issues of the *Medicare A Bulletin*.

The latest versions of the ICD-9-CM manuals (as well as a variety of other coding materials) may be obtained from:

American Medical Association (800)621-8335	Medicode Publications (800) 999-4600	St. Anthony’s Publishing (800) 632-0123
---	---	--

ICD-9-CM and other coding materials may also be obtained from local medical publishing and consulting firms. ❖

Source: CMS Transmittal AB-2085, CR 2194

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## 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 31023

**Reason Message:** The claim is being returned due to all line items receiving a reject or denial on the line level. Please review all line items for edits received and utilize the reason code narratives to identify the billing error(s). If the primary procedure line is not payable due to an edit assigned, then all incidental lines will not be payable due to other related edits. Primary billing errors relate to demand bills incorrectly submitted, the claim should be submitted as a payable claim with the appropriate condition code, then the system logic will assign an additional development request or denial edit.

#### Tips to Avoid RTPs on Reason Code 31023

- When submitting “demand bills,” code as a covered stay and use the appropriate condition code (20 or 21).
- When working a previously RTP’d claim, review accompanying edits. If the detail line requires revision, the entire line needs to be deleted and re-keyed in its entirety in order for the previous edit to be deleted. If the procedure line is deleted and re-keyed, then the incidental lines will also need to be deleted and re-keyed. On demand bills, the type of bill (TOB) and covered days need to be reset, as well.

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## Diabetes Self-Management Training Payment

The Centers for Medicare & Medicaid Services (CMS) has notified fiscal intermediaries to disregard prior instructions stating that the amount paid for the diabetes self-management training (DSMT) benefit should be comparable to the physician fee schedule.

Services for DSMT furnished in a hospital outpatient setting, will be paid based on the CORF fee schedule.

Providers must submit, if not done so, a copy of their American Diabetes Association (ADA) recognition certificate to their fiscal intermediary. If a provider does not submit the ADA recognition certificate, payment cannot be made for rendering this service. ❖

Source: CMS Transmittal A-02-032, CR 2049

### 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 the beneficiary eligibility files in the direct data entry system 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](http://www.palmettogba.com).
- Condition code **07 must** be submitted with any claim for services unrelated to the terminal condition.

### Reason Code 31131

**Reason Message:** The medical record number entered contains a character that will cause a problem in the ANSI (American National Standards Institute) translator. Each position of this field can contain only an alpha or numeric character, a dash, or a space.

#### Tips to Avoid RTPs on Reason Code 31131

- Sight-verify the medical record number to ensure the field contains only an alpha or numeric character, a dash, or a space. All other characters will cause your claim to RTP.

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 adds unnecessary costs to the Medicare program. ❖

## Billing for Pleurx Pleural Catheters

The Centers for Medicare & Medicaid Services (CMS) has determined that since Pleurx pleural catheters are implanted prostheses, claims for catheters are billed to the Medicare Part A fiscal intermediary. However, since the drainage kits are an external accessory to the implanted catheter, claims for the kit supplies are billed to the local Medicare Part B carrier. Therefore, the Part B carrier, not the durable medical equipment regional carrier, is responsible for processing claims for the Pleurx pleural drainage kits, including service areas.

CMS anticipates that HCPCS codes for the catheter and vacuum bottle will be established by January 1, 2003. ❖

Source: CMS Region IV Notification dated July 1, 2002.

## Services Subject to Home Health Consolidated Billing

In April 2001, the Centers for Medicare & Medicaid Services (CMS) established the process of periodically updating the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the home health prospective payment system (HH PPS). That instruction indicated the lists would be updated annually, in conjunction with the overall annual HCPCS code set update.

CMS has determined that more frequent updates of the HH consolidated billing code lists are necessary. This is to reflect the creation of temporary HCPCS codes ('K' codes) throughout the course of a year that may describe services subject to consolidated billing. For example, such codes may be created at the request of durable medical equipment regional carriers (DMERCs), to reflect new technologies or clarify coding in support of local medical review policies. To account for any mid-year coding changes, CMS will update the HH consolidated billing code lists as frequently as quarterly. Some quarters there may be no update, if no new codes need to be reflected.

As with previous updates, the new coding identified in each update will describe the same services that were used to determine the HH PPS payment rates. Additional services not reflected in the HH PPS rates will not be added by these updates.

### Current Update

The current update is to reflect a new set of 'K' codes for ostomy supplies. The following new 'K' codes replace codes currently on the HH consolidated billing code list. Each deleted code in the list below is replaced by two new codes:

Deleted Code and Description	New Codes and Descriptions
A4370: Skin barrier paste per oz	K0561: Non-pectin based ostomy paste
A4374: Skin barrier extended wear	K0562: Pectin based ostomy paste
A4386: Ost skn barr w flng ex wr	K0563: Ext wear ost skn barr <4sq"
A5061: Pouch drainable w barrier at	K0564: Ext wear ost skn barr >4sq"
A5123: Skin barrier with flange	K0565: Ost skn barr w flng <4sq"
	K0566: Ost skn barr w flng >4sq"
	K0567: 1 pc drainable ost pouch
	K0568: 1 pc cnvx drainabl ost pouch
	K0570: Ostomy skn barr w flng <4sq"
	K0571: Ostomy skn barr w flng >4sq"

The following new 'K' codes are added to the HH consolidated billing code list, without a replacement:

K0569: 2 pc drainable ost pouch	K0577: Ostomy pouch odor barrier
K0574: Ostomy pouch filter	K0578: Urinary pouch faucet/drain
K0575: Ost pouch rustle free mat	K0579: Ost pouch absorbent material
K0576: Ostomy pouch comfort panel	K0580: Ost pouch locking flange

CMS has determined that the following codes are **not** subject to HH consolidated billing.

K0572 Non-waterproof tape	K0573 Waterproof tape
---------------------------	-----------------------

### Nonrouting Supply Codes

The resulting list of 207 nonroutine supply codes that follows replaces the previous list of 194. The list of 69 therapy codes that are subject to HH consolidated billing is not affected by this update.

A4212	A4335	A4371	A4396	A5063	A6154	A6221	A6247	A7505
A4310	A4338	A4372	A4397	A5071	A6196	A6222	A6248	A7506
A4311	A4340	A4373	A4398	A5072	A6197	A6223	A6251	A7507
A4312	A4344	A4375	A4399	A5073	A6198	A6224	A6252	A7508
A4313	A4346	A4376	A4400	A5081	A6199	A6228	A6253	A7509
A4314	A4347	A4377	A4402	A5082	A6200	A6229	A6254	K0561
A4315	A4348	A4378	A4404	A5093	A6201	A6230	A6255	K0562
A4316	A4351	A4379	A4421	A5102	A6202	A6231	A6256	K0563
A4319	A4352	A4380	A4455	A5105	A6203	A6232	A6257	K0564
A4320	A4353	A4381	A4460	A5112	A6204	A6233	A6258	K0565
A4321	A4354	A4382	A4462	A5113	A6205	A6234	A6259	K0566
A4322	A4355	A4383	A4481	A5114	A6206	A6235	A6261	K0567
A4323	A4356	A4384	A4622	A5119	A6207	A6236	A6262	K0568
A4324	A4357	A4385	A4623	A5121	A6208	A6237	A6266	K0569
A4325	A4358	A4387	A4625	A5122	A6209	A6238	A6402	K0570
A4326	A4359	A4388	A4626	A5126	A6210	A6239	A6403	K0571
A4327	A4361	A4389	A4649	A5131	A6211	A6240	A6404	K0574
A4328	A4362	A4390	A5051	A6010	A6212	A6241	A6405	K0575
A4330	A4364	A4391	A5052	A6020	A6213	A6242	A6406	K0576
A4331	A4365	A4392	A5053	A6021	A6214	A6243	A7501	K0577
A4332	A4367	A4393	A5054	A6022	A6215	A6244	A7502	K0578
A4333	A4368	A4394	A5055	A6023	A6219	A6245	A7503	K0579
A4334	A4369	A4395	A5062	A6024	A6220	A6246	A7504	K0580

Source: CMS Transmittal AB-02-092, CR 2247

## Newsletters Will Not Be Printed Between July and September 2002

In an effort to save funds that will be used to help providers better understand the Health Insurance Portability and Accountability Act (HIPAA) via HIPAA-specific educational outreach events, pamphlets, etc., the Centers for Medicare & Medicaid Services (CMS) has instructed Medicare contractors to discontinue printing and mailing any bulletins or newsletters scheduled for distribution between July 1, 2002, and September 30, 2002. This decision affects two publications that were scheduled during this period. The Fourth Quarter 2002 *Medicare A Bulletin* is scheduled for distribution in mid August, and a Special Issue *Bulletin* is planned for the 2003 ICD-9-CM update. The ICD-9-CM Special Issue was expected to be released in late August.

FCSO will develop these materials and post them to our provider Web site [www.floridamedicare.com](http://www.floridamedicare.com). However, these issues will **not** be available in hard copy format. The Fourth Quarter 2002 *Bulletin* will be posted to the Web site by August 12, 2002. The exact posting date of the ICD-9-CM Special Issue is dependent upon the date CMS releases the update to fiscal intermediaries; however, this issue should be posted no later than September 1, 2002.

To receive quick, automatic notification when new issues of the *Medicare A Bulletin* are posted to the Web site, subscribe to our *eNews* mailing list. It's very easy to do; simply go to our Web site, click on the yellow "Join our electronic mailing list" bar and follow the prompts.

In the event additional publications become necessary during this time, these too will only be posted to the Web site; *eNews* notifications of these postings will be sent.

### Frequently Asked Questions

**Q. What do I do if I don't have Internet access? How am I to receive and know what is updated?**

A. Public libraries have PCs with Internet access available for anyone to use. Providers without Internet access might consider asking a colleague who does for assistance.

**Q. What is the rationale for this change?**

A. Funds initially intended for contractors' general provider education and training activities, including hard copy publications, have been re-allocated to help providers better understand HIPAA, via HIPAA-specific educational outreach events, pamphlets, etc.

**Q. Is Medicare going to waive any changes in updates to allow processing?**

A. No. Providers will be responsible for the information posted to the Web site, as if it were published in hard copy format.

**Q. Will the First Quarter 2003 issue be published at its regular scheduled timeframe?**

A. At this time, we anticipate a return to the normal publication schedule. The First Quarter 2003 issue is scheduled to be provided at least 45 days prior to January 1, 2003. However, beginning with the First Quarter 2003 issue, full-text local medical review policies will be available *only* on the Internet. Hard copy publications will provide a summary of policies or policy changes, with a reference to the full-text on the Web site.

**Q. Is Medicare trying to put us out of business? I don't want to buy a PC.**

A. You don't have to purchase a PC, but you will need to have access to one, for example, at a library (refer to question 1). Providing publications only on the Web site is simply a more cost-effective delivery method for the Medicare program, allowing more funds to be utilized for implementation of HIPAA (refer to question 2).

**Q. Can a Customer Service Representative go on the Web, print the article and fax or mail it to my office?**

A. No. At this time, we feel our CSRs can better serve the provider community by concentrating on responding to specific issues. Refer to question 1 for information on obtaining the *Medicare A Bulletin* if you do not have Internet access.

**Q. Is there an easy way to know when Medicare has posted something new to the Web site?**

A. To receive quick, automatic notification when new issues of the *Medicare A Bulletin* (and other items of interest) are posted to the Web site, providers may subscribe to our *eNews* mailing list. It's very easy to do; simply go to the Web site, click on the yellow "Join our electronic mailing list" bar and follow the prompts. ❖

## Provider Information Available on CMS Web site

The Centers for Medicare & Medicaid Services (CMS) released the first issue of *The CMS Quarterly Provider Update* on April 22, 2002. Future issues will be released the first work day of each subsequent calendar quarter. These quarterly updates will include all changes to Medicare instructions that affect providers, or may be of interest to them. They will provide a single source for national Medicare provider information and give providers advance notice on upcoming instructions and regulations.

The first release is a Web-based document and is available at <http://www.cms.hhs.gov/providerupdate>. For ease of use by individual providers, regulations and instructions are collated and sorted based on the interests of the user.

Each update will include the full text of instructions to be implemented 90 or more days after its release. For

example, instructions included in the April *Update* have an implementation date of July 1, 2002 or later. The listings of regulations will be presented in two parts. One part will list all regulations CMS plans to publish within the next 90 days. The second part will include hyperlinks to the text of all regulations published in the previous quarter.

CMS' goal is to make it easier for providers to understand and comply with Medicare regulations and instructions and to give them time to review and react to upcoming program changes. To improve future issues of the *Update* and ensure they are responsive to provider needs, a feedback form is included with each issue. CMS encourages anyone accessing the *Update* to use the feedback form to forward comments on its utility, organization and format. ❖

Source: CMS Transmittal AB-02-049, CR 1868

**Third-party Web sites.** This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.



## Rebilling of Inpatient Claims

In situations where a hospital determines before submitting an inpatient claim to the intermediary that the services do not meet inpatient criteria, the facility can bill only the inpatient (Medicare Part B) ancillary charges using a 12x type of bill code.

Per Section 228 of the Hospital Manual (CMS Pub. 10), the following services are billable on a 12x claim when Part A no longer applies:

- Diagnostic laboratory tests
- Diagnostic X-rays, radiological services, radium and radioactive isotope therapy
- Surgical dressings, splints, casts and other devices used for the reduction of fractures and dislocations
- Leg, arm, back and neck braces, trusses, and artificial legs, arms and eyes (including adjustment, repairs and replacements)
- Vaccinations or inoculations specifically for flu, PPV and hepatitis B
- Approved oral cancer and anti-emetic drugs
- Hemophilia clotting factor
- Ambulance
- Physical, occupational and speech therapy
- Inpatient dialysis services (billed under revenue code 0801).

## Payment Limit for Drugs and Biologicals

The Centers for Medicare & Medicaid Services (CMS) has reissued instructions to retain and provide continuity to the current regulations for the payment of drugs and biologicals based on the lower of the billed charge or 95 percent of the average wholesale price (AWP) as described below. Therefore, information provided in this article remains unchanged.

### Payment for Drugs and Biologicals

Drugs and biologicals not paid on a cost or prospective payment basis are paid based on the lower of the billed charge or 95 percent of the AWP as reflected in sources such as the *Red Book*, *Price Alert*, or *Medispan*. Examples of drugs that are paid on this basis include but are not limited to:

- Drugs furnished incident to a physician's service
- Immunosuppressive drugs furnished by pharmacies
- Drugs furnished by pharmacies under the durable medical equipment benefit
- Covered oral anticancer drugs
- Drugs furnished by independent dialysis facilities that are not included in the end stage renal disease composite rate payment.

### Calculation of the AWP

For a **single-source** drug or biological, the AWP equals the AWP of the single product.

For a **multisource** drug or biological, the AWP is equal to the lesser of the median AWP of all of the generic forms of the drug or biological or the lowest brand name product AWP. A "brand name" product is defined as a product that is marketed under a labeled name that is other than the generic chemical name for the drug or biological.

After determining the AWP, the amount is multiplied by 0.95. This is the new drug payment allowance limit. ❖

Source: CMS Transmittal AB-02-075 CR 2123

In situations where a hospital submits an inpatient claim to the intermediary in error because the hospital later determines that the patient did not meet inpatient criteria and the claim is paid, the facility should do the following:

- Cancel the original claim.
- Wait for the intermediary to process the cancellation request.
- Resubmit a new claim using type of bill code 12x.

As a Medicare provider, it is the accountability of the facility to make this determination prior to submitting an inpatient claim.

The following is required when canceling a claim:

- Resubmit the claim as type of bill code 118 (cancel claim).
- A condition code is required indicating why the claim is being canceled.
- Include the document control number (DCN) of the claim being canceled in form locator 37A or the electronic equivalent.
- Add remarks to document the reason for the cancel.

Once the claim cancellation is finalized (location B9997), the provider can resubmit a new claim using type of bill code 12x. ❖

## New Patient Status Code 64

Effective for discharges on or after October 1, 2002, the National Uniform Billing Committee has approved a new patient status (PS) code for form locator (FL) 22 of Form UB-92 CMS-1450 or electronic equivalent format.

- 64** Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare.

Form locator 22 is a required field for all Part A inpatient, skilled nursing facilities (SNF), hospice, inpatient rehabilitation facilities (IRF), and outpatient hospital services and indicates the patient's status as of the "through" date of the billing period.

Patient status 64 does not affect payment for acute care hospitals, SNFs, hospices, or outpatient hospitals, however, these facilities are still required to use this code when appropriate. For standard system assignment of review codes in the inpatient PRICER, PS 64 should be treated like PS code 04.

When IRFs use PS code 64, their payment will be affected under the transfer provision of the IRF prospective payment system (PPS).

Previously, IRF providers were instructed to code PS code 03, whether the nursing facility was a Medicare or Medicaid certified nursing facility. Now, providers will use PS code 03 when discharging/transferring to an SNF and use PS 64 when discharging/transferring to a Medicaid-only nursing facility. The applicable transfer PS codes for IRF PPS are 02, 03, 61, 62, 63, and 64. ❖

Source: CMS Transmittal AB-02-041, CR 2093

## Responses to Provider Correct Coding Initiative Questions

Medicare provider customer service representatives (CSRs) are responsible to provide accurate and complete information and truly want to give answers to customer questions. However, supplying the right Healthcare Common Procedure Coding System (HCPCS) codes and Correct Coding Initiative (CCI) modifiers for specific claims is beyond the scope of their work. The HCPCS contains more than 12,000 codes, 7,000 of which describe physician procedures from all specialties and require specialized training to be able to describe. In contrast, the average individual practitioner only uses 150-300 of these codes to describe his/her services. Therefore, it is Medicare expectation that the responsibility to supply the correct code on the Medicare claim lies with the practitioner or the provider. CSRs are able to give the definitions or explain the use of the CCI modifiers. ❖

Source: CMS Transmittal AB-02-079 CR 2113

## 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 May 8, 2002**, the interest rate applied to Medicare overpayments is **11.75 percent**, based on the revised PCR. The following table lists previous interest rates.

Period	Interest Rate
February 1, 2002 – May 7, 2002	12.625%
October 31, 2001 – January 31, 2002	13.25%
August 7, 2001 – October 30, 2001	13.25%
April 26, 2001 – August 6, 2001	13.75%
February 7, 2001 – April 25, 2001	14.125%
October 24, 2000 – February 6, 2001	13.875%
August 1, 2000 – October 23, 2000	13.875%
May 3, 2000 – July 31, 2000	13.75%
February 2, 2000 – May 2, 2000	13.50%
October 28, 1999 – February 1, 2000	13.375%
August 4, 1999 – October 27, 1999	13.25%
May 5, 1999 – August 3, 1999	13.375%
February 1, 1999 – May 4, 1999	13.75%
October 23, 1998 – January 31, 1999	13.50%
July 31, 1998 – October 22, 1998	13.75%
May 13, 1998 – July 30, 1998	14.00 %
January 28, 1998 – May 12, 1998	14.50%
October 24, 1997 – January 27, 1998	13.875%
July 25, 1997 – October 23, 1997	13.75%
April 24, 1997 – July 24, 1997	13.50%
January 23, 1997 – April 23, 1997	13.625% ❖

Source: Transmittal AB-02-068, CR 1898

## Billing for Screening Mammography Services

The Centers for Medicare & Medicaid Services (CMS) has identified some inconsistencies in the billing and payment of screening mammography claims.

Providers billing for screening mammography services are reminded that *CPT* code 76085 must be billed on the same claim in conjunction with *CPT* code 76092. Claims received for *CPT* code 76085 without *CPT* code 76092 will be returned to the provider with an explanation that payment for code 76085 cannot be made when billed alone or on a separate claim from the screening mammography service.

In addition, claims are being submitted with both *CPT* code 76092 (screening mammography-film) and HCPCS code G0202 or G0203 (screening mammography-digital) when only one type of screening mammography must be billed. Claims reflecting both a film screening mammography (76092) and a digital screening mammography (G0202 or G0203) cannot be submitted since payment will not be made for both. ❖

Source CMS Notification Dated July 19, 2002

## Medicare Fraud Alert

A provider is reportedly traveling to various carrier jurisdictions purchasing medical practices from other chiropractors. This provider renders services, submits claims to insurance carriers for these services, and sets up accounts receivables for the business. The claims are processed and paid by the Medicare or other carrier; however, he does not close out the accounts receivables in his accounting records. The provider then sells the practice to another chiropractor and promotes to the purchaser that there are outstanding accounts receivables not satisfied with the Medicare or other insurance carrier, when in fact, these claims were already processed and paid. The purchaser is encouraged to submit claims to carriers for the false outstanding accounts receivables. The purchasing chiropractor, relying on this provider's misrepresentation, is submitting duplicate claims for services already reimbursed by the carriers to the subject provider. ❖

Source: CMS Restricted Medicare Fraud Alert 2002-02

# GENERAL COVERAGE

## Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases

Effective for services performed on or after **October 1, 2002**, IVIg for the treatment of autoimmune mucocutaneous blistering diseases is covered for treatment of the following biopsy-proven conditions:

- Pemphigus vulgaris, ICD-9-CM code: 694.4, pemphigus
  - Pemphigus foliaceus, ICD-9-CM code: 694.4, pemphigus
  - Bullous pemphigoid, ICD-9-CM code: 694.5, pemphigoid
  - Mucous membrane pemphigoid (a.k.a., Cicatricial pemphigoid), ICD-9-CM code: 694.6, Benign mucous membrane pemphigoid
    - ICD-9-CM code: 694.60; without mention of ocular involvement
    - ICD 9-CM code: 694.61; with ocular involvement
  - Epidermolysis bullosa acquisita, ICD-9-CM code: 694.8, Other specified bullous dermatoses
- Patients must meet at least one of the following criteria:
- Failed conventional therapy,
  - Conventional therapy is contraindicated, or
  - Have rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional agents. In these situations, IVIg therapy would be given along with conventional treatment(s) and the IVIg would be used only until conventional therapy could take effect.

**Note:** In addition, IVIg for the treatment of autoimmune mucocutaneous blistering disease must be used only for short-term therapy and not as a maintenance therapy. Contractors have the discretion to decide what constitutes short-term therapy, and failure and/or contraindications to conventional therapy.

### Billing Instructions

IVIg for the treatment of autoimmune mucocutaneous blistering disease is billed on the Form UB-92 CMS-1450, or electronic equivalent format, by following the general bill review instructions in section 3604 of the Medicare Intermediary Manual, Part 3.

*Italicized and/or quoted material is excerpted from the American Medical Association Current Procedural Terminology. CPT codes, descriptions and other data only are copyrighted 2001 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.*

### Applicable CPT and HCPCS Codes

- 90780** *Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour.*
- 90781** *Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; each additional hour up to 8 hours.*
- J1563** Injection, immune globulin, intravenous, 1 g
- Q0081** Infusion therapy, using other than chemotherapeutic drugs, per visit

**Note:** For hospital outpatient departments (except critical access hospitals electing method 2), HCPCS code Q0081 should be reported in place of CPT code 90780 or 90781.

### Applicable Bill Types

The applicable types of bill are 13x and 85x.

### Applicable Revenue Codes

The appropriate revenue code is 636 for reporting HCPCS code J1563.

HCPCS code Q0081 may be reported under any valid, appropriate revenue code.

For CAHs, method 2 (professional), the appropriate revenue codes are 96x, 97x or 98x for the reporting of CPT/HCPCS codes 90781, J1563 or 90780.

### Payment Requirements

Payment is as follows:

- Hospital outpatient departments – Reimbursement made under the outpatient prospective payment system (OPPS) or current payment methodologies for hospitals not subject to OPPS for HCPCS code J1563 and Q0081 only.
- Critical access hospitals
  - Method 1 and method 2 (technical) – Reimbursement made under reasonable cost
  - Method 2 (professional) – Reimbursement made under the Medicare physician fee schedule

Deductible and coinsurance apply to this service. ❖

Source: CMS Transmittal AB-02-093, CR 2192

## Payment for Services Furnished by Audiologists

The Centers for Medicare & Medicaid Services (CMS) has made the medical coverage determinations for audiology tests similar and comparable to ophthalmology tests as outlined in section 2320 of the Medicare Carriers Manual and section 3157 of the Medicare Intermediary Manual.

Diagnostic testing, including hearing and balance assessment services, performed by a qualified audiologist is paid for as “other diagnostic tests” under section 1861(s)(3) of the Social Security Act (the Act) when a physician orders testing to obtain information as part of his/her diagnostic evaluation or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem. Services are excluded by virtue of section 1862(a)(7) of the Act when the diagnostic information required to determine the appropriate medical or surgical treatment is already known to the physician, or the diagnostic services are performed only to determine the need for, or the appropriate type of, a hearing aid.

Diagnostic services performed by a qualified audiologist and meeting the above requirements are payable as “other diagnostic tests.” The payment for these services is determined by the reason the tests were performed, rather than the diagnosis or the patient’s condition. Payment for these services is based on the physician fee schedule amount, except for audiology services furnished in a hospital outpatient department, that are paid under the outpatient prospective payment system. Nonhospital entities billing for the audiologist’s services may accept assignment under the usual procedure or, if not accepting assignment, may charge the patient and submit an unassigned claim on their behalf.

If a physician refers a beneficiary to an audiologist for evaluation of signs or symptoms associated with hearing loss or ear injury, the audiologist’s diagnostic services should be covered even if the only outcome is the prescription of a hearing aid. If a beneficiary undergoes diagnostic testing performed by an audiologist without a physician referral, the tests are not covered even if the audiologist discovers a pathologic condition.

As provided in section 1861 (l)(3) of the Act, a qualified audiologist is an individual with a master’s or doctoral degree in audiology and who:

- Is licensed as an audiologist by the state in which the individual furnishes such services; or
- In the case of an individual who furnishes services in a state which does not license audiologists, has:
  - Successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience),
  - Performed not less than nine months of supervised full-time audiology services after obtaining a master’s or doctoral degree in audiology or a related field, and
  - Successfully completed a national examination in audiology approved by the Secretary of Health & Human Services.

There is no provision for direct payment to audiologists for therapeutic services.

This Medicare provision became effective on or after **July 7, 2002.** ❖

Source: CMS Transmittal AB-02-080, CR 2073

## New Waived Tests

Listed below are two tests approved by the Food and Drug Administration (FDA) as waived tests under the Clinical Laboratory Improvement Amendments (CLIA) effective **April 12, 2002.** The *Current Procedural Terminology (CPT)* codes for these new tests must be submitted with modifier QW to be recognized as a waived test.

- Forefront Diagnostics Drugfree@Home THC/COC Test Kit, effective July 27, 2001, *CPT* code: 80101QW
- GDS Technology STAT-Site M<sub>Hgb</sub> Test System, effective: February 11, 2002, *CPT* code: 85018QW

### Newly Added Test Granted Waived Status under CLIA

TEST NAME	MANUFACTURER	CPT CODE	USE
Forefront Diagnostics Drugfree@Home THC/COC Test Kit	Forefront Diagnostics Drug Inc.	82101QW	Screening test for the presence/detector metabolites in urine
GDS Technology STAT-Site M <sub>Hgb</sub> Test System	GDS Technology	85018QW	Monitors hemoglobin level in blood

Listed below are the latest tests approved by the FDA as waived tests under CLIA, **effective June 17, 2002.** *CPT* codes for these new tests must have modifier QW to be recognized as a waived test.

- Enterix InSure™ Fecal Occult Blood Test, effective: January 1, 2002, *CPT* code: 82274QW
- Alatec Scientific Peace of Mind Multiple Drugs of Abuse Test, effective: February 21, 2002, *CPT* code: 80101QW
- Metrika A1c Now for Prescription Home Use (K020234), effective: March 8, 2002, *CPT* code: 83036QW
- Metrika A1c Now for Professional Use (K020235), effective: March 8, 2002, *CPT* code: 83036QW.



*New Waived Tests (continued)*

In addition, the *CPT* code for the Diagnostic Chemicals ImmunoDip™ Urinary Albumin Screen (Urine Dipstick) has been changed from 82044QW to 83518QW, effective: June 3, 2002. Effective June 17, 2002, the *CPT* codes for the Boehringer Mannheim Chemstrip Micral and the Roche Diagnostics Chemstrip Micral (urine dipstick) have also been changed from 82044QW to 83518QW, since both tests use methodologies that are similar to the Diagnostic Chemicals ImmunoDip™ Urinary Albumin Screen (Urine Dipstick).

TEST NAME	MANUFACTURER	CPT CODE	USE
Boehringer Mannheim Chemstrip Micral	Boehringer Mannheim	83518QW	Determination of low concentrations of albumin in urine by immunoassay, which is helpful for early detection in patients at risk for developing renal disease
Roche Diagnostics Chemstrip Micral (urine dipstick)	Roche Diagnostics Corporation	83518QW	Determination of low concentrations of albumin in urine by immunoassay, which is helpful for early detection in patients at risk for developing renal disease
Diagnostic Chemicals ImmunoDip™ Urinary Albumin Screen (Urine Dipstick)	Diagnostic Chemicals Limited (USA)	83518QW	Determination of low concentrations of albumin in urine by immunoassay, which is helpful for early detection in patients at risk for developing renal disease
*Enterix InSure™ Fecal Occult Blood Test	Enterix, Inc.	82274QW	Detection of blood in feces from whatever cause, benign or malignant (colorectal cancer screening) by immunoassay
*Alatex Scientific Peace of Mind Multiple Drugs of Abuse Test	Advantage Diagnostics Corporation, Ltd.	80101QW	Screening test for the presence/detection of cannabinoids (THC), cocaine metabolites, methamphetamines, morphine, and phencyclidine (PCP) in urine
*Metrika A1c Now for Prescription Home Use (K020234)	Metrika, Inc.	83036QW	Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes
*Metrika A1c Now for Professional Use (K020235)	Metrika, Inc.	83036QW	Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes

\* Newly added waived test system

Information on CLIA services may be found in:  
*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-02-070, CR 2163  
 CMS Transmittal AB-02-091, CR 2263

## Correction to Billing for Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes

**B**illing guidelines for the diagnosis and treatment of peripheral neuropathy with loss of protective sensation in people with diabetes were published in the Third Quarter 2002 *Medicare A Bulletin* (pages 8-9). In that article, type of bill 23x was included as applicable. Type of bill 23x is not appropriate for billing of the peripheral neuropathy with loss of protective sensation in people with diabetes. Therefore, the applicable types of bill are:

13x 71x 73x 74x 75x 85x

All other information and instructions remain in effect. ❖

Source: CMS Transmittal A-02-039, CR 2184

## Medical Nutrition Therapy Services for Beneficiaries with Diabetes or Renal Disease

Effective for services provided on or after January 1, 2002, Medical Nutrition Therapy (MNT) is covered by Medicare under the Part B provision of the program, for beneficiaries with diabetes or renal disease conditions when provided by a qualifying registered dietitian or nutrition professional. Other types of providers do not qualify for reimbursement for this service.

The following notification is being published for Part A providers per request from the Centers for Medicare & Medicaid Services (CMS) to provide information on the coverage and billing guidelines of this policy.

**Claims for MNT services *must* be billed on a claim Form CMS-1500 or electronic equivalent format to the local Medicare carrier. MNT services *cannot* be billed on a UB-92 CMS-1450. There is no separate facility payment for this benefit.**

### MNT Initiative Background

Section 105 of the Benefits Improvement and Protection Act of 2000 permits Medicare coverage of (MNT) services when furnished by a registered dietitian or nutrition professional meeting certain requirements. The benefit is available for beneficiaries with diabetes or renal disease, when a physician makes a referral as defined in section 1861 (r) (l) of the Social Security Act (the Act). Nonphysician practitioners cannot make referrals for this service. It also allows registered dietitians and nutrition professionals to receive direct Medicare reimbursement for the first time.

The benefit consists of an initial visit for an assessment, follow-up visits for interventions, and reassessments as necessary during the 12-month period beginning with the initial assessment (“episode of care”) to assure compliance with the dietary plan. For purposes of coverage, the benefit is defined as a maximum of three hours that may be reimbursed in the initial episode of care. In subsequent years, beneficiaries may receive two hours of MNT with a physician referral. The number of hours covered for diabetes is the same as the number of hours covered for renal disease.

For the purposes of this benefit, renal disease means chronic renal insufficiency, end-stage renal disease when dialysis is not received, and the medical condition of a beneficiary for 36 months after a kidney transplant. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate (GFR) 13-50 ml/min/1.73m<sup>2</sup>).

Diabetes is defined as diabetes mellitus type I (an autoimmune disease that destroys the beta cells of the pancreas, leading to insulin deficiency), type II (familial hyperglycemia), and gestational diabetes. Gestational diabetes is any degree of glucose intolerance with onset or first recognition during pregnancy. The diagnostic criterion for a diagnosis of diabetes is a fasting glucose greater than or equal to 126 mg/dl. These definitions come from the Institute of Medicare 2000 report, *The Role of Nutrition in Maintaining Health in the Nation's Elderly*.

### General Conditions of Coverage

The following are the general conditions of coverage:

- The treating physician must make a referral and indicate a diagnosis of diabetes or renal disease as described

herein. A treating physician means the primary care physician or specialist coordinating care for the beneficiary with diabetes or renal disease.

- The number of hours covered in an episode of care may not be exceeded, unless a second referral is received from the treating physician.
- Services may be provided either on an individual or group basis without restrictions.
- For a beneficiary with a diagnosis of diabetes, diabetes self-management training (DSMT) and MNT services can be provided within the same time period, and the maximum number of hours allowed under each benefit is covered. The only exception is that DSMT and MNT may not be provided on the same day to the same beneficiary. For a beneficiary with a diagnosis of diabetes who has received DSMT and is also diagnosed with renal disease in the same episode of care, the beneficiary may receive MNT services based on a change in medical condition, diagnosis, or treatment as stated in 42 CFR 410.132(b)(5).
- A professional as defined below must provide MNT services.

### Limitations on Coverage

The following limitations apply:

- MNT services are not covered for beneficiaries receiving maintenance dialysis for which payment is made under section 1881 of the Act.
- A beneficiary may not receive MNT and DSMT on the same day.

### Referrals

Referral may only be made by the treating physician when the beneficiary has been diagnosed with diabetes or renal disease as defined herein with documentation maintained by the referring physician in the beneficiary's medical record. Referrals must be made for each episode of care and any reassessments prescribed during an episode of care as a result of a change in medical condition or diagnosis. The registered dietitian or nutrition professional must submit the referring physician UPIN (unique provider identification number) on the claim Form CMS-1500 or electronic equivalent format. Claims submitted without the referring physician UPIN will be returned to the provider.

### Additional Covered Hours for MNT Services

Additional hours of MNT services may be covered beyond the number of hours typically covered under an episode of care when the treating physician determines there is a change of diagnosis or medical condition within such episode of care that makes a change in diet necessary. Appropriate medical review for this provision may be performed on a postpayment basis. Outliers may be judged against nationally accepted dietary or nutritional protocols in accordance with 42 CFR 410.132(a).

### Professional Standards for Dietitians and Nutritionists

For Medicare Part B coverage of MNT, only a regis-

*Coverage of Medical Nutrition Therapy Services for Beneficiaries with Diabetes or Renal Disease (continued)*

tered dietitian or nutrition professional may provide the services. "Registered dietitian or nutrition professional" means a dietitian or nutritionist licensed or certified in a state as of December 21, 2000 (they are not required to meet any other requirements); or an individual whom, on or after December 22, 2000:

- Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized for this purpose. The academic requirements of a nutrition or dietetics program may be completed after the completion of the degree;
- Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. Documentation of the supervised dietetics practice may be in the form of a signed document by the professional/facility that supervised the individual; and
- Is licensed or certified as a dietitian or nutrition professional by the state in which the services are performed. In a state that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of the first two bullets of this section.

**Payment for MNT**

Payment will be made under the physician fee schedule for dates of service on or after January 1, 2002, to a registered dietitian or nutrition professional that meets the above requirements.

Deductible and coinsurance apply. As with the DSMT benefit, payment is only made for MNT services actually attended by the beneficiary and documented by the provider, and for beneficiaries who are not inpatients of a hospital or skilled nursing facility.

Payment is based on the lesser of the actual charge, or 85 percent of the physician fee schedule amount when rendered by a registered dietitian or nutrition professional. Coinsurance is based on 20 percent of the lesser of these two amounts. As required by statute, use this same methodology for services provided in the hospital outpatient department.

Payment will be made under the following *CPT* codes:

- 97802 *Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.*  
(**Note:** This *CPT* code must only be used for the initial visit.)
- 97803 *re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes*
- 97804 *group (2 or more individual(s)), each 30 minutes*

**Instructions for Use of the Medical Nutrition Therapy Codes**

*CPT* code 97802 must be used only once a year, for initial assessment of a new patient. All subsequent individual visits (including reassessments and interventions) are to be coded as 97803. All subsequent group visits are to be billed as 97804.

*CPT* code 97803 must be billed for all individual reassessments and all interventions after the initial visit (see 97802). This code should also be used when there is a change in the patient's medical condition affecting his or her nutritional status.

*CPT* code 97804 must be billed for all group visits, initial and subsequent. This code may also be used when there is a change in a patient's condition affecting his or her nutritional status and the patient is attending in a group.

**Note:** The above codes can only be paid if submitted by a registered dietitian or nutrition professional that meets the specified requirements. These services cannot be paid "incident to" physician services. The payments can be reassigned to the employer of a qualifying dietitian or nutrition professional.

**General Claims Processing Information**

**Registered dietitians and nutrition professionals must accept assignment.** If a claim is submitted as unassigned, the carrier will change it to an assigned claim. Since these providers must accept assignment, the limiting charge does not apply.

Registered dietitians and nutrition professionals can be part of a group practice, in which case the provider identification number of the registered dietitian or nutrition professional that performed the service must be entered in item 24k of Form CMS-1500, or electronic equivalent format.

**Enrollment of Dietitians and Nutritionists**

Beginning January 1, 2002, MNT is a covered Medicare service when provided by a qualifying registered dietitian or nutrition professional. Other types of providers do not qualify for reimbursement for this service.

If you are a registered dietitian or nutrition professional and want to become a Medicare provider, please see <http://www.hcfa.gov/Medicare/enrollment> to determine the local carrier for your area. The carrier will require you to submit a completed Form CMS-855.

First Coast Service Options, Inc. is the local carrier servicing registered dietitians and nutrition professionals practicing in the State of Florida.

Registered dietitians and nutrition professionals are paid for MNT services through local carriers. In order to file claims for MNT, a registered dietitian/nutrition professional must be enrolled as a provider in the Medicare program and meet the requirements outlined above. The specialty code for "dietitians/nutritionists" is 71. MNT services can be billed with the effective date of the provider's license and the establishment of the practice location, but not before January 1, 2002. ❖

Source CMS Transmittal AB-02-059, CR 2142

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## Revision to HCPCS Codes for Diagnosis and Treatment of Peripheral Neuropathy

Coverage and billing instructions for diagnosis and treatment of peripheral neuropathy with loss of protective sensation (LOPS) in people with diabetes was published in the Third Quarter 2002 *Medicare A Bulletin* (pages 8-9). Since then, the Centers for Medicare & Medicaid Services (CMS) has issued a revision to the HCPCS code descriptors used to report these services.

- HCPCS codes G0245 and G0246 have been revised to describe them more accurately as evaluation and management codes.
- HCPCS codes G0246 and G0247 have been revised to indicate that they are physician services.

### HCPCS Descriptions

Revisions to the descriptors are showing in *italics*. The revised descriptors are:

- G0245 Initial physician evaluation *and management* of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), which must include:
1. The diagnosis of LOPS.
  2. A patient history.
  3. A physical examination that consists of at least the following elements:
    - (a) Visual inspection of the forefoot, hindfoot, and toe web spaces,
    - (b) Evaluation of a protective sensation,
    - (c) Evaluation of foot structure and biomechanics,
    - (d) Evaluation of vascular status and skin integrity, and
    - (e) Evaluation and recommendation of footwear.
  4. Patient education.

G0246 Follow-up *physician evaluation and management* of a diabetic patient with diabetic sensory neuropathy resulting in a LOPS to include at least the following:

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

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

1. local care of superficial wounds,
2. debridement of corns and calluses, and
3. trimming and debridement of nails.

A local medical review policy for the coverage of diagnosis and treatment of peripheral neuropathy with LOPS in people with diabetes has been developed. See page 86 of this publication.

### Reporting Modifier 25

Modifier 25 must be appended to codes G0245 or G0246 when they are billed with code G0247 to the fiscal intermediary. ❖

Source: CMS Transmittal AB-02-096, CR 2269

## Positron Emission Tomography Scans—Requirements for Breast Cancer and Revised Coverage Conditions for Myocardial Viability

Positron emission tomography (PET) is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images, which are obtained from positron emitting radioactive tracer substances (radiopharmaceuticals) such as 2-[F-18] Fluoro-D-Glucose (FDG), that are administered intravenously to the patient.

### Coverage of FDG PET for Breast Cancer

Effective for dates of service **on or after October 1, 2002**, Medicare will cover FDG PET as an adjunct to other imaging modalities for staging and restaging for locoregional, recurrence or metastasis. Monitoring treatment of a locally advanced breast cancer tumor and metastatic breast cancer when a change in therapy is contemplated is also covered as an adjunct to other imaging modalities. The baseline PET study for monitoring should be done under the code for staging or restaging.

### Limitations

Medicare continues to have a national noncoverage determination for initial diagnosis of breast cancer and initial staging of axillary lymph nodes.

Effective for dates of service **on or after October 1, 2002**, Medicare coverage now includes PET as an adjunct to standard imaging modalities for staging patients with distant metastasis or restaging patients with locoregional, recurrence or metastasis; as an adjunct to standard imaging modalities for monitoring for women with locally advanced and metastatic breast cancer when a change in therapy is contemplated.

### Coverage for Myocardial Viability

FDG PET is covered for the determination of myocardial viability following an inconclusive single photon computed tomography test (SPECT) **from July 1, 2001, through September 30, 2002**. Only full ring scanners are covered as the scanning medium for this service from July 1, 2001 through December 31, 2001. However, as of **January 1, 2002**, full and partial ring scanners are covered for myocardial viability following an inconclusive SPECT.



**PET—Coverage Requirements for Breast Cancer and Revised Coverage Conditions for Myocardial Viability (continued)**

Beginning **October 1, 2002**, Medicare will cover FDG PET for the determination of myocardial viability as a primary or initial diagnostic study prior to revascularization, and will continue to cover FDG PET when used as a follow-up to an inconclusive SPECT. However, if a patient received a FDG PET study with inconclusive results, a follow-up SPECT is not covered. FDA full and partial ring PET scanners are covered.

**Limitations**

In the event a patient receives a SPECT with inconclusive results, a PET scan may be performed and covered by Medicare. However, a SPECT is not covered following a FDG PET with inconclusive results.

The referring physician as part of the beneficiary's medical record should maintain documentation that these conditions are met.

Conditions and coverage guidelines for both conditions are summarized in the following table.

Clinical Condition	Effective Date	Coverage
*Breast cancer	October 1, 2002	As an adjunct to standard imaging modalities, staging distant metastasis or restaging patients with locoregional recurrence or metastasis; and as an adjunct to standard imaging modalities for monitoring response to treatment for locally advanced and metastatic disease to determine if therapy should be changed.
Myocardial viability	July 1, 2001 to September 30, 2002	Covered only following inconclusive SPECT
Myocardial viability	October 1, 2002	Primary or initial diagnosis prior to revascularization, or following an inconclusive SPECT.

\* **Note:** for breast cancer, monitoring is allowed when a change in treatment is contemplated.

**General Conditions of Coverage by Allowable Type of FDG PET Scanner**

Covered clinical condition	Allowable Type of FDG PET System		
	Prior to July 1, 2001	July 1, 2001 through December 31, 2001	On or after January 1, 2002
Breast Cancer	Not covered	Not covered	Effective October 1, 2002, full and partial ring
Myocardial viability primary or initial diagnosis prior to revascularization (Continued coverage following an inconclusive SPECT is also allowed)	Not covered	Not covered	Effective October 1, 2002, full and partial ring

**HCPCS Codes for Breast Cancer PET Scans Performed on or after October 1, 2002**

- G0252 PET imaging, *full and partial-ring PET scanners only*, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes), not covered by Medicare
- G0253 PET imaging for breast cancer, *full and partial-ring PET scanners only*, staging/restaging of local regional recurrence or distant metastases, i.e., Staging/restaging after or prior to course of treatment
- G0254 PET imaging for breast cancer, *full and partial-ring PET scanners only*, evaluation of response to treatment, performed during course of treatment

**CPT/HCPCS Codes for Myocardial Viability PET Scans Performed on or after October 1, 2002**

- G0230 PET imaging; metabolic assessment for myocardial viability following inconclusive SPECT study; *full- and partial-ring PET scanners only*  
(G0230 should continue to be billed following an inconclusive SPECT)
- 78459 *Myocardial imaging, positron emission tomography (PET), metabolic evaluation*  
(78456 should be used for determination of myocardial viability as a primary or initial diagnostic study prior to revascularization)

**Billing Requirements**

Claims for PET scan procedures must be billed on Form UB-92 CMS-1450, or the electronic equivalent, with the appropriate diagnosis HCPCS "G" codes to indicate the conditions under which a PET scan was done. These codes represent the technical component costs associated with these procedures when furnished to hospital outpatients, and are paid under the outpatient prospective payment system.

These codes are billed under revenue code 404 (PET scan).

Applicable types of bill include: 12x 13x 21x 22x 23x 85x. ❖

Source: CMS Transmittal AB-02-065, CR 2138

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## Coding Changes for Sodium Hyaluronate

The Centers for Medicare & Medicaid Services (CMS) has established the new payment code Q3030 – Sodium hyaluronate, per 20 to 25 mg dose, for intra articular injection. This code is effective July 1, 2002 for claims with dates of service on or after that date. The current code for this drug will be discontinued as of July 1, 2002, with a 90-day grace period. Providers should submit a claim with one code or the other, but not both.

Due to systems limitations, CMS will not be able to accept the new code for payment until October 1, 2002. Therefore, claims containing services submitted with HCPCS code Q3030 will be returned to the provider until

October 1, 2002. Providers may hold these claims and submit them using HCPCS code Q3030 beginning October 1, 2002, or they may continue to submit claims through September 30, 2002 using HCPCS code J7316. If there is a payment differential between HCPCS codes J7316 and Q3030, providers may adjust the claim on or after October 1, 2002, for claims with dates of service from July 1, 2002, through September 30, 2002. Providers choosing to hold claims containing HCPCS code Q3030, may submit the remaining services for payment. ❖

Source: CMS Transmittal AB-02-082, CR 2230

## Rehabilitation Services for Beneficiaries with Vision Impairment

A Medicare beneficiary with vision loss may be eligible for rehabilitation services designed to improve functioning, by therapy, to improve performance of activities of daily living, including self care and home management skills. Evaluation of the patient's level of functioning in activities of daily living, followed by implementation of a therapeutic plan of care aimed at safe and independent living, is critical and should be performed by an occupational or physical therapist. (Physical therapy and occupational therapy assistants cannot perform such evaluations.)

Vision impairment ranging from low vision to total blindness may result from a primary eye diagnosis, such as macular degeneration, retinitis pigmentosa or glaucoma, or as a condition secondary to another primary diagnosis, such as diabetes mellitus or acquired immune deficiency syndrome (AIDS).

### Coverage and Limitations

In accordance with established conditions, all rehabilitation services to beneficiaries with a primary vision impairment diagnosis must be provided pursuant to a written treatment plan established by a Medicare physician, and implemented by approved Medicare providers (occupational or physical therapists) or incident to physician services. Some of the following rehabilitation programs/services for beneficiaries with vision impairment may include Medicare covered therapeutic services:

- Mobility
- Activities of daily living
- Other rehabilitation goals that are medically necessary.

The patient must have a potential for restoration or improvement of lost functions, and must be expected to improve significantly within a reasonable and generally predictable amount of time. Rehabilitation services are not covered if the patient is unable to cooperate in the treatment program or if clear goals are not definable. Most rehabilitation is short-term and intensive, and maintenance therapy – services required to maintain a level of functioning – are not covered. For example, a person with an ICD-9-CM diagnosis 369.08 (profound impairment in both eyes, i.e., best corrected visual acuity is less than 20/400 or visual field is 10 degrees or less) would generally be eligible for, and may be provided, rehabilitation services under CPT code 97535, (self care/home management training, i.e., activities of daily living, compensatory training, meal preparation, safety procedures, and instruction in the use of adaptive equipment).

Services may be provided by a physician as defined in sections 1861(r)(1) and (4) of the Social Security Act, a qualified occupational therapist, or a qualified physical therapist. Services furnished by an employee of the physician may only be provided incident to the physician's professional services, must be furnished under the physician's direct personal supervision, and must meet other incident to requirements provided in section 2050 of the Medicare Carriers Manual. Certified occupational therapy and physical therapy assistants must perform under the appropriate level of supervision as other therapy services.

### Applicable CPT Therapeutic Procedures

The following list contains examples that are not meant to limit the provision of other medically necessary services:

- 97110 *Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility*
- 97116 *gait training (includes stair climbing)*
- 97532 *Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes*
- 97533 *Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes*
- 97535 *Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instruction in use of assistive technology/adaptive equipment) direct one-on-one contact by provider, each 15 minutes*

**Medicare Coverage of Rehabilitation Services for Beneficiaries With Vision Impairment (continued)**

97537 *Community/work reintegration (e.g., shopping, transportation, money management, avocational activities and/or work environment modification analysis, work task analysis), direct one-on-one contact by provider, each 15 minutes*

**Note:** Community reintegration when performed in conjunction with other therapeutic procedures such as gait training and self-care/home management training is bundled into the payment for those other services. Therefore, these services are not separately reimbursable by Florida Medicare.

**ICD-9-CM Codes for Vision Impairment that Support Medical Necessity**

The following are appropriate diagnoses to use for the therapeutic procedures specified above:

<b>BE = Better Eye</b>		<b>LE = Lesser Eye</b>	
368.41	Scotoma central area	369.12	BE – severe impairment LE – total impairment
368.45	Generalized contraction or constriction	369.13	BE – severe impairment LE – near-total impairment
368.46	Homonymous bilateral field defects	369.14	BE – severe impairment LE – profound impairment
368.47	Heteronymous bilateral field defects	369.16	BE – moderate impairment LE – total impairment
369.01	BE – total impairment LE – total impairment	369.17	BE – moderate impairment LE – near-total impairment
369.03	BE – near-total impairment LE – total impairment	369.18	BE – moderate impairment LE – profound impairment
369.04	BE – near-total impairment LE – near-total impairment	369.22	BE – severe impairment LE – severe impairment
369.06	BE – profound impairment LE – total impairment	369.24	BE – moderate impairment LE – severe impairment
369.07	BE – profound impairment LE – near-total impairment	369.25	BE – moderate impairment LE – moderate impairment
369.08	BE – profound impairment LE – profound impairment		

**Definition of Levels of Vision Impairment:**

**Moderate** – best-corrected visual acuity is less than 20/60

**Severe (legal blindness)** – best corrected visual acuity is less than 20/160, or visual field is 20 degrees or less

**Profound (moderate blindness)** – best corrected visual acuity is less than 20/400, or visual field is 10 degrees or less

**Near-total (severe blindness)** – best corrected visual acuity is less than 20/1000, or visual field is 5 degrees or less

**Total (total blindness)** – no light perception. ❖

Source: CMS Transmittal AB-02-078; CR 2083

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# CRITICAL ACCESS HOSPITAL SERVICES

## Update to the Medicare Outpatient Code Editor

The Medicare outpatient code editor (OCE) specifications (version 17.2) have been updated with new additions, changes, and deletions to the *Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS)* codes.

This OCE is used to process bills from Indian health service hospitals, critical access hospitals, Maryland hospitals, and hospitals located in American Samoa, Guam, and Saipan. Claims from Virgin Island hospitals with dates of service on or after January 1, 2002 are also processed through this OCE. Below are CMS requirements.

### New HCPCS Procedure Codes

The following new HCPCS codes were added to the list of valid codes for the OCE software, **effective July 1, 2002**.

G0245    G0246    G0247    G0248    G0249    G0250

The following new HCPCS codes were added to the list of valid codes for the OCE software, **retroactive to April 1, 2002**.

G0251    K0561 - K0580

### Deleted CPT Codes

The following *CPT* codes were deleted from the list of noncovered procedures, **retroactive to April 1, 2002**.

93784    93786    93790

The following *CPT* code was deleted from the list of procedures for females only, **retroactive to August 1, 2000**.

84234 ❖

Source: CMS Transmittal A-02-047, CR 2188



# INPATIENT HOSPITAL SERVICES

## Revision to Billing for Swing Bed Services Under Skilled Nursing Facility Prospective Payment System

Coverage and billing instructions for the conversion of hospital swing bed facilities to the skilled nursing facility prospective payment system (SNF PPS) was published in the Third Quarter 2002 *Medicare A Bulletin* (pages 13-20). Since then, the Centers for Medicare & Medicaid Services (CMS) has issued a revision to the type of bill (TOB) to be used for services excluded from SNF PPS.

The correct TOB for excluded services is 13x.

The entire section on “Special Billing Requirements Under SNF PPS” is being published and revisions to the sections are shown in *bold italics*.

### Billing Requirements for Swing Beds 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 Social Security 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 fiscal intermediary (FI) for the SNF PPS-excluded service. This bill must use TOB *13x* with all appropriate revenue codes, HCPCS codes, and line item date of service billing information. See the Third Quarter 2002 of the *Medicare A Bulletin* (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 *outpatient* Part B services and will be paid as *outpatient* Part B services under the outpatient prospective payment system (OPPS). Note that 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 be billed as *hospital* inpatient Part B services, and payable under the OPPS. ❖

Source: CMS Transmittal A-02-060, CR 2257

## Excluding Hospitals Providing Part B only Services from the Outpatient Prospective Payment System

Effective for services provided **on or after January 1, 2002**, Medicare will exclude from payment under the outpatient prospective payment system (OPPS), covered Part B only services provided to inpatient beneficiaries when they are furnished by a hospital that does not submit claims for outpatient services under Medicare 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 of the Medicare Part A Intermediary Manual 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
- Artificial limbs and eyes.

### Implementation Guidelines

Implementation date for this initiative is scheduled for **January 1, 2003** for services provided **on or after January 1, 2002**.

Hospitals must notify their fiscal intermediary if they do not submit claims for outpatient Part B services, so that their claims (type of bill 12x) for Part B only services furnished to their inpatients can be identified, and appropriate payments made.

Until this provision is implemented on January 1, 2003, hospitals may hold claims for type of bill 12x or submit them for payment. Claims that are submitted for payment will be paid under OPPS and an adjustment bill may be submitted after January 1, 2003, in order to receive appropriate payment under this provision.

Medicare payment for excluded Part B only services for claims submitted on or after January 1, 2003, will be reimbursed using the method under which the hospital was paid prior to the OPPS implementation. That methodology would be an inclusive rate for hospitals paid that way prior to implementation of OPPS or a reasonable cost basis for other hospitals. ❖

Source CMS Transmittal A-02-064, CR 2204

## Hospitals Transferring Patients to IRFs

After the implementation of inpatient rehabilitation facility (IRF) prospective payment system (PPS) in January 1, 2002, the Centers for Medicare & Medicaid Services (CMS) discovered that the common working file (CWF) A/B crossover edit 7111 is setting inappropriately when there is a transfer from an inpatient acute hospital to an IRF.

Acute hospital claims are receiving CWF A/B crossover edit 7111 because the THRU date of the acute claim is equal to the FROM date of an IRF claim. The 7111 edit ensures that two PPS payments do not get paid for the same day. In the case of an acute hospital transferring a patient to an IRF (with patient status code 62 on the claim), it is appropriate that the two facilities receive payment.

A change to CWF edit 7111 is scheduled for the October 2002 quarterly release.

Due to the high volume of claims and dollars involved, CWF has created a temporary workaround to allow payment to affected acute facilities until the change to the edit is made.

### Workaround Steps

The workaround requires that claims be processed in date of service order. The acute claim, reflecting the appropriate patient status (62), must be processed prior to the IRF claim. If the IRF claim was processed prior to the acute hospital claim, the following workaround must be used for claims pending as a result of edit 7111:

1. The IRF claim will be canceled on the CWF system.
2. The acute claim will be released to the CWF system.
3. The canceled IRF resubmit to CWF system.

### Fiscal Intermediary Actions

If First Coast Service Options, Inc. (FCSO) services the IRF and acute providers, a cancellation of the IRF claim is being submitted to the CWF system and the acute claim will be placed on hold in the system with reason code C7111 until the CWF accepts the canceled IRF claim. Once the canceled IRF claim has been accepted by CWF, the claim from the acute provider will be released for processing followed by the resubmission of the canceled IRF claim.

If another intermediary services the IRF provider, FCSO is contacting the intermediary processing the IRF claim and the acute claim processed by FCSO will be on hold in the system with reason code C7111 until the IRF claim has been canceled. At that time, the pending acute claim will be released.

### Action Required by Providers

Acute providers, whose claims may have been rejected with reason code C7111, must resubmit their claims electronically at their earliest convenience. This will allow the workaround process to be initiated.

With the help of IRF and acute providers serviced by all intermediaries, the workaround can be accomplished successfully; otherwise, claims will continue to pend in the contractor's system until the CWF change is implemented in the October 2002 quarterly release. ❖

Source: CMS Notification Dated June 4, 2002

## Inpatient Rehabilitation Facility PRICER Annual Update

A final rule that established the prospective payment system (PPS) for inpatient rehabilitation facilities (IRFs) was published in the *Federal Register* on August 7, 2001, as authorized under section 1886(j) of the Social Security Act. In that final rule, the Centers for Medicare & Medicaid Services (CMS) set forth per discharge federal rates for federal fiscal year (FY) 2002.

These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002. Annual updates to the IRF PPS rates are required by section 1886(j)(3)(C) of the Act.

### Annual PRICER Update

The prospective payment rates applicable for IRFs for FY 2003 were published in the *Federal Register* on August 1, 2002. A new IRF PRICER software package will be released by October 1, 2002 that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2002 through September 30, 2003. ❖

Source: CMS Transmittal A-02-058, CR 2250

# ESRD SERVICES

## End-Stage Renal Disease Drug Pricing Update

The following revised end-stage renal disease (ESRD) drug-pricing list updates and replaces section 22 of the Medicare Part A ESRD processing manual. This list may also be used as a stand-alone reference for ESRD drugs and/or pharmacy services. Prices are effective for services rendered **on and after July 1, 2002**, and represent the Medicare maximum reimbursement for separately billable ESRD drugs and/or pharmaceuticals.

All prices, as mandated by the Centers for Medicare & Medicaid Services (CMS), are 95 percent of either:

- the lesser of the median average wholesale price of all generic forms of the drug, or
- the lowest brand name average wholesale price.

ESRD providers may order the 2002 *Drug Topics® Red Book®*. Call **(800) 222-3045**, toll-free, or write to:  
 Drug Topics® Red Book®  
 5 Paragon Drive  
 Montvale, NJ 07645-1742

- The drugs listed in this section are arranged in alphabetical order, based on the first initial of the drug name.
- When a drug is billed on Form UB-92 CMS-1450, or electronic equivalent format, an ICD-9-CM diagnosis code (excluding 585 – Chronic renal disease) must be reported.
- Diagnosis code 585 – (Chronic renal disease) must be reported as principal diagnosis code on all ESRD type of bill (TOB 72x).
- The drug prices in this revision include a five percent price reduction as mandated by CMS.

**CPT/HCPCS CODE** Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS), and locally assigned code reportable on Form UB-92 CMS-1450 or electronic equivalent.

**NAME** Name of drug (brand name and/or generic).

**PRICE** Medicare Part A reimbursement allowance for specific drug administered via ESRD environment.

CPT/HCPCS CODE	NAME	PRICE
J0170	Adrenalin, epinephrine, 1 mg/1 cc ampule	\$ 2.26
J0210*	Aldomet, methyldopate HCL, up to 250 mg	\$11.87
J2997	Alteplase, recombinant, activase, 1 mg	\$35.62
00047	Amikin, Amikacin, 100 mg/2 cc	\$41.84
J0280	Aminophylline, aminophyllin, 250 mg	\$ 0.91
J0285	Amphotericin B, Fungizone, 50 mg	\$17.66
J0290	Ampicillin sodium, 500 mg	\$ 1.85
J0690	Ancef, cefazolin sodium, Kefzol, 500 mg	\$ 4.94
J3430	Aquamephyton, phytonaidione (vitamin K), 1 mg	\$ 2.39
J0380*	Aramine, metaraminol bitartrate, 10 mg	\$ 1.26
J7504	Atgam, lymphocyte immune globine, 250 mg	290.31
J2060	Ativan, lorazepam, 2 mg	\$ 3.13
J0460	Atropine sulfate, 0.3 mg	\$ 4.65
X0004	Azactam, Aztreonam, 1 gm	\$19.56
00151	Bactrim, 80 mg/ml-16 mg/ml, 5 cc	\$ 3.00
J0530	Bicillin C-R, penicillin-G, 600,000 units	\$ 8.80

CPT/HCPCS CODE	NAME	PRICE
J0540	Bicillin C-R, penicillin-G, 1,200,000 units	\$17.97
J0550	Bicillin C-R, penicillin-G, 2,400,000 units	\$35.95
J0560	Bicillin L-A, penicillin-G, 600,000 units	\$ 7.41
J0570	Bicillin L-A, penicillin-G, 1,200,000 units	\$19.61
J0580	Bicillin L-A, penicillin-G, 2,400,000 units	\$29.65
X0007	Buprenex, Buprenorphine, .3 mg/1 cc	\$ 2.91
J0635	Calcijex, calcitriol, 1 mcg/ml	\$13.82
J0630	Calcitonin-salmon, up to 400 units	\$ 3.73
X0014	Calcium chloride 10%, 10 cc	\$3.22
J0610	Calcium gluconate, 10 ml	\$ 1.34
J1955	Carnitine, levocarnitine, 1 gm	\$32.06
J0710	Cefadyl, cephapirin sodium, 1 gm	\$ 1.55
J0715	Ceftizoxime sodium, Cefizox, 500 mg	\$10.82
00248	Cefobid, Cefoperazone sodium, 1 gm	\$17.09
X0016	Cefotan, Cefotetan disodium gm	\$10.60
J0698	Cefotaxime sodium, Claforan, 1 gm	\$10.45

\*This drug is included in the composite rate.

# END STAGE RENAL DISEASE

## End-Stage Renal Disease Drug Pricing Update (continued)

CPT/HCPCS CODE	NAME	PRICE
J0697	Cefuroxime sodium, 750 mg	\$ 6.42
J0702	Celestone Soluspan, 3 mg-3mg/ml	\$ 3.88
J0743	Cilastatin sodium imipenem, Primaxin I.V., 250 mg	\$15.87
87000	Cipro, 200 mg	\$14.82
X0017	Cleocin Phosphate, clindamycin phosphate, 300 mg	\$6.16
J0745	Codeine phosphate, 30 mg	\$ 1.20
J0800	Corticotropin Acthar Gel 40 Units	\$88.84
J0835	Cortrosyn, cosyntropin, 0.25 mg	\$16.75
J9070	Cyclophosphamide, Cytoxan, 100 mg	\$ 5.97
J9080	Cyclophosphamide, Cytoxan, 200 mg	\$11.34
J9090	Cyclophosphamide, Cytoxan, 500 mg	\$24.12
J9091	Cyclophosphamide, Cytoxan, 1 gm	\$47.64
J9092	Cyclophosphamide, Cytoxan, 2 gm	\$95.26
J2597	DDAVP, desmopressin acetate), 1 mcg	\$4.67
J1100	Decadron, dexamethasone sodium phosphate, 1 mg	\$ 0.17
J2175	Demerol, meperidine HCL, 100 mg	\$ .79
J1070	Depo-Testosterone, up to 100 mg	\$ 4.70
J1080	Depo-Testosterone, 1 cc, 200 mg	\$19.29
J0895	Desferal, deferoxamine mesylate), 500 mg/5 cc	\$14.15
J1100	Dexamethasone sodium phosphate, 1 mg/ml	\$ 0.17
J7060	Dextrose 5%, 500 cc	\$ 6.99
J1730*	Diazoxide, Hyperstat, 300 mg/20 ml	122.95
J1450	Diflucan, Fluconazole, 200 mg	\$90.86
J1160*	Digoxin, Lanoxin, up to 0.5 mg	\$ 2.64
J1165	Dilantin, phenytoin sodium, 50 mg	\$ 1.23
J1170	Dilaudid, hydromorphone, 4 mg	\$ 1.54
J1200*	Diphenhydramine HCL (Benadryl), up to 50 mg	\$ 0.80
X0023*	Dopamine HCL, Intropin, 40 mg/1 cc	\$ 1.02
J1240	Dramamine, dimenhydrinate, 50 mg	\$ 0.38
J1364	Erythromycin lactobionate, 500 mg	\$ 3.50
J0970	Estradiol valerate, Delestrogen, up to 40 mg	\$22.60
J2915	Ferlecit, sodium ferric gluconate, 62.5 mg/5 ml	\$40.85

CPT/HCPCS CODE	NAME	PRICE
00623	Flagyl, Metronidazole, 500 mg	\$31.10
J9190	Fluorouracil, 500 mg	\$ 2.88
X0100	Folic Acid, 5 mg/cc	\$1.22
J0713	Fortaz, ceftazidime, 500 mg	\$ 9.67
J1470	Gamma globulin, 2 cc	\$42.75
J1550	Gamma globulin, 10 cc	\$114.00
J1570	Ganciclovir sodium, Cytovene, 500 mg	\$35.24
J1580	Garamycin, gentamicin, 80 mg	\$ 3.58
J1630	Haldol, haloperidol, 5 mg	\$ 7.91
J1644*	Heparin sodium 1000 units	\$ 0.39
00739	Hepatitis B immune globulin, 1 ml	135.43
90371	Hepatitis B immune globulin, 5 ml	649.80
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	203.78
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use	105.81
J0360*	Hydralazine HCL, Apresoline, 20 mg	\$ 14.25
J1720	Hydrocortisone sodium succinate (Solu-Cortef), 100 mg	\$ 1.80
J3410	Hydroxyzine HCL, 25 mg	\$ 0.70
J1561	Immune globulin, Gammimmune N, 5%, 500 mg)	\$38.00
J1563	Immune globulin, intravenous, 1 gm	\$76.00
J7501	Imuran, Azathioprine, 100 mg	\$59.84
J1790	Inapsine, droperidol), 5 mg	\$ 1.55
J1800*	Inderal, propranolol HCL, 1 mg/1 cc	\$ 5.93
J1750	Infed, iron dextran), 50 mg	\$17.91
90657	Influenza virus vaccine, split virus, 6-35 months dosage	\$ 4.91
90658	Influenza virus vaccine, split virus, 3 years and above dosage	\$ 6.70
90659	Influenza virus vaccine, whole virus	\$ 4.91
J1820*	Insulin, 100 units	\$ 4.76
J1840	Kantrex, kanamycin sulfate, 500 mg	\$3.29
J1890	Keflin, cephalothin sodium, 1 gm	\$10.26
J3301	Kenalog, triamcinolone acetonide), 10 mg	\$ 1.48

\*This drug is included in the composite rate.



*End-Stage Renal Disease Drug Pricing Update (continued)*

<b>CPT/HCPCS CODE</b>	<b>NAME</b>	<b>PRICE</b>
J1940	Lasix, furosemide, 20 mg	\$ 1.17
X0056	Levophed bitartrate, Norepinephrine bitartrate 4 cc	\$10.43
X0043	Levothyroxine, 0.2 mg	\$48.67
J1990	Librium, chlordiazepoxide hydrochloride, 100 mg	24.99
J2000*	Lidocaine HCL, 50 cc	\$ 3.45
00971	Mandol, Cefamandole, 1 gm	\$ 8.60
J2150*	Mannitol 25%, in 50 cc	\$3.94
J1050	Medroxyprogesterone acetate, Depo-Provera, 100 mg	\$33.91
J0694	Mefoxin, cefoxitin sodium, 1 gm	\$10.36
00987	Mezlin, Mezlocillin, 1 gm	\$ 4.24
J2270	Morphine sulfate, 10 mg	\$ 0.77
J7505	Muromonab-CD3, parenteral, 5 mg	741.00
X0027	Nafcil, nafcillin sodium, 500 mg	\$ 1.12
J2320	Nandrolone decanoate, Deca-Durabolin, 50 mg	\$ 5.20
J2321	Nandrolone decanoate, Deca-Durabolin, 100 mg	\$ 6.98
J2322	Nandrolone decanoate, Deca-Durabolin, 200 mg	\$25.49
J2310	Narcan, naloxone HCL, 1 mg	\$ 4.20
J3260	Nebcin, tobramycin sulfate, 80 mg	\$10.80
J2300	Nubain, nalbuphine HCL, 10 mg/1 cc	\$ 1.90
J2700	Oxacillin sodium, 250 mg	\$ 0.66
J2500	Paracalcitol, 5 mcg	\$25.09
J2510	Penicillin G procaine, aqueous, 600,000 units	\$ 8.07
X0101	Pentam, 300 mg	\$93.81
J2550	Phenergan, promethazine HCL, 50 mg	\$ 0.57
J2560	Phenobarbital sodium, 120 mg	\$ 6.04
01231	Pipracil, Piperacillin sodium, 1 gm	\$ 7.00
90732	Pneumovax, Pneumococcal vaccine 0.5 cc	\$13.09
J3480*	Potassium chloride, per 2 mEq/ml	\$ 0.27
J1410	Premarin, estrogen conjugated, 25 mg	\$56.75
J0743	Primaxin-I.M., 500 mg	\$15.87
J0743	Primaxin-I.V., 250 mg	\$15.87
J0780	Prochlorperazine, Compazine, up to 10 mg	\$ 3.20

<b>CPT/HCPCS CODE</b>	<b>NAME</b>	<b>PRICE</b>
X0076	Prolastin, 500 mg	104.50
J2680	Prolixin Decanoate, fluphenazine, 25 mg	\$15.20
J2690*	Pronestyl, procainamide HCL, 1 gm	\$11.02
J2720*	Protamine sulfate, 10 mg	\$1.00
J2765	Reglan, metoclorpramide HCL, 10 mg	\$ .80
J0696	Rocephin, ceftriaxone sodium, 250 mg	\$16.16
89991	Sandoglobulin, 1gm	\$86.81
X0102	Septra, 80 mg/ml-16 mg/ml, 5 ml	\$3.00
X0038	Sodium bicarbonate 8.4%, 50 cc	\$ 2.74
00515	Sodium chloride 9%, 30 cc	\$1.61
00510	Sodium chloride 9%, 50 cc	\$3.01
00511	Sodium chloride 9%, 100 cc	\$ 6.78
00512	Sodium chloride 9%, 150 cc	\$10.02
00513	Sodium chloride 9%, 250 cc	\$10.15
00514	Sodium chloride 9%, 500 cc	\$9.18
J1720	Solu Cortef, hydrocortisone sodium succinate 100 mg	1.94
X0040	Solu Cortef 500 mg	\$7.96
J2920	Solu-Medrol, methylprednisolone sodium succinate, up to 40 mg	\$ 1.94
J2930	Solu-Medrol, methylprednisolone sodium succinate, up to 125 mg	\$ 3.23
01478	Stadol, 1 mg	\$ 7.45
01479	Stadol, 2 mg	\$ 8.34
J3010	Sublimaze, fentanyl citrate, 2 cc	\$ 2.52
J3070	Talwin Lactate, pentazocine HCL, 30 mg	\$ 3.95
01601	Talwin Lactate, 60 mg	\$ 7.91
J3120	Testosterone enanthate, Delatestryl enanthate, up to 100 mg	\$ 0.57
J3130	Testosterone enanthate, Delatestryl enanthate, up to 200 mg	\$ 1.14
J3150	Testosterone propionate, up to 100 mg	\$ 1.09
90703	Tetanus toxoid, 1. ml	\$ 7.65
J3230	Thorazine, chlorpromazine HCL, up to 50 mg	\$ 1.90
01671	Ticar, Ticarcillin, 1 gm	\$ 4.25
J3250	Tigan trimethobenzamide HCL, up to 200 mg	\$ 3.04

\*This drug is included in the composite rate.

## END STAGE RENAL DISEASE

### End-Stage Renal Disease Drug Pricing Update (continued)

CPT/HCPCS CODE	NAME	PRICE
X0042	Timentin, 100 mg-3 gm	\$14.31
J3280	Torecan, thiethylprazine maleate, up to 10 mg	\$ 4.97
J3320	Trobicin, spectinomycin dihydrochloride, up to 2 g	\$26.79
X0099	Unasyn, 3 gm	\$14.00
J3360	Valium, diazepam, 5 mg	\$ 3.36
J3370	Vancocin, vancomycin HCL, 500 mg	\$10.42
W0233	Venofer, 100 5 mg	\$65.36
X0057*	Verapamil, 5 mg	\$ 2.13
J2250	Versed, midazolam HCL, 1 mg	\$ 2.63

CPT/HCPCS CODE	NAME	PRICE
X0044	Vibramycin, Doxycycline, 100 mg	\$17.94
J3420	Vitamin B-12 cyanocobalamin, up to 1,000 mcg	\$ .23
00522	Water for injection, 30 cc	\$ 2.09
00521	Water for injection, 500 cc	\$ 4.17
J2500	Zemplar, 5 mcg	\$25.09
J0697	Zinacef, cefuroxime sodium, 750 mg	\$6.42
X0062	Zofran, 2 mg/1 cc	\$12.17
01958	Zovirax, 500 mg	\$61.75

\* This drug is included in the composite rate.

### Billing Issues with Levocarnitine – HCPCS Code J1955

The Centers for Medicare & Medicaid Services (CMS) has determined that there was a problem with end-stage renal disease (ESRD) claims hitting an edit implemented with the April 2002 outpatient code editor (OCE) update. HCPCS code J1955 – levocarnitine was assigned as a nonallowed item or service with a service indicator of 'E'.

With the implementation of the July 2002 OCE update, the service indicator for HCPCS code J1955 has been changed to B – nonallowed item or service for OPSS, since this code is payable if billed by an ESRD facility.

#### Action Required by Providers

ESRD providers may adjust any claim that has a line item rejection as a result of billing for HCPCS code J1955, processed on or after April 1, 2002. ❖

Source: CMS Transmittal A-02-056, CR 2208

# MEDICAL POLICIES

The Centers for Medicare & Medicaid Services (CMS) instructions regarding development of local medical review policies (LMRPs) are addressed in the Medicare Intermediary Manual (CMS publication 13-3, section 3911), indicating, “Medical review policy is a composite of statutory provisions, regulations, nationally published Medicare coverage policies, and LMRPs.” In the absence of statute, regulations, or national coverage policy, Medicare contractors are instructed to develop LMRPs to describe when and under what circumstances an item or service is covered. LMRPs are also developed to clarify or to provide specific details on national coverage guidelines and are the basis for medical review decisions made by the Medicare contractor’s medical review staff.

Medical review initiatives are designed to ensure the appropriateness of medical care and to ensure that medical policies and review guidelines developed are consistent with the accepted standards of medical practice.

## LMRP Format

Each LMRP is written in a standard format designed to convey pertinent information about an item or service in an organized and concise manner. The format is divided into distinct sections containing information the provider must know to ensure compliance.

## Effective Dates

In accordance with CMS guidelines, a minimum 30-day advance notice is required when initially implementing a final LMRP. The LMRPs published in this section, are effective approximately 30 days from the date of this publication. Therefore, the policies contained in this section are effective for claims processed **September 23, 2002**, and after, unless otherwise noted.

*Final LMRPs are available on the Florida Medicare provider Web site ([www.floridamedicare.com](http://www.floridamedicare.com)).*

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## Effective Date for Local Medical Review Policies

Medicare contractors are required to offer a 45-day notice period prior to implement local medical review policies (LMRPs). This period typically begins by publishing LMRPs through the contractors’ bulletins.

Since the Centers for Medicare & Medicaid Services (CMS) has instructed contractors to discontinue printing and mailing providers’ bulletins between July 1, 2002, and September 30, 2002, the 45-day notice period for the LMRPs in this publication will begin on the date the LMRP is posted to provider Web site [www.floridamedicare.com](http://www.floridamedicare.com). ❖

Source: CMS Memorandum dated June 28, 2002

## 22520: Percutaneous Vertebroplasty

*Revision Overview: "Indications and Limitations of Coverage and/or Medical Necessity" and "Coding Guidelines" sections of the policy have been revised.*

**Policy Number**

22520

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Percutaneous Vertebroplasty

**AMA CPT Copyright Statement**

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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**

07/18/2002

**Revision Ending Date**

07/17/2002

**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. Conscious sedation with additional local anesthesia (1% lidocaine) is generally utilized; however, patients who experience difficulties with ventilation or are unable to tolerate prone

position during the procedure may require general anesthesia or deep sedation with airway and ventilation support. 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 body metastatic disease;
- Painful multiple myeloma involving the vertebral body;
- Painful and/or aggressive hemangioma;
- Painful, debilitating, osteoporotic vertebral collapse/compression fractures that have not responded to conservative medical treatment (e.g., 2-4 week period of immobilization such as restricted activity/bracing and analgesia/scheduled narcotic usage); and
- Severe pain and functional debilitation related to activities of daily living due to chronic vertebral collapse/compression fractures that require hospitalization for pain control and treatment. Conservative medical management is not considered appropriate for such patients. It is expected that this circumstance will occur rarely to occasionally.

The decision to perform this procedure should take 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



**22520: Percutaneous Vertebroplasty (continued)**

**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

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

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

**Diagnoses that Support Medical Necessity**

N/A

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

N/A

**Diagnoses that DO NOT Support Medical Necessity**

N/A

**Reasons for Denials**

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

**Noncovered ICD-9-CM Codes**

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

**Noncovered Diagnosis**

N/A

**Coding Guidelines**

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

**Documentation Requirements**

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

When the service is performed for painful, debilitating, osteoporotic vertebral collapse/compression fractures, documentation must support that conservative treatment has failed, unless the patient experienced severe pain and functional limitation in performing activities of daily living due to chronic vertebral collapse/compression fractures and required hospitalization for pain control and treatment. Under those circumstances, documentation must support the severity of pain and functional limitations related to performance of activities of daily living requiring hospitalization.

**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](http://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 include representatives from the Florida Radiological Society, Inc.

**Start Date of Comment Period**

N/A

**End Date of Comment Period**

N/A

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number:	1
Start Date of Comment Period:	N/A
Start Date of Notice Period:	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Revised Effective Date	07/18/2002
Explanation of Revision:	The deletion of the term “multi disciplinary”, a revision to the statement regarding general anesthesia, and the addition of the indication for those individuals with severe pain and debilitation requiring hospitalization for pain control and treatment.
Revision Number:	Original
Start Date of Comment Period:	01/18/2002
Start Date of Notice Period:	05/01/2002
	3 <sup>rd</sup> Qtr 2002 <i>Bulletin</i>
Original Effective Date	06/24/2002 ❖

**22899: Kyphoplasty**

**Policy Number**

22899

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Kyphoplasty

**AMA CPT Copyright Statement**

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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**

09/23/2002

**Original Policy Ending Date**

N/A

**Revision Effective Date**

N/A

**Revision Ending Date**

N/A

**LMRP Description**

Balloon kyphoplasty is a minimally invasive surgical procedure for the reduction and internal fixation of vertebral body compression fractures (VCFs). The procedure is similar to vertebroplasty in that there is percutaneous placement of tools for insertion of the bone cement polymethylmethacrylate (PMMA). However, balloon kyphoplasty involves the inflation of a balloon tamp which creates a cavity into which the PMMA is injected under low pressure.

The physician makes a small incision in the patient's back to allow access into the fractured vertebral body. A small orthopedic balloon is placed through transpedicular or extrapedicular approaches to the vertebral body and inflated. The balloon is then deflated and removed, leaving a space within the vertebral body. The space is then injected with PMMA to support the bone and help prevent further collapse. There are instances when two balloons, rather than one, may be placed bilaterally via the

transpedicular or extrapedicular approaches (T9-L5 fractures). The procedure is performed under fluoroscopic guidance.

Balloon kyphoplasty may be done under local or general anesthesia, generally takes about an hour per fracture, and the patient is observed for four hours afterward (some patients may require an overnight hospital stay). Balloon kyphoplasty is generally used for more recent VCFs (less than 10 weeks). It has been used in VCFs due to primary osteoporosis, secondary osteoporosis, multiple myeloma, and osteolytic metastatic disease.

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

Florida Medicare will consider the performance of a kyphoplasty procedure medically reasonable and necessary for the following indications:

- Painful osteolytic vertebral body metastatic disease;
- Painful multiple myeloma involving the vertebral body;
- Painful, debilitating osteoporotic VCFs that have not responded to conservative medical treatment (e.g., 2-4 week period of immobilization such as restricted activity/bracing and analgesia/scheduled narcotic usage); and
- Severe pain and functional debilitation related to activities of daily living due to chronic VCFs that require hospitalization for pain control and treatment. Conservative medical management is not considered appropriate for such patients. It is expected that this circumstance will occur rarely to occasionally.

The decision to perform this procedure should take 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. It is expected that only those skilled in this procedure/technique will perform it. Rapid access to emergency equipment and personnel is required for balloon kyphoplasty.

The balloon kyphoplasty procedure is contraindicated in non-painful stable VCFs, clinically improving VCFs, osteomyelitis, uncorrectable coagulopathy, allergy to the PMMA, retropulsed fracture fragment(s) or tumor mass causing significant spinal canal compromise, or when it is technically not feasible (e.g., vertebra plana).

**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**

N/A

**22899: Kyphoplasty (continued)**

**Not Otherwise Classified Codes (NOC)**

22899 Unlisted procedure, spine

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

170.2	Malignant neoplasm of vertebral column, excluding sacrum and coccyx
198.5	Secondary malignant neoplasm of bone and bone marrow
203.00-203.01	Multiple myeloma
238.6	Neoplasm of uncertain behavior of plasma cells
733.13	Pathologic fracture of vertebrae
805.2	Fracture of vertebral column without mention of spinal cord injury, dorsal [thoracic], closed
805.4	Fracture of vertebral column without mention of spinal cord injury, lumbar, closed

**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**

Procedure code 22899 should only be billed one time per vertebra, regardless of the number of injections or balloon tamps into a single vertebra.

**Documentation Requirements**

Medical record documentation (e.g., office/progress notes, procedure notes) 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 VCFs, documentation must support that conservative treatment has failed, unless the patient experienced severe pain and functional limitation in performing activities of daily living due to chronic VCFs and required hospitalization for pain control and treatment. Under those circumstances, documentation must support the severity of pain and functional limitations related to performance of activities of daily living requiring hospitalization.

**Utilization Guidelines**

N/A

**Other Comments**

N/A

**Sources of Information and Basis for Decision**

Lieberman, I.H., Dudeney, S., Reinhardt, M.K., & Bell, G. (2001). Initial outcome and efficacy of “kyphoplasty” in the treatment of osteoporotic vertebral compression fractures. *Spine*, 26 (14): 1631-1638. Provided the indications of coverage for kyphoplasty.

**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 include representatives from numerous societies.

**Start Date of Comment Period**

01/11/2002

**End Date of Comment Period**

02/25/2002

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number	Original
Start Date of Comment Period:	01/11/2002
Start Date of Notice Period:	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Original Effective Date	09/23/2002 ❖

**36521: Protein A Column Apheresis (ProSORBA®)**

**Policy Number**

36521

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Protein A Column Apheresis (ProSORBA®)

**AMA CPT Copyright Statement**

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**CMS National Coverage Policy**

Coverage Issues Manual, Section 35-90  
Hospital Manual, Section 440.2

**Primary Geographic Jurisdiction**

Florida

**Secondary Geographic Jurisdiction**

N/A

**CMS Region**

Region IV

**CMS Consortium**

Southern

**Original Policy Effective Date**

09/23/2002

**Original Policy Ending Date**

N/A

**Revision Effective Date**

N/A

**Revision Ending Date**

N/A

**LMRP Description**

Protein A columns are plasma treatment devices that contain highly-purified staphylococcal A protein bound to an inert silica matrix. The technique involves pumping the patient's blood through a cell separator and perfusing the collected plasma over the adsorbent column. The mechanism of action is presumed to be an immunoadsorption of circulating immune complexes and platelet-specific autoantibodies. Extracorporeal Immunoadsorption (ECI), using protein A columns, has been developed for the purpose of selectively removing circulating immune complexes (CIC) and immunoglobulins (IgG) from patients in whom these substances are associated with their diseases.

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

Protein A column apheresis will be covered by Florida Medicare when used for the treatment of refractory idiopathic thrombocytopenia purpura (ITP) and rheumatoid arthritis (RA).

Refractory ITP is defined, for the purposes of this policy, as meeting the following criteria:

- Prior treatment failure with corticosteroids and/or splenectomy
- No concurrent illness/disease explaining thrombocytopenia
- Platelet counts persistently at or below 25,000/cu mm

RA is defined, for the purposes of this policy, as meeting the following criteria:

- Disease must be severe
- Disease must be active as evidenced by having:
  - greater than 5 swollen joints,
  - greater than 20 tender joints, **and**
  - morning stiffness greater than 60 minutes.
- Patient must have failed an adequate course of a minimum of three disease modifying drugs (DMARDs). Failure does not include intolerance.

**CPT/HCPCS Section & Benefit Category**

Surgery/Cardiovascular System

**Type of Bill Code**

Hospital – 13x  
Critical Access Hospital – 85x

**Revenue Codes**

36x Operating Room Services  
51x Clinic  
760 General Classification, Treatment or Observation Room  
761 Treatment Room  
940 General Classification, Other Therapeutic Services

**CPT/HCPCS Codes**

36521 *Therapeutic apheresis; with extracorporeal affinity column adsorption and plasma reinfusion*

**Not Otherwise Classified Codes (NOC)**

N/A

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

287.3 Primary thrombocytopenia  
714.0 Rheumatoid arthritis  
714.1 Felty's syndrome  
714.2 Other rheumatoid arthritis with visceral or systemic involvement  
714.30-714.33 Juvenile chronic polyarthritis

**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



**36521: Protein A Column Apheresis (Prosorba®) (continued)**

**Reasons for Denials**

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

**Noncovered ICD-9-CM Codes**

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

**Noncovered Diagnosis**

N/A

**Coding Guidelines**

N/A

**Documentation Requirements**

Medical record documentation that is maintained by the performing physician must substantiate the medical necessity for the use of Protein A Column Apheresis by clearly indicating the relevant clinical signs and symptoms related to the condition for which this therapy is indicated. This documentation is usually found in the history and physical or in the office/progress notes.

The medical record must clearly reflect the failure of conservative therapies for chronic refractory ITP as defined under “Indications and Limitations of Coverage and/or Medical Necessity.” The medical record must also identify the failed DMARDS.

**Utilization Guidelines**

N/A

**Other Comments**

N/A

**Sources of Information and Basis for Decision**

Caldwell, J., Gendreau, R., & Furst, D. (1999). A pilot study using a staph protein a column (Prosorba®) to treat refractory rheumatoid arthritis. *Journal of Rheumatology*, 26, (8), 1657-1662.

Felson, D., LaValley, M., Baldassare, A., Block, J., Caldwell, J., Cannon, G., Deal, C., Evans, S., Fleischmann, R., Gendreau, R., Harris, E., Matteson, E., Roth, S., Schumacher, H., Weisman, M., & Furst, D. (1999). The Prosorba column A for treatment of refractory rheumatoid arthritis: a randomized, double-blind, sham-controlled trial. *Arthritis Rheumatism*, 42, (10), 2153-2159.

Handin, R.I. (1998). Disorders of the platelet and vessel wall. K.J. Isselbacher, E. Braunwald, J.D. Wilson, J.B. Martin, A.S. Fauci, & D.L. Kasper (Vol. Eds.), *Harrison’s principles of internal medicine*: Vol. 1 (14<sup>th</sup> ed., p. 732). New York: McGraw-Hill.

Prescribing Information, Prosorba® Protein A Immunoabsorption Column, Cypress Bioscience, Inc.

Wiesenhutter, C., Irish, B., & Bertram, J. (1994). Treatment of patients with refractory rheumatoid arthritis with extracorporeal protein a immunoabsorption columns: a pilot trial. *The Journal of Rheumatology*, 21, (5), 04-815.

**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 include representatives from numerous societies.

**Start Date of Comment Period**

02/21/2000

**End Date of Comment Period**

04/06/2000

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number	Original
Start Date of Comment Period:	02/21/2000
Start Date of Notice Period:	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Original Effective Date	09/23/2002 ❖

**43235: Diagnostic and Therapeutic Esophagogastroduodenoscopy**

**Policy Number**

43235

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Diagnostic and Therapeutic Esophagogastroduodenoscopy

**AMA CPT Copyright Statement**

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**CMS National Coverage Policy**

Coverage Issues Manual, Section 35-59

**Primary Geographic Jurisdiction**

Florida

**Secondary Geographic Jurisdiction**

N/A

**CMS Region**

Region IV

**CMS Consortium**

Southern

**Original Policy Effective Date**

09/23/2002

**Original Policy Ending Date**

N/A

**Revision Effective Date**

N/A

**Revision Ending Date**

N/A

**LMRP Description**

Upper intestinal endoscopy is performed with a lighted, flexible, fiberoptic instrument passed through the cricopharynx. The patient receives conscious sedation. A topical anesthetic is sometimes applied to the posterior pharynx. Direct visualization of the entire esophagus, stomach, and duodenum (to the junction of the second and third portions) can be accomplished easily with modern instruments that are less than 12mm in diameter. Esophagogastroduodenoscopy (EGD) is a technique utilized to examine, obtain samples, and in some instances, to treat pathological conditions.

Diagnostic observations are made concerning focal benign or malignant lesions, diffuse mucosal changes, luminal obstruction, motility, and extrinsic compression by contiguous structures. A diagnostic EGD allows the examiner to visualize abnormalities detectable by the technique and to photograph, biopsy, and/or remove lesions as appropriate.

The purpose of the therapeutic EGD is to manage hemorrhage; remove foreign bodies and neoplastic growths; to relieve obstruction due to stricture, malignancy, or other causes through dilatation or the placement of stents; and to assist in the placement of percutaneous gastrostomy tubes.

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

Florida Medicare will consider EGD(s) to be medically reasonable and necessary under the following diagnostic conditions:

- Patient has upper abdominal distress (e.g., gastroesophageal reflux disease) which persists despite an appropriate trial of symptomatic therapy;
- Patient has upper abdominal distress associated with a short history of signs and symptoms suggesting significant associated disease or illness (e.g., weight loss, anorexia, vomiting, nonsteroidal anti-inflammatory drug [NSAID] intake, other gastric irritant intake);
- Patients over the age of 40 who have experienced a significant history of heartburn that returns after a course of symptomatic therapy;
- Patients who have dysphagia or odynophagia;
- Patient has persistent, unexplained vomiting;
- Patient has upper gastrointestinal X-ray findings of:
  - any lesion that requires biopsy for diagnosis; or
  - gastric ulcer suspicious of cancer; or
  - evidence of stricture or obstruction;
- To assess acute injury after caustic agent ingestion;
- When anti-reflux surgery is contemplated; or
- Patient has gastrointestinal bleeding:
  - in most actively bleeding patients; or
  - for presumed chronic blood loss and iron deficiency anemia when investigation of large bowel is negative.

Florida Medicare will consider EGD(s) to be medically reasonable and necessary for the following therapeutic purposes:

- Treatment of bleeding lesions;
- Removal of foreign bodies;
- Sclerotherapy and/or band ligation for bleeding from esophageal or gastric varices;
- Dilatation of strictures in the upper intestinal tract;
- Removal of selected polypoid lesions;
- Placement of feeding tubes; or
- Palliative therapy of stenosing neoplasms (e.g., laser, stent placement).

**Gastrointestinal bleeding** may be treated with a variety of methods. Direct contact heater probes and hemostatic injections into or around the bleeding vessels are both effective therapy for acute bleeding.

**43235: Diagnostic and Therapeutic Esophagogastroduodenoscopy (continued)**

**Foreign body removal** from the stomach or esophagus is usually successful with these flexible instruments. The foreign bodies can be retrieved by either of two methods. The first method is to capture the foreign body with a snare device/grasping forceps and pull the item out with the endoscope. The second method is accomplished by piecemeal destruction and pushing the bolus through the esophagus into the stomach.

**Esophageal varices** may be injected with a variety of sclerosing solutions. Eradication of varices requires, on the average, five sclerotherapy sessions, with multiple injections given during each session.

**Dilatation of strictures** may be accomplished with a balloon placed through the endoscope and inflated using hydrostatic pressure. Bougies are rubber dilators available in various sizes up to approximately 2.0cm. Plastic bougies and other dilating probes are usually passed over a guide wire. This procedure involves placing the guide wire into the stomach through the endoscope. The endoscope is then withdrawn leaving the guide wire in place. The dilating probes and plastic bougies are then passed over the guide wire. After the largest dilator is used, the dilator and guide wire are removed. Esophageal dilation is performed after a definitive diagnosis has been established in patients exhibiting dysphagia. The goal in most cases is a luminal diameter of 16-17mm which allows passage of solid food. A series of dilators may be passed over the guide wire to reach the goal of therapy.

Florida Medicare will consider follow-up EGD(s) medically reasonable and necessary for the following indications:

- Biopsy surveillance of patients with Barrett’s esophagus every 12 to 24 months. However, if dysplasia is present, earlier surveillance intervals of from three to six months may be required;
- Follow-up of gastric ulcers to healing or satisfaction that they are benign;
- Follow-up and treatment of esophageal strictures requiring guidewire dilation;
- Follow-up of duodenal ulcer or other lesions of the upper gastrointestinal tract that have resulted in serious consequences (e.g., hemorrhage);
- Follow-up of patients having a previous gastric polypectomy for adenoma; or
- Follow-up and treatment of patients with esophageal varices or bleeding lesions requiring recurrent therapy (e.g., esophageal varices, gastric varices, angiodysplastic or watermelon stomach lesions, radiation gastritis).

Periodic EGD is NOT usually indicated in the following situations:

- Surveillance of healed, benign disease such as gastric or duodenal ulcer or benign esophageal strictures; or
- Cancer surveillance in patients with pernicious anemia, treated achalasia, or prior gastric resection.

EGD is generally contraindicated for patients with recent myocardial infarction.

**CPT/HCPCS Section & Benefit Category**

Digestive System/Surgery

**Type of Bill Code**

Hospital – 13x  
Critical Access Hospital – 85x

**Revenue Codes**

360 Operating Room Services, General Classification  
361 Operating Room Services, Minor Surgery  
750 Gastro-Intestinal Services, General Classification

**CPT/HCPCS Codes**

- 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) with biopsy, single or multiple*
- 43239 *with transendoscopic intraluminal tube or catheter placement*
- 43241 *with injection sclerosis of esophageal and/or gastric varices*
- 43243 *with band ligation of esophageal and/or gastric varices*
- 43244 *with dilation of gastric outlet for obstruction (eg, balloon, guide wire, bougie)*
- 43245 *with directed placement of percutaneous gastrostomy tube*
- 43246 *with removal of foreign body*
- 43247 *with insertion of guide wire followed by dilation of esophagus over guide wire*
- 43248 *with balloon dilation of esophagus (less than 30mm diameter)*
- 43249 *with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery*
- 43250 *with removal of tumor(s), polyp(s), or other lesion(s) by snare technique*
- 43251 *with control of bleeding, any method*
- 43255 *with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique*
- 43258

**Not Otherwise Classified Codes (NOC)**

N/A

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

- |             |   |
|-------------|---|
| 040.2       | Whipple’s disease   |
| 112.84      | Candidal esophagitis  |
| 150.0-152.9 | Malignant neoplasm of esophagus, stomach, and small intestine, including duodenum |
| 155.0       | Malignant neoplasm of liver, primary  |
| 156.0-156.9 | Malignant neoplasm of gallbladder and extrahepatic bile ducts                     |
| 157.0-157.9 | Malignant neoplasm of pancreas  |
| 159.8       | Malignant neoplasm of other sites of digestive system and intra-abdominal organs  |
| 176.3       | Kaposi’s sarcoma of gastrointestinal sites  |

**43235: Diagnostic and Therapeutic Esophagogastroduodenoscopy (continued)**

197.4	Secondary malignant neoplasm of small intestine, including duodenum	575.5	Fistula of gallbladder
		576.0	Postcholecystectomy syndrome
197.6	Secondary malignant neoplasm of retroperitoneum and peritoneum	576.4	Fistula of bile duct
		577.0-577.2	Disease of pancreas
198.89	Secondary malignant neoplasm of other specified sites	578.0-578.9	Gastrointestinal hemorrhage
		579.0-579.9	Intestinal malabsorption
202.80	Other lymphomas, unspecified site, extranodal and solid organ sites	694.0	Dermatitis herpetiformis
		710.1	Systemic sclerosis
211.0-211.9	Benign neoplasm of other parts of digestive system	747.61	Gastrointestinal vessel anomaly
		750.3-750.7	Other congenital anomalies of upper alimentary tract
214.3	Lipoma of intra-abdominal organs		Anorexia
214.9	Lipoma, unspecified site	783.0	
215.9	Other benign neoplasm of connective and other soft tissue, site unspecified	783.21-783.3	Abnormal loss of weight and underweight and feeding difficulties and mismanagement
228.04	Hemangioma of intra-abdominal structures		Other voice disturbance
230.1-230.8	Carcinoma in situ of digestive organs	784.49	Other symptoms involving head and neck
235.2-235.4	Neoplasm of uncertain behavior of digestive system	784.9	Cough
		786.2	Chest pain
239.0	Neoplasms of unspecified nature of digestive system	786.50-786.59	Swelling, mass, or lump in chest
		786.6	Symptoms involving digestive system
251.5	Abnormality of secretion of gastrin	787.01-787.91	Abdominal pain
261	Nutritional marasmus	789.00-789.09	Abdominal or pelvic swelling, mass, or lump
263.0-263.9	Other and unspecified protein-calorie malnutrition	789.30-789.39	Abdominal tenderness
		789.60-789.69	Other nonspecific abnormal serum enzyme levels
280.0-280.9	Iron deficiency anemias	790.5	Other nonspecific findings on examination of blood
285.1	Acute posthemorrhagic anemia		Nonspecific abnormal findings in stool contents
300.11	Conversion disorder	790.99	Nonspecific abnormal findings on radiologic and other examination of gastrointestinal tract
306.4	Gastrointestinal malfunction arising from mental factors		Nonspecific abnormal findings on radiologic and other examination of abdominal area, including retroperitoneum
		792.1	Cachexia
307.1	Anorexia nervosa		Injury to esophagus, without mention of open wound into cavity
307.50-307.54	Other and unspecified disorders of eating	793.4	Open wound of pharynx, without mention of complication and complicated
438.82	Dysphagia		Foreign body in esophagus or stomach
447.2	Rupture of artery		Foreign body in intestine and colon
448.0	Hereditary hemorrhagic telangiectasia	793.6	Foreign body in digestive system, unspecified
456.0-456.21	Esophageal varices		Burn of mouth and pharynx
507.0	Pneumonitis due to inhalation of food or vomitus		Burn of esophagus and gastrointestinal tract
		799.4	Injury of head, face, and neck
530.0-530.89	Diseases of esophagus	862.22	Toxic effect of caustic alkalis and caustic, unspecified
531.00-531.91	Gastric ulcer		Effects of radiation, unspecified (soft tissue radionecrosis)
532.00-532.91	Duodenal ulcer		Complications of transplanted liver
533.00-533.91	Peptic ulcer, site unspecified	874.4-874.5	Digestive system complications
534.00-534.91	Gastrojejunal ulcer		Accidental poisoning by corrosives and caustics, not elsewhere classified
535.00-535.61	Gastritis and duodenitis	935.1-935.2	Assault by corrosive or caustic substance, except poisoning
536.1-536.8	Disorders of function of stomach	936	
537.0-537.89	Other disorders of stomach and duodenum	938	
		947.0	
551.3	Diaphragmatic hernia with gangrene	947.2-947.3	
552.3-552.8	Diaphragmatic hernia and hernia of other specified sites, with obstruction		
		959.01-959.09	
553.3	Diaphragmatic hernia without mention of obstruction or gangrene	983.2-983.9	
555.0-555.9	Regional enteritis		
560.9	Unspecified intestinal obstruction	990	
562.01-562.03	Diverticula of small intestine		
569.62	Mechanical complication of colostomy and enterostomy	996.82	
		997.4	
569.82	Ulceration of intestine	E864.1-E864.4	
571.1-571.6	Chronic liver disease and cirrhosis		
572.3	Portal hypertension	E961	
574.00-574.41	Cholelithiasis		
575.0	Acute cholecystitis		



**43235: Diagnostic and Therapeutic Esophagogastroduodenoscopy (continued)**

V10.00	Personal history of malignant neoplasm of gastrointestinal tract, unspecified
V10.03-V10.04	Personal history of malignant neoplasm of esophagus and stomach
V10.09	Personal history of malignant neoplasm, other
V12.72	Personal history of colonic polyps
V18.5	Family history of digestive disorders
V58.61	Long-term (current) use of anticoagulants
V58.69	Long-term (current) use of other medications
V69.1	Inappropriate diet and eating habits

**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**

Surgical endoscopy always includes diagnostic endoscopy according to the *Current Procedural Terminology (CPT)* book. Medicare has special payment rules related to endoscopic procedures. The higher valued endoscopy includes the value of the base endoscopy of the same family.

If the endoscopist has not traversed the pyloric channel into the duodenum, then an EGD has not been performed. Report the actual service performed under the esophagoscopy/esophagogastroscope procedural family (procedure codes 43200-43234).

Some procedure codes listed in this policy represent the biopsy of one or more lesions or the removal of one or more polyps or foreign bodies. Bill the applicable procedure code once, regardless of the number of biopsies, polyps or foreign bodies obtained during the session.

Upper GI bleeding can be treated by several endoscopic techniques. All methods used during the session to control bleeding are reported using a single procedure code (43255).

**Documentation Requirements**

The patient’s medical record (e.g., history and physical, office/progress notes, procedure report) maintained by the ordering/referring physician must clearly indicate the reason for the EGD. Also, the results of the EGD must be included in the patient’s medical record.

**Utilization Guidelines**

N/A

**Other Comments**

**Terms defined:**

*Odynophagia* – pain when swallowing.

*Dysphagia* – inability or difficulty swallowing.

*Achalasia* – failure of the sphincter to relax. Failure of the cardiac sphincter to relax results in difficulty passing food to the stomach.

**Sources of Information and Basis for Decision**

American Medical Association. (1994). Gastrointestinal endoscopy codes. *CPT Assistant*, 4, 1-8.

American Society for Gastrointestinal Endoscopy. (1998). The role of endoscopy in the surveillance of premalignant conditions of the upper gastrointestinal tract. *Gastrointestinal Endoscopy*, 48 (6), 663-668.

Grendell, J. H., McQuaid, K. R., & Friedman, S. L. (Eds.). (1996). *Current diagnosis and treatment in gastroenterology*. Stamford, CT: Appleton and Lange.

Laine, L., El-Newihi, H., Migikovsky, B., Sloane, R., & Garcia, F. (1993). Endoscopic ligation compared with sclerotherapy for the treatment of bleeding esophageal varices. *Annals of Internal Medicine*, 119, 1-7.

Silverstein, F. (1998). Gastrointestinal endoscopy. In A. F. Fauci, E. Braunwald, K. Isselbacher, J. Wilson, J. B. Martin, D. L. Kasper, S. L. Hauser, & D. L. Longo (Eds.), *Harrison’s principles of internal medicine* (pp. 1583-1585). New York, NY: McGraw-Hill.

Steigman, G. V., Goff, J. S., Michaletz-Onody, P. A., Korula, J., Lieberman, D., Saeed, Z. A., Reveille, R. M., Sun, J. H., & Lowenstein, S. R. (1992). Endoscopic sclerotherapy as compared with endoscopic ligation for bleeding esophageal varices. *The New England Journal of Medicine*, 326 (23), 1527-1532.

Waye, J. (1991). Diagnostic and therapeutic endoscopy. In D. B. Sachar, J. D. Waye & B. S. Lewis (Eds.), *Pocket guide to gastroenterology* (pp. 309-312). Baltimore, MD: Williams & Wilkins.

**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 include representatives from numerous societies.

**Start Date of Comment Period**

05/10/2002

**End Date of Comment Period**

06/24/2002

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number:	Original
Start Date of Comment Period	05/10/2002
Start Date of Notice Period	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Original Effective Date:	09/23/2002 ❖

**69220: Mastoidectomy Cavity Debridement**

**Policy Number**

69220

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Mastoidectomy Cavity Debridement

**AMA CPT Copyright Statement**

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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**

09/23/2002

**Original Policy Ending Date**

N/A

**Revision Effective Date**

N/A

**Revision Ending Date**

N/A

**LMRP Description**

A mastoidectomy cavity is created as a result of ear operations such as radical mastoidectomy, modified radical mastoidectomy, atticotomy, fenestration operation, temporal bone resection, etc. Such operations are performed to eradicate disease of the middle ear and mastoid. An automastoidectomy may also occur as a result of a cholesteatoma. Complications may occur postoperatively or any time after the creation of the cavity and necessitate debridement of the cavity.

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

Florida Medicare will consider the debridement of the mastoidectomy cavity medically reasonable and necessary under the following circumstances:

For patients who have undergone any of the following surgical procedures: a radical mastoidectomy, a modified mastoidectomy, atticotomy, fenestration operation, temporal bone resection, or developed an automastoidectomy (as a result of cholesteatoma), resulting in the formation of a mastoid cavity, and present with any of the following signs/symptoms:

- Persistent earache
- Ear drainage
- Excess crusting

- Ear pressure
- New onset of hearing loss
- Dizziness
- New onset of facial muscle weakness

**Simple debridement (69220)**

A simple debridement of the mastoidectomy cavity (routine cleaning) is considered medically reasonable and necessary for those presenting with dry debris or excess crusting of the mastoidectomy cavity. It is generally expected that a simple debridement of the mastoidectomy cavity would be performed no more than once every three months. However, the frequency at which a simple debridement of the mastoidectomy cavity is performed is dependent on the clinical presentation of the individual patient.

**Complex debridement (69222)**

A complex debridement of the mastoidectomy cavity is considered medically reasonable and necessary for those presenting with any of the following conditions: lack of previous meatoplasty or stenosis of the ear canal, bleeding, recurrent cholesteatoma, granulation tissue, presence of labyrinthine fistula, absence of tympanic membrane, active infection, inadequate lowering of the facial ridge, presence of cholesterol granuloma cysts, severe pain, severe vertigo or increased vertigo during debridement, or an uncooperative patient (e.g., young child).

The frequency at which a complex debridement of the mastoidectomy cavity is performed is dependent on the clinical presentation of the individual patient. For example, debridement of the mastoidectomy cavity may be required on multiple visits at close intervals due to inter-current infection and the attempt to reduce mucolized surfaces and remove granulomatous tissue.

**Note:** It is inappropriate to bill either procedure code 69220 or 69222 for removal of impacted cerumen or debridement of the external auditory canal.

**CPT/HCPCS Section & Benefit Category**

Auditory System/Surgery

**Type of Bill Code**

Hospital - 13x  
Critical Access Hospital - 85x

**Revenue Codes**

360 Operating Room Services, General Classification

**CPT/HCPCS Codes**

- 69220 *Debridement, mastoidectomy cavity, simple (eg, routine cleaning)*
- 69222 *Debridement, mastoidectomy cavity, complex (eg, with anesthesia or more than routine cleaning)*

**Not Otherwise Classified Codes (NOC)**

N/A

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

- 381.00-381.03 Acute nonsuppurative otitis media
- 381.10-381.19 Chronic serous otitis media
- 381.20-381.29 Chronic mucoid otitis media
- 381.3 Other and unspecified chronic nonsuppurative otitis media

**69220: Mastoidectomy Cavity Debridement (continued)**

382.00-382.01	Acute suppurative otitis media
382.1	Chronic tubotympanic suppurative otitis media
382.2	Chronic atticofacial suppurative otitis media
382.3	Unspecified chronic suppurative otitis media
382.4	Unspecified suppurative otitis media
382.9	Unspecified otitis media
383.00-383.02	Acute mastoiditis
383.1	Chronic mastoiditis
383.30-383.33	Complications following mastoidectomy
385.30-385.9	Other disorders of middle ear and mastoid
386.19	Other peripheral vertigo (otogenic vertigo)
386.40-386.48	Labirinthine fistula
387.9	Otosclerosis, unspecified
388.60-388.69	Otorrhea
388.70-388.72	Otalgia
389.00	Conductive hearing loss, unspecified
389.03	Conductive hearing loss, middle ear
389.08	Conductive hearing loss of combined types
389.10	Sensorineural hearing loss, unspecified
389.11	Sensory hearing loss
389.12	Neural hearing loss
389.18	Sensorineural hearing loss combined types
389.2	Mixed conductive and sensorineural hearing loss
389.8	Other specified forms of hearing loss

**Diagnoses that Support Medical Necessity**

N/A

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

N/A

**Diagnoses that DO NOT Support Medical Necessity**

N/A

**Reasons for Denials**

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

**Noncovered ICD-9-CM Codes**

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

**Noncovered Diagnosis**

N/A

**Coding Guidelines**

N/A

**Documentation Requirements**

Medical record documentation (e.g., office/progress notes, procedure notes) maintained by the performing provider must indicate the medical necessity for performing the service. It is expected that the following information will be clearly documented in the medical record to support the mastoidectomy cavity debridement code billed:

- Documentation of previous radical mastoidectomy, modified radical mastoidectomy, atticotomy, fenestration operation, temporal bone resection or development of an automastoidectomy (as a result of a cholesteatoma);
- The extent of the current disease pathology necessitating debridement; and
- The method utilized for debridement, including any anesthesia (when applicable).

**Utilization Guidelines**

The frequency at which a debridement of the mastoidectomy cavity is performed is dependent on the clinical presentation of the patient. However, it is generally expected that a simple debridement of the mastoidectomy cavity would be performed no more than once every three months.

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**

**Terms defined:**

*Atticotomy* – a surgical operation to remove cholesteatoma from the ear. It is a form of limited mastoidectomy.

*Cholesteatoma* – a skin-lined sac containing debris from dead skin cells that grows from the eardrum into the mastoid bone eroding normal structures in its path. Left untreated, it can carry infection to the brain, causing meningitis and cerebral abscess. Treatment is by means of mastoidectomy.

*Mastoidectomy* – an operation to remove some or all of the air cells in the bone behind the ear (the mastoid process of the temporal bone) when they have become infected or invaded by cholesteatoma.

**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](http://www.floridamedicare.com).

**Advisory Committee Notes**

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

**Start Date of Comment Period**

05/10/2002

**End Date of Comment Period**

06/24/2002

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number:	Original
Start Date of Comment Period:	05/10/2002
Start Date of Notice Period:	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Original Effective Date	09/23/2002 ❖

## 71250: Computerized Axial Tomography of the Thorax

*Revision Overview: The following sections of the policy have been revised: "Indications and Limitations of Coverage and/or Medical Necessity," "Type of Bill Code," "ICD-9-CM that Support Medical Necessity" and "Noncovered ICD-9-CM Codes."*

### Policy Number

71250

### Contractor Name

First Coast Service Options, Inc.

### Contractor Number

090

### Contractor Type

Intermediary

### LMRP Title

Computerized Axial Tomography of the Thorax

### AMA CPT Copyright Statement

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### CMS National Coverage Policy

Coverage Issues Manual, Section 50-12

### Primary Geographic Jurisdiction

Florida

### Secondary Geographic Jurisdiction

N/A

### CMS Region

Region IV

### CMS Consortium

Southern

### Original Policy Effective Date

09/21/2001

### Original Policy Ending Date

N/A

### Revision Effective Date

06/21/2002

### Revision Ending Date

06/20/2002

### LMRP Description

A computed tomographic (CT) image is a display of the anatomy of a thin slice of the body developed from multiple X-ray absorption measurements made around the body's periphery. Unlike conventional tomography, where the image of a thin section is created by blurring out the information from unwanted regions, the CT image is constructed mathematically using data arising only from the section of interest. Generating such an image is confined to cross-sections of the anatomy that are oriented essentially perpendicular to the axial dimensions of the body. Reconstruction of the final image can be accomplished in any plane. The CT of the thorax extends from the lung apices to the posterior costophrenic sulci and may extend inferiorly to image the adrenal glands.

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

Florida Medicare will consider a CT of the thorax medically reasonable and necessary under the following circumstances:

- Evaluation of abnormalities of the lungs, mediastinum, pleura and chest wall initially found on a standard chest radiograph or barium swallow.
- Evaluation, staging, and follow-up after therapy (e.g., surgery, radiation, and/or chemotherapy) of lung and other primary thoracic malignancies.
- Evaluation of a patient with extrathoracic malignancies/tumors/masses in which the lungs are suspected as being the primary site.
- Evaluation of a patient who sustained trauma to the pleura, chest wall, mediastinum, and lung.
- Localization of a thoracic mass prior to biopsy.
- Evaluation of a patient with suspected congenital or acquired abnormalities.
- Evaluation of a patient with myasthenia gravis to rule out thymic tumors.
- Performance of CT-guided biopsies and drainage procedures when fluoroscopy is inadequate.
- Evaluation of a patient presenting with signs and/or symptoms suggestive of an aortic dissection. The most common symptom of an aortic dissection (occurring in approximately 90% of the cases) is sudden, excruciating pain most commonly located in the anterior chest. Patients may describe the pain as "cutting," "ripping," or "tearing." A sudden neurologic episode usually accompanies the onset of most instances of "painless" aortic dissection.
- Evaluation of a patient with any other condition/symptom when there is support in medical and scientific literature for the effective use of the scan for the condition being evaluated and the scan is reasonable and necessary for the individual patient.

**Note:** Posterior and lateral views of the chest represent the basic screening tool in identifying abnormalities involving the thorax. It is expected that the chest X-ray is used to evaluate patients who present with signs and/or symptoms suggestive of chest pathology prior to proceeding to a CT scan. However, in limited circumstances, a CT of the Thorax may be used as a primary diagnostic tool if the documentation supports that the initial test was reasonable and necessary and the medical literature supports the CT scan as the primary diagnostic test for the condition being evaluated.

In addition to the medical necessity requirements, the CT scan must be performed on a model of CT equipment that meets the following criteria:

- The model must be known to the Food and Drug Administration; and
- Must be in the full market release phase of development.



71250: *Computerized Axial Tomography of the Thorax (continued)*

**CPT/HCPCS Section & Benefit Category**

Radiology/Diagnostic Radiology

**Type of Bill Code**

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

**Revenue Code**

32x Diagnostic Radiology  
 350 CT Scan, General Classification

**CPT/HCPCS Codes**

71250 Computerized axial tomography, thorax; without contrast material  
 71260 with contrast material(s)  
 71270 without contrast material, followed by contrast material(s) and further sections

**Not Otherwise Classified Codes (NOC)**

N/A

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

N/A

**Diagnoses that Support Medical Necessity**

N/A

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

N/A

**Diagnoses that DO NOT Support Medical Necessity**

N/A

**Reasons for Denials**

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

**Noncovered ICD-9-CM Codes**

N/A

**Noncovered Diagnosis**

N/A

**Coding Guidelines**

N/A

**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.

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**

American College of Radiology. (1997). *American College of Radiology Standards*.  
 Armstrong, P. & Wastie, M. L. (4<sup>th</sup> ed.). (1998). *Diagnostic imaging*. Malden MA: Blackwell Science, Inc.  
 Golish, J. A. (Ed.). (1994). *Diagnostic procedure handbook*. Hudson: Lexi-Comp Inc.  
 Haaga, J. R., Sartoris, D. J., Lanzieri, C. F., & Zerhouni, E. A. (3<sup>rd</sup> ed.). (1994). *Computed tomography and magnetic resonance imaging of the whole body*. St Louis: Mosby-Year Book Inc.  
 Juhl, J. H., Crummy, A. B., & Kuhlman, J. E. (Eds.). (7<sup>th</sup> ed.). (1998). *Essentials of radiologic imaging*. Philadelphia: Lippincott-Raven.  
 Lee, J. K. T., Stanley, R. J., Sagel, S. S., & Keiken, J. P. (Eds.). (3<sup>rd</sup> ed.). (1998). *Computed body tomography with MRI correlation*. Philadelphia: Lippincott-Raven.  
 Schlant, R. C., & Alexancer, R. W. (Eds.). (1994). *Hurst’s the heart*. New York: McGraw-Hill Inc.

**Advisory Committee Notes**

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

**Start Date of Comment Period**

N/A

**End Date of Comment Period**

N/A

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number	2
Start Date of Comment Period	N/A
Start Date of Notice Period	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Revised Effective Date	06/21/2002
Explanation of Revision:	CT scans are utilized for a number of conditions, which can incorporate several diagnoses. Since the ICD-9-CM codes associated with the many indications for CT of the Thorax can be numerous and the ability to identify every appropriate diagnosis code for this service would result in an extensive diagnosis list, the policy was revised deleting the diagnoses list. In addition, indications for coverage were added to the policy.
Revision Number	1
Start Date of Comment Period	N/A
Start Date of Notice Period	02/01/2002
	2 <sup>nd</sup> Qtr 2002 <i>Bulletin</i>
Revised Effective Date	12/05/2001
Explanation of Revision:	Diagnosis 494 was expanded due to specificity. In addition, a lung nodule should be billed under diagnosis 518.89, therefore, it was added to the policy.
Revision Number	Original
Start Date of Comment Period:	06/12/2000
Start Date of Notice Period:	08/01/2001
	4 <sup>th</sup> Qtr 2001 <i>Bulletin</i>
Original Effective Date	09/28/2001 ❖

**77280: Therapeutic Radiology Simulation-Aided Field Setting**

*Revision Overview: The complete policy has been revised to provide further clarification regarding the indications and limitations of coverage, as well as appropriate coding guideline for these services. The previous published policy must be discarded.*

**Policy Number**

77280

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Therapeutic Radiology Simulation-Aided Field Setting

**AMA CPT Copyright Statement**

CPT codes, descriptions, and other data only are copyright 2001 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply.

**CMS National Coverage Policy**

N/A

**Primary Geographic Jurisdiction**

Florida

**Secondary Geographic Jurisdiction**

N/A

**CMS Region**

Region IV

**CMS Consortium**

Southern

**Original Policy Effective Date**

02/24/1997

**Original Policy Ending Date**

N/A

**Revision Effective Date**

09/23/2002

**Revision Ending Date**

09/22/2002

**LMRP Description**

Following treatment planning, simulation is utilized to actually direct the treatment beams to the specific treatment volume determined. Simulation is usually performed on a dedicated simulator, but can be performed on other pieces of equipment such as a radiation therapy treatment unit, virtual reality-based 3D simulation system or other dedicated diagnostic X-ray, magnetic resonance, ultrasound, or nuclear medicine equipment that has been modified to localize treatment volumes in order to define the area that requires treatment.

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

Florida Medicare will consider therapeutic radiology simulation-aided field testing medically reasonable and necessary for patients with documented cases of neoplasm

for whom a radiation therapy treatment course needs to be established. The complexity of simulation is based on the number of ports of entry, treatment volumes and the inclusion and type of treatment devices. However, the number of films taken per treatment volume, the modality from which images for simulation are obtained, and the use of fluoroscopy are not determinants of complexity. Portal changes based on unsatisfactory initial simulation(s) are not reported as additional simulations. However, additional simulations may be required during treatment in order to account for changes in ports due to changes in treatment volume. Minor changes in port size, without substantial changes in treatment volume, do not warrant an additional charge or a higher level of complexity.

**77280 Therapeutic radiology simulation-aided field setting; simple**

If any or all of the following factors are present, the simulation will remain simple:

- single treatment volume with either a simple port or parallel opposed ports (2), with simple or no blocking;
- block verification simulation; and/or
- subsequent simulations (e.g. orthogonal films) for brachytherapy source verification (radioactive or dummy).

**77285 Therapeutic radiology simulation-aided field setting; intermediate**

If any of the following factors are present, the simulation will be considered intermediate:

- simulation of three or more converging ports, or two separate treatment volumes; and/or
- multiple blocks, if clinically necessary.

**77290 Therapeutic radiology simulation-aided field setting; complex**

If any and/or all of the following factors are present, the simulation will be considered complex:

- three or more treatment volumes;
- rotation or arc therapy;
- complex blocking, custom made shielding blocks based on clinical necessity;
- any use of contrast media (e.g. body cavity, GI tract, or intravascular) to define anatomic structures and treatment volume, or for initial brachytherapy simulation;
- tangential ports with multiple devices; and/or
- custom immobilization devices.

**77295 Therapeutic radiology simulation-aided field setting; three-dimensional**

Three-dimensional simulations and treatment is clinically warranted if one or more of the following exists:

- the volume of interest is irregular and in close proximity to normal structures that must be protected;

**77280: Therapeutic Radiology Simulation-Aided Field Setting (continued)**

- the volume of interest is in such a location that its parameters can only be defined by MRI or CT;
- multiple or conformal portals are necessary to cover the volume of interest with close margins and protect immediate adjacent structures;
- beam’s eye view of multiple portals must be established for conformal treatment delivery;
- an immediately adjacent area has been irradiated and abutting portals must be established with high precision;
- three-dimensional reconstruction of the tumor volume and the critical structure volume in brachytherapy cases is used to develop dose volume histograms (DVH) for the tumor and critical structures.

This procedure involves three-dimensional, computer-generated reconstruction of tumor volume and surrounding critical normal tissue structures from direct CT scan and/or MRI data in preparation for non-coplanar or coplanar therapy. This simulation utilizes documented three-dimensional beam’s eye view volume-dose displays of multiple or moving beams. Documentation must include a hard copy of computer-generated, three-dimensional tumor volume and critical structure or critical area reconstruction and three-dimensional representation of dose distribution in the form of dose clouds and/or DVH of volume of interest and critical structures with evidence of review by physician.

The typical course of radiation therapy will consist of between one and three simulations. However, no more than one simulation should be reported per day. Frequency in excess of three simulations may require supporting documentation.

**CPT/HCPCS Section & Benefit Category**

Radiology/Radiation Oncology

**Type of Bill Code**

Hospital – 12x, 13x

Critical Access Hospital – 85x

**Revenue Codes**

333 Radiation Therapy

**CPT/HCPCS Codes**

77280 *Therapeutic radiology simulation-aided field setting; simple*

77285 *intermediate*

77290 *complex*

77295 *three-dimensional*

**Not Otherwise Classified Codes (NOC)**

N/A

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

N/A

**Diagnoses that Support Medical Necessity**

N/A

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

N/A

**Diagnoses that DO NOT Support Medical Necessity**

N/A

**Reasons for Denials**

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

**Noncovered ICD-9-CM Codes**

N/A

**Noncovered Diagnosis**

N/A

**Coding Guidelines**

Procedure code 77295 may be billed once per treatment course per treatment volume. CPT 77295 includes those activities necessary to perform a three-dimensional treatment plan, including digitally reconstructed radiographs of the beam’s eye view, and either cross-sectional reconstructions of the dose distributions in three dimensions, or a review of the dose-volume histograms of the resultant treatment. In most circumstances, the anatomy and the planning tumor volume for the highest dose regions will not change throughout the treatment course. Therefore, in general, a single 77295 activity and reimbursement shall suffice. If more than one set of beams utilizing different beam and gantry angles is used to treat a larger “nodal” volume and a smaller “cone-down” volume, and both sets of treatments are planned off of the same CT dataset, two sets of beam’s eye view portals can be generated. Only one set of dose-volume histograms is necessary for documentation in this case, the dose-volume histograms representing the cumulative dose distributions from the two plans. Therefore, only one 77295 charge is appropriate.

In those uncommon circumstances where there is a substantial change in either patient anatomy or tumor conformation where a second CT dataset is required to produce an accurate, efficacious and safe “cone-down” plan, a second 77295 charge may be appropriate. When the physician deems this to be the case, the medical necessity for the second 77295 simulation must be documented.

Procedure code 77295 precludes the use of teletherapy isodose plan (77305-77315) for the same volume. CPT code 77295 is not appropriately reported for two-dimensional or multiple two-dimensional beam’s eye view plans without three-dimensional, computer-generated reconstruction. Dose volume histogram is part of 77295 and is not to be billed separately. Simulation procedures (77280-77290) may be performed if medically necessary to prepare the patient for treatment planning and to ensure accurate treatment delivery. The professional components of 76375 (3-D reconstruction) and 76370 (computerized axial tomographic guidance for placement of radiation therapy fields) are included in CPT code 77295. The technical component of 76370 may be charged by the provider of the technical service, which may be the radiation oncologist in the freestanding setting. To bill the professional component of the CT codes, a complete diagnostic interpretation is required.

77280: Therapeutic Radiology Simulation-Aided Field Setting (continued)

**Documentation Requirements**

Documentation of simulation requires a written record of the procedure, hard copy or electronically archived images, and evidence of image review by the physician, including signature or initials and date of review. Electron ports or clinical simulations may also be documented photographically.

For procedure code 77295, documentation requires a computer-generated graphic, permanent record including the following elements:

- three-dimensional tumor volume;
- appropriate critical normal structures; and
- a reconstruction and three-dimensional representation of dose distribution in the form of dose clouds and/or dose volume histograms of the volume of interest and appropriate critical structures with evidence of review by the physician designated by signature or initials and date.

**Utilization Guidelines**

The typical course of radiation therapy will consist of between one and three simulations. However, no more than one simulation should be reported per day. Frequency in excess of three simulations may require supporting documentation.

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**

American Society for Therapeutic Radiology and Oncology (ASTRO) and the American College of Radiology (ACR). 2001. *Radiation oncology coding user's guide*. ASTRO/ACR Joint Economics Committee. Provides the indications and limitations of coverage, as well as the coding guidelines.

**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 include representatives from numerous societies.

**Start Date of Comment Period**

05/10/2002

**End Date of Comment Period**

06/24/2002

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number:	3
Start Date of Comment Period:	05/10/2002
Start Date of Notice Period:	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Revised Effective Date	09/23/2002
Explanation of Revision:	Complete deletion of old policy and revised to provide further clarification regarding the indications and limitations of coverage, as well as appropriate coding guidelines, for these services.
Revision Number:	2
Start Date of Comment Period:	N/A
Start Date of Notice Period:	02/25/2000
	February 25, 2000
	<i>Bulletin</i>
Revised Effective Date	08/01/2000
Explanation of Revision:	Outpatient PPS implementation.
Revision Number:	1
Start Date of Comment Period:	N/A
Start Date of Notice Period:	12/1997
Revised Effective Date	01/01/1998
Explanation of Revision:	1998 HCPCS
Revision Number:	Original
Start Date of Comment Period:	N/A
Start Date of Notice Period:	01/22/1997
Original Effective Date	02/24/1997 ❖



## 77300: Basic Radiation Dosimetry Calculation

*Revision Overview: The following sections of the policy have been revised to provide further clarification regarding basic radiation dosimetry: “LMRP Description,” “Indications and Limitations of Coverage and/or Medical Necessity,” “Coding Guidelines” and “Utilization Guidelines.”*

### Policy Number

77300

### Contractor Name

First Coast Service Options, Inc.

### Contractor Number

090

### Contractor Type

Intermediary

### LMRP Title

Basic Radiation Dosimetry Calculation

### AMA CPT Copyright Statement

CPT codes, descriptions, and other data only are copyright 2001 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply.

### CMS National Coverage Policy

N/A

### Primary Geographic Jurisdiction

Florida

### Secondary Geographic Jurisdiction

N/A

### CMS Region

Region IV

### CMS Consortium

Southern

### Original Policy Effective Date

02/24/1997

### Original Policy Ending Date

N/A

### Revision Effective Date

09/23/2002

### Revision Ending Date

09/22/2002

### LMRP Description

Basic radiation dosimetry calculation (CPT code 77300) is a mathematical computation of the amount of radiation being received at a tumor site or other independent calculations and is only performed when requested by the radiation oncologist. This is performed either by the radiation oncologist, a qualified medical radiological physicist, a qualified medical treatment planning dosimetrist, or a qualified radiation therapy technologist under the technical supervision of the radiation oncologist.

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

Florida Medicare will consider basic radiation dosimetry calculation to be medically necessary for each treatment field (area), for off-axis dose calculations, or because of a change in one of the initial calculation

parameters (e.g., port size or shape, depth dose, blocking factor, tumor dose). Recalculation of previously determined dose points by the same methodology does not justify additional dosimetry charges

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

The typical course of radiation therapy will consist of one to six dosimetry calculations, depending on the complexity of the case. Radiation treatments to the head/neck, prostate, or for Hodgkin’s disease may require eight or more calculations.

### CPT/HCPCS Section & Benefit Category

Radiology/Radiation Oncology

### Type of Bill Code

Hospital – 12x, 13x  
Critical Access Hospital – 85x

### Revenue Code

333 Radiation Therapy

### CPT/HCPCS Codes

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

### Not Otherwise Classified Codes (NOC)

N/A

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

N/A

### Diagnoses that Support Medical Necessity

N/A

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

N/A

### Diagnoses that DO NOT Support Medical Necessity

N/A

### Reasons for Denials

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

### Noncovered ICD-9-CM Codes

N/A

### Noncovered Diagnosis

N/A

77300: Basic Radiation Dosimetry Calculation (continued)

**Coding Guidelines**

The calculation of different projections for the same site are considered to be included as one calculation if all treatment parameters other than beam angle are the same. For example, in a four-port box treatment of the pelvis, the anterior and posterior opposed ports and the right and left lateral opposed ports are treated. If the anterior and posterior ports are identical in size, shape and depth, they are considered to be one calculation. The same holds true for the lateral ports. If two entirely separate sets of calculations are performed in AP or lateral opposed fields because of irregular fields that require variable blocking, weighting or depth, two separate calculations should be reported.

Both external beam and brachytherapy require specific calculations to be made before or during the course of therapy. For external beam, code 77300 is used to report dosimetry calculations. However, multiple points of calculation within an isodose plan should not be reported independently or individually. For brachytherapy, code 77300 may be reported when an independent calculation is performed exclusive of the isodose plan.

**Documentation Requirements**

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

- identification of all body area(s) being treated and requiring dosimetry calculations;
- an explanation of the need for additional calculations;
- the calculation of the radiation dose distribution (i.e., the radiation dosage and length of time to deliver the dose) either by hand calculation or computer; and
- evidence that the calculations were reviewed, signed, and dated by a physician.

**Utilization Guidelines**

The typical course of radiation therapy will consist of one to six dosimetry calculations, depending on the complexity of the case. Radiation treatments to the head/neck, prostate, or for Hodgkin's disease may require eight or more calculations.

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**

American Society for Therapeutic Radiology and Oncology (ASTRO) and the American College of Radiology (ACR). 2001. *Radiation oncology coding user's guide*. ASTRO/ACR Joint Economics Committee. Provides the coding guidelines.

**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 include representatives from numerous societies.

**Start Date of Comment Period**

05/10/2002

**End Date of Comment Period**

06/24/2002

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number: 4  
 Start Date of Comment Period 05/10/2002  
 Start Date of Notice Period 08/01/2002  
 4<sup>th</sup> Qtr 2002 *Bulletin*  
 Revised Effective Date: 09/23/2002  
 Explanation of Revision: To provide further clarification regarding appropriate coding for basic radiation dosimetry calculations.

Revision Number: 3  
 Start Date of Comment Period N/A  
 Start Date of Notice Period 02/01/2002  
 2<sup>nd</sup> Qtr 2002 *Bulletin*  
 Revised Effective Date: 03/29/2002  
 Explanation of Revision: Type of Bill code 71x was deleted and Type of Bill code 85x was added.

Revision Number: 2  
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**77301: Intensity Modulated Radiation Therapy (IMRT)****Policy Number**

77301

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Intensity Modulated Radiation Therapy (IMRT)

**AMA CPT Copyright Statement**

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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**

09/23/2002

**Original Policy Ending Date**

N/A

**Revision Effective Date**

N/A

**Revision Ending Date**

N/A

**LMRP Description**

Intensity Modulated Radiation Therapy (IMRT) is a new technology; a computer-based method of planning for, and delivery of patient specific, spatially modulated beams of radiation to solid tumors within a patient. IMRT planning and delivery uses a new approach for obtaining the highly conformal dose distributions needed to irradiate complex targets positioned near, or invaginated by, sensitive normal tissues, thus improving the therapeutic ratios. IMRT delivers a more precise radiation dose to the tumor while sparing the surrounding normal tissues by using non-uniform radiation beam intensities determined by various computer-based optimization techniques.

The computer based optimization process is referred to as 'inverse planning.' Inverse planning develops a dose distribution based on the input of specific dose constraints for the planned treatment volume (PTV) and nearby clinical structures, and is the beginning of the IMRT treatment planning process. The gross tumor volume (GTV), the PTV and surrounding normal tissues must be identified by a

contouring procedure, and the optimization must sample the dose with a grid spacing of one centimeter or less.

IMRT uses non-uniform and customized fluence distributions in treatment delivery. Delivery of IMRT requires use of a multi-leaf collimator (MLC) with leaves that project to a nominal 1cm or less at the treatment unit isocenter. The MLC may be in a dynamic (DMLC) or segmented mode (SMLC) to create the three-dimensional, intensity-modulated dose distribution. Since other delivery techniques are available and new ones may be developed, the exact delivery method is not restricted as long as the particular technique chosen has the ability to model the highly modulated intensity patterns that result from the planning process described above. However, use of simple one-dimensional ramp intensity distributions is excluded, because the inverse planning process is not expected to produce these intensity patterns. IMRT delivery imposes a more stringent requirement than conventional radiation therapy in terms of accounting for patient position and organ motion. Methods that account for organ motion include but are not limited to: 1) use of published studies on organ movement when developing the PTV, 2) image guided adaptive radiotherapy (e.g., ultrasound guided or portal image guided setup with implanted fiducial markers), and 3) respiratory gating of diaphragm movement for thoracic and upper abdominal sites.

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

The decision process for using IMRT requires an understanding of accepted practices that take into account the risks and benefits of such therapy compared to conventional treatment techniques. While IMRT technology may empirically offer advances over conventional or three-dimensional conformal radiation, a comprehensive understanding of all consequences is required before applying this technology.

IMRT is not a replacement therapy for conventional radiation therapy methods. Florida Medicare will consider IMRT reasonable and necessary in instances where sparing the surrounding normal tissue is essential and the patient has at least one of the following conditions:

1. Important dose limiting structures adjacent to but outside the PTV are sufficiently close and require IMRT to assure for safety and morbidity reduction.
2. An immediately adjacent volume has been irradiated and abutting portals must be established with high precision.
3. GTV margins are concave or convex and in close proximity to critical structures that must be protected to avoid unacceptable morbidity.
4. Only IMRT techniques would decrease the probability of grade 2 or grade 3 radiation toxicity, as compared to conventional radiation in greater than 15 percent of radiated similar cases.

IMRT is indicated for primary brain tumors, brain metastasis, prostate cancer, lung cancer (with special provision for organ motion), pancreas cancer and other upper abdominal sites (with special provision for organ

**77301: Intensity Modulated Radiation Therapy (IMRT) (continued)**

motion), spinal cord tumors, head and neck cancer, adrenal tumors, pituitary tumors and situations in which extremely high precision is required.

**CPT/HCPCS Section & Benefit Category**

Radiology/Radiation Oncology

**Type of Bill Code**

Hospital – 12x, 13x

Critical Access Hospital – 85x

**Revenue Codes**

333 Radiation Therapy

**CPT/HCPCS Codes**

- 77301 Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
- 77418 Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams (e.g., binary, dynamic MLC), per treatment session

**Not Otherwise Classified Codes (NOC)**

N/A

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

- 142.0-142.9 Malignant neoplasm of major salivary glands
- 144.0-144.9 Malignant neoplasm of floor of mouth
- 145.0-145.9 Malignant neoplasm of other and unspecified parts of mouth
- 146.0-146.9 Malignant neoplasm of oropharynx
- 147.0-147.9 Malignant neoplasm of nasopharynx
- 148.0-148.9 Malignant neoplasm hypopharynx
- 149.0-149.9 Malignant neoplasm of other and ill defined sites with in the lip, oral cavity, and pharynx
- 150.0-150.9 Malignant neoplasm of esophagus
- 153.0-153.9 Malignant neoplasm of colon
- 154.0-154.8 Malignant neoplasm of rectum, rectosigmoid junction, and anus
- 155.0-155.2 Malignant neoplasm of liver and intrahepatic bile ducts
- 156.0-156.9 Malignant neoplasm of gallbladder and extrahepatic bile ducts
- 157.0-157.9 Malignant neoplasm of pancreas
- 158.0-158.9 Malignant neoplasm of retroperitoneum and peritoneum
- 160.0-160.9 Malignant neoplasm of nasal cavities, middle ear, and accessory sinuses
- 162.0-162.9 Malignant neoplasm of trachea, bronchus, and lung
- 163.0-163.9 Malignant neoplasm of pleura
- 164.0-164.9 Malignant neoplasm of thymus, heart, and mediastinum
- 171.0-171.9 Malignant neoplasm of connective tissue and other soft tissue
- 174.0-174.8 Malignant neoplasm of female breast
- 175.0-175.9 Malignant neoplasm of male breast
- 185 Malignant neoplasm of prostate
- 190.0-190.9 Malignant neoplasm of eye
- 191.0-191.9 Malignant neoplasm of brain

- 192.0-192.9 Malignant neoplasm of other and unspecified parts of nervous system
- 193 Malignant neoplasm of thyroid gland
- 194.0 Malignant neoplasm of adrenal gland
- 194.1 Malignant neoplasm of parathyroid gland
- 195.0-195.8 Malignant neoplasm of other and ill defined sites
- 198.3 Secondary malignant neoplasm of other and specified sites, brain and spinal cord
- 225.1 Benign neoplasm of cranial nerves
- 225.2 Benign neoplasm of cerebral meninges
- 227.3 Benign neoplasm of pituitary gland and craniopharyngeal duct (pouch)
- 227.4 Benign neoplasm of pineal gland
- 227.6 Benign neoplasm of aortic body and other paraganglia
- 747.81 Anomalies of cerebrovascular system (congenital)

**Diagnoses that Support Medical Necessity**

N/A

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

N/A

**Diagnoses that DO NOT Support Medical Necessity**

N/A

**Reasons for Denials**

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

**Noncovered ICD-9-CM Codes**

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

**Noncovered Diagnosis**

N/A

**Coding Guidelines**

N/A

**Documentation Requirements**

Medical record documentation maintained by the provider must indicate the medical necessity for IMRT, and include all of the following:

1. The prescription must define the goals and requirements of the treatment plan, including the specific dose constraints for the target(s) and nearby critical structures.
2. A statement by the treating physician documenting the special need for performing IMRT on the patient in question, rather than performing conventional or three-dimensional treatment planning and delivery.
3. Signed IMRT inverse plan that meets prescribed dose constraints for the PTV and surrounding normal tissue using a treatment delivery technique to produce the various intensity maps required.



**77301: Intensity Modulated Radiation Therapy (IMRT) (continued)**

4. The target verification methodology must include the following:
  - a. Documentation of the CTV and the PTV.
  - b. Documentation of immobilization and patient positioning.
  - c. Means of dose verification and secondary means of verification.
5. The monitor units (MUs) generated by the IMRT treatment plan must be independently checked before the patient's first treatment.
6. Documentation of fluence distributions re-computed in a phantom is required.
7. Documentation is required to account for structures moving in and out of high and low dose regions created by respiration. Voluntary breath holding *is not* considered appropriate and the solution for movement can best be accomplished with gating technology.

**Utilization Guidelines**

N/A

**Other Comments**

N/A

**Sources of Information and Basis for Decision**

American College of Radiology, American Society for Therapeutic Radiology and Oncology (2001). *Model Policy on Intensity Modulated Radiation Therapy*. Fairfax, VA. Author. This source supports the appropriate indication for use.

DeVita, V., Hellman, S., & Rosenberg, S. (Ed.). (1999). *Cancer, Principles & Practice of Oncology*. (5th ed., Vol. 2). Philadelphia: Lippincott-Raven. This source provides a description of services and provides indications for the appropriate use.

Fraass, B.A., Kessler, M.L., McShan, D.L., Marsh, L.H., Watson, B.A., Dusseau, W.J. Eisbruch, A., Candler, H.M., Lichter, A.S. (1999). Optimization and clinical use of multisegment intensity-modulated radiation therapy for high-dose conformal therapy. *Seminars Radiation Oncology*, 9(1), 60-67. This source supports the appropriate indication for use.

Intensity-Modulated Radiotherapy Collaborative Working Group. (2001). Intensity-modulated radiotherapy: current status and issues of interest. *International Journal of Radiation Oncology, Biology, Physics*, 54(4), 880-914. This source supports the appropriate indication for use.

Kuppersmith, R.B., Greco, S.C., The, B.S., et al. (1999). Intensity modulated radiotherapy: first results with this new technology on neoplasms of the head and neck. *Ear Nose Throat Journal*, 78(4), 238-248. This source provides a description of services and provides indications for the appropriate use.

Nutting, C.M., Convery, D.J., Cosgrove, V.P., et al. (2000). Reduction of small and large bowel irradiation using an optimized intensity modulated pelvic radiotherapy technique in-patients with prostate cancer. *International Journal of Radiation Oncology, Biology, Physics*, 48 (3), 649-656. This source supports the appropriate indication for use.

Pirzkall, A., Carol, M., Lohr, F., et al. (2000). Comparison of intensity modulated radiotherapy with conventional conformal radiotherapy for complex-shaped tumors. *International Journal of Radiation Oncology, Biology, Physics*, 48(5), 1371-1380. This source supports the appropriate indication for use.

Shu, H.G., Lee, T, Vigneault, E., et al. (2001). Toxicity following high-dose 3-dimensional and intensity-modulated radiation therapy for clinically localized prostate cancer. *Urology*, 57(1), 102-107. This source provides a description of services and provides indications for the appropriate use.

Teh, B.S., Woo, S.Y., & Butler, E. B. (1999). Intensity modulated radiation therapy (IMRT): a new promising technology in radiation oncology. *Oncologist*, 4(6), 433-442. This source provides a description of services.

Leibel, S. & Phillips, T. (Ed.). (1998). *Textbook of Radiation Oncology*. (1st ed). St. Louis: Saunders. This source provides a description of services and provides indications for the appropriate use.

Xia, P., Fu, K., Wong, G., et al. (2000). Comparison of treatment plans involving intensity modulated radiotherapy for nasopharyngeal carcinoma. *International Journal of Radiation Oncology, Biology, Physics*, 48 (2), 329-337. This source supports the appropriate indication for use.

Zeleftsky, M. J., Fuks, Z., et al (2000). Clinical experiences with intensity modulated radiation therapy (IMRT) in prostate cancer. *Radiotherapy Oncology*, 55(3), 241-249. This source supports the appropriate indication for use.

**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 include representatives from oncologist and radiology societies.

**Start Date of Comment Period**

05/10/2002

**End Date of Comment Period**

06/24/2002

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number:	Original
Start Date of Comment Period:	05/10/2002
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	4 <sup>th</sup> Qtr 2002 Bulletin
Original Effective Date	09/23/2002 ❖

## 77332: Treatment Devices, Design, and Construction

*Revision Overview: The complete policy has been revised to provide further clarification regarding the indications and limitations of coverage, as well as appropriate coding guideline for these services. The previous published policy must be discarded.*

**Policy Number**

77332

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Treatment Devices, Design, and Construction

**AMA CPT Copyright Statement**

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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**

02/24/1997

**Original Policy Ending Date**

N/A

**Revision Effective Date**

09/23/2002

**Revision Ending Date**

09/22/2002

**LMRP Description**

Many different types of treatment devices are used in the successful delivery of radiation oncology treatments. Examples include: beam-shaping devices, custom-fabricated patient-immobilization devices, beam-modification devices, and equipment used to shield critical structures. Their use is determined by the clinical judgment of the radiation oncologist, based on patient anatomy and disease state. They are fabricated as the direct result of physician work and supervision. During the course of fractionated radiation therapy, the accuracy of their use is the direct responsibility of the treating physician.

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

Florida Medicare will consider treatment devices, design and construction to be medically reasonable and necessary for patients with a documented diagnosis of a neoplasm, who require custom-designed and fabricated devices during the course of radiation therapy. Multiple

treatment devices may be charged during a course of therapy if documentation substantiates multiple treatment fields, the use of custom-made devices, and/or the necessity of replacement devices.

Treatment devices, designs and construction are broken down into the following three levels of complexity: simple, intermediate and complex.

**77332 Treatment devices, design and construction; simple (simple block, simple bolus)**

**Simple Block**

Treatment blocks made in the form of squares, rectangles, circles and other, irregular, multi-use shapes that are placed by hand on the blocking tray each day at the time of the patient's setup constitute simple blocks. The physician selects the shape and designs the placement of these blocks with the intent to protect certain areas of a radiation port during treatment. No special fabrication is necessary for these blocks.

**Simple Bolus**

The use of bolus material to modify the radiation beam as it transitions from air to tissue constitutes a simple treatment device. These pre-made, reusable articles are typically used with other treatment devices. Bolus material is billable only in the situation where it is used as the only treatment device for a particular radiation port, i.e., no other, more complex treatment devices are being used. When more complex treatment devices are used, the bolus charge becomes subordinate to the more complex charge, with no charge being submitted for the bolus material.

**Passive, Multi-Use Devices**

Passive restraints, pillows, straps, sandbags, amorphous devices and other minor devices are widely used in radiation oncology. Their reimbursement is blended into treatment delivery and they are not billable as separate treatment devices.

**77333 Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)**

**Blocks**

A pre-cast or pre-made standard-shaped block used from patient to patient, where there is no particular custom fabrication to the patient's individual anatomy, constitutes an intermediate device.

**Stents**

A pre-fabricated stent used to modify a patient's anatomy for the proper delivery of a radiation dose is billed as an intermediate treatment device.

**Bite Blocks**

A custom-fabricated bite block for manipulation of the oral cavity and oropharyngeal anatomy is billed as an intermediate treatment device.

**Special Bolus**

Custom fabrication of bolus material to compensate for tissue defects is billed as an intermediate treatment device.

77332: *Treatment Devices, Design, and Construction (continued)*

**77334 Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts) Irregular Blocks**

A custom-fabricated cast block designed specifically for one patient constitutes a complex treatment device. These devices require direct input from the physician for design, selection, placement and daily reproduction.

**Immobilization Devices**

Treatment devices may be used for patient immobilization to accurately reproduce the anatomic isocenter on a daily basis. These include any of the thermal plastic devices, solidifying polymers or vacuum devices. These devices are fabricated under the supervision of a physician and are specifically designed for an individual patient's treatment course.

**Wedges**

Wedges, or treatment devices that shape the profile of a treatment beam to compensate for an angular plane of entry, are mechanical devices usually affixed to the machine head, and are considered complex treatment devices. They are billable in this fashion only when used alone. In the more common circumstance, when they are used in conjunction with other complex treatment devices on the same port, only a single complex treatment device may be billed. An exception to this rule is when the wedge has been specifically fabricated for a particular patient's situation.

**Compensators**

Custom-fabricated compensators designed to eliminate dose inhomogeneities secondary to irregular surface contours are billed as complex treatment devices. When custom designed for a particular port, it may be billed individually and in addition to other complex treatment devices that may be used.

**Eye Shields**

Eye shields are multiple-use devices whose application is highly complex and precise. They are used under initial direct supervision of the radiation oncologist and are clinically placed for each treatment. When used, they are billed as complex treatment devices.

The purpose of the device(s), the risks involved by its use or non-use, and the complexity of its design determine the complexity level. The choice to custom-make a device for a given patient is justified only for clinical necessity and should be documented for patients treated with palliative intent. The code for complex devices (77334) is reserved for those cases in which a highly complex irregular port is designed for the protection of sensitive vital tissues. In addition, a complex device is unique to that particular patient and port. Examples of complex devices are a mantle port block or those for head and neck treatments with multiple areas protected. Pre-made, multiple-patient use, generic cast blocks (e.g., beam-splitter block, two- or four-corner pelvis blocks, midline spinal cord blocks) do not constitute custom blocks.

The typical course of radiation therapy may consist of up to five professional charges for devices. Prostate and head/neck treatments may require eight devices. Frequency in excess of these values may require supporting documentation.

Products used for patient comfort (e.g., pillows, pads, cushions) should not be charged as treatment devices.

**CPT/HCPCS Section & Benefit Category**

Radiology/Radiation Oncology

**Type of Bill Code**

Hospital – 12x, 13x  
Critical Access Hospital – 85x

**Revenue Codes**

333 Radiation Therapy

**CPT/HCPCS Codes**

- 77332 *Treatment devices, design and construction; simple (simple block, simple bolus)*
- 77333 *intermediate (multiple blocks, stents, bite blocks, special bolus)*
- 77334 *complex (irregular blocks, special shields, compensators, wedges, molds or casts)*

**Not Otherwise Classified Codes (NOC)**

N/A

**Diagnoses that Support Medical Necessity**

N/A

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

N/A

**Diagnoses that DO NOT Support Medical Necessity**

N/A

**Reasons for Denials**

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

**Noncovered ICD-9-CM Codes**

N/A

**Noncovered Diagnosis**

N/A

**Coding Guidelines**

If the blocks can be designed from the same simulation image and are identical in shape except opposed in location (mirror images), this should be regarded as a single design of a set of blocks. Such an example is the design of AP and PA blocks for parallel opposed beams in which the patient does not move and the gantry of the treatment unit is rotated 180 degrees to the opposed port. For these blocks, a single charge is made for their design and professional supervision. A separate technical charge is made for the fabrication of each individual device. An example of this charging structure is a treatment plan involving a four-field box to the pelvis. In this example, one professional charge is made for the AP and PA blocks and another for the right and left lateral blocks, but four technical treatment device charges should be made for the fabrication of each of the AP, PA, right lateral, and left lateral blocks.

Minor port changes should not necessitate additional device charges. However, significant changes in the shape of the port(s), beam direction or size (i.e., boosts) may require additional device charges. Modern linear accelerators with multi-leaf collimation can create shielding that is equivalent to a complex fabricated block. Independent jaw

77332: Treatment Devices, Design, and Construction (continued)

motion to a single static position or pre-programmed motions of the jaw to simulate half-beam blocks are coded as simple treatment devices. Use of an independent jaw (as in dynamic wedge) or multi-leaf collimator to substitute for a complex treatment device is coded as a complex device (77334).

The same principles for determining the level of complexity apply to the design of a wedge, compensator or bolus. The professional reimbursement applies to the work associated with the supervision of the design and construction for all of the devices utilized to modify photon fluence for each portal or symmetrical pair of portals. If a patient has some combination of a wedge, compensator, bolus or port block covering the same treatment portal, this should be reported as a single complex treatment device rather than a separate charge for each item. If beam-modification devices of two separate levels of complexity are utilized for the same treatment port, only the one of highest complexity will be billable. However, a technical charge may be assessed for the construction of each device, at the appropriate level of complexity. Only in the most unique situation are separate charges made (e.g., two or more devices that were unique and specially designed for an individual port).

Restraining and custom positioning devices (e.g., thermo-plastic face and body masks, Styrofoam body casts, bite-block head holders) and beam-modification devices may be billed separately for the same volume of interest, but the professional reimbursement for only one restraining device may be billed for each volume of interest treated. That is to say, positioning and restraining devices may be charged separately from beam-modifying devices.

It is the physician's responsibility to ensure that the codes reported correspond to the level of professional activity provided. Documentation of physician participation in this aspect of the process of care is signified by the physician's signature and date in simulation images and port images.

Multiple services are allowed on the same day with appropriate documentation. Medically necessary changes in the beam geometry or port configuration periodically during a course of treatment may require the redesign and fabrication of new treatment devices. An individual treatment device is reported and charged only one time for the entire course of treatment, regardless of the number of times the device is actually used.

Devices will be billed at the beginning of the treatment course and then may be repeated later in the course of treatment when additional or new devices are required due to a reduction of the treatment field. This reduction in treatment field is a result of a reduction of the target volume. In all levels of complexity, the physician must be directly involved in the design, selection, and initial placement of any of the devices.

**Documentation Requirements**

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

- a signed and dated physician order for each different kind of custom device;

- physician's documentation of his/her input in terms of selection, design, and initial position/placement of these devices;
- specific notation indicating each custom-designed device for a particular application; and
- an explanation for the need for additional or revised devices during the course of therapy (i.e., specific treatment field modification, etc.).

**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.

The typical course of radiation therapy may consist of up to five professional charges for devices. Prostate and head/neck treatments may require eight devices. Frequency in excess of these values may require supporting documentation.

**Other Comments**

Please note that the plural use of the word "devices" in the CPT definitions in no way implies any substantive meaning regarding reimbursement policy, but instead designates that there are many types of devices at each complexity level. It is erroneous to suggest that the plural "devices" implies that multiple devices can be charged once per treatment course.

**Sources of Information and Basis for Decision**

American Society for Therapeutic Radiology and Oncology (ASTRO) and the American College of Radiology (ACR). 2001. *Radiation oncology coding user's guide*. ASTRO/ACR Joint Economics Committee. Provides the indications and limitations of coverage, as well as the coding guidelines.

**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 include representatives from numerous societies.

**Start Date of Comment Period**

05/10/2002

**End Date of Comment Period**

06/24/2002

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number:	2
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Start Date of Notice Period:	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Revised Effective Date	09/23/2002
Explanation of Revision:	To provide further clarification regarding the indications and limitations of coverage, as well as appropriate coding guidelines, for these services. ❖



**77336: Radiation Physics Consultation**

*Revision Overview: The complete policy has been revised to provide further clarification regarding the indications and limitations of coverage, as well as appropriate coding guideline for these services. The previous published policy must be discarded.*

**Policy Number**

77336

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Radiation Physics Consultation

**AMA CPT Copyright Statement**

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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**

09/15/2000

**Original Policy Ending Date**

N/A

**Revision Effective Date**

09/23/2002

**Revision Ending Date**

09/22/2002

**LMRP Description**

Under Medicare regulation, medical radiation physics services consist of specific tests, measurements, calculations and fabrication of materials that are deemed necessary by the radiation oncologist, and ultimately selected and used by the radiation oncologist for the benefit of a patient undergoing radiation therapy. Often, these procedures are necessary for the development and implementation of a final treatment plan. Some procedures may be necessary only to verify or validate that the treatment plan is correct, or the ongoing treatment is being correctly applied. Under all circumstances, the physician is responsible for ordering the patient related physics services and ultimately placing them into clinical use.

**Indications and Limitations of Coverage and/or Medical Necessity****Procedure Code 77336**

Continuing medical physics consultation includes documented weekly checking of the patient's treatment chart by, or under the supervision of, a qualified medical physicist to assure that the treatment administered conforms to that prescribed by the radiation oncologist. It includes verification of accurate dose calculations,

accurate data entry in the patient's chart, proper patient positioning and beam orientation, patient radiation safety, and correct summation of dose at the conclusion of treatment. Examination of the patient setup may be required to assure the correct placement of wedges or other beam modifiers.

The service also includes initial acceptance testing and commissioning and ongoing review of the performance of treatment equipment such as simulators (computed tomography and conventional simulators), linear accelerators, brachytherapy sources and devices, treatment device manufacturing equipment, and treatment planning computers. These tasks, performed by the qualified medical physicist, are essential in ensuring that the physician's prescription is being followed accurately throughout the course of radiation therapy. Documentation of physics services performed is essential. Documentation of calibration and maintenance of radiation therapy equipment is routinely kept within the radiation oncology department, and is not part of the treatment chart. These services are not considered special physics consultations, and are not to be billed as such.

**Procedure Code 77370**

The special medical radiation physics consultation code is used when the radiation oncologist makes a direct request to the qualified medical physicist for a special consultative report or for specific physics services on an individual patient. Such a request may be made when the complexity of the treatment plan is of such magnitude that a thorough written analysis is necessary to address a specific problem or when the service to be performed requires the expertise of a qualified medical physicist. The clinical indication that justifies the request for the special physics consultation should also be documented.

Examples of problems that might justify use of this code include:

- the complex interrelationships of electron and photon ports, intensity modulated radiation therapy and complex dosimetric considerations in brachytherapy, including high dose rate remote afterloader applications, and interstitial radioactive seed implantation;
- analysis of customized beam modification devices and special blocking procedures (and their dosimetric evaluation) to protect critical organs during treatment; or
- analysis of the effects of previous radiation therapy with assessment of cumulative radiation dose to critical organs.

Computation of dose to the fetus of a pregnant patient undergoing radiation therapy may be reported using this code. Special brachytherapy equipment developed by the qualified medical physicist to treat a particular patient can also be reported with this code. The qualified medical physicist will spend a considerable amount of time and effort on behalf of a specific patient and will render a customized written report (which will form part of the patient's chart) to the radiation oncologist in reference to the problem or service being addressed. Documentation of

**77336: Radiation Physics Consultation (continued)**

the physician's request and the physics consultations should not be charged when a qualified medical physicist verifies the calculations performed by others or performs the duties of other members of the treatment team (e.g., dosimetrists).

A special medical radiation physics consult (code 77370) is generally required once per course of radiation therapy. However, additional medical physics work in support of a specific patient's treatment (e.g., total body irradiation, etc.) may require additional medical physics consultation. Frequency in excess of this value may require supporting documentation.

**CPT/HCPCS Section & Benefit Category**

Radiology/Radiation Oncology

**Type of Bill Code**

Hospital – 12x, 13x

Critical Access Hospital – 85x

**Revenue Codes**

333 Radiation Therapy

**CPT/HCPCS Codes**

- 77336 *Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy*
- 77370 *Special medical radiation physics consultation*

**Not Otherwise Classified Codes (NOC)**

N/A

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

N/A

**Diagnoses that Support Medical Necessity**

N/A

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

N/A

**Diagnoses that DO NOT Support Medical Necessity**

N/A

**Reasons for Denials**

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

**Noncovered ICD-9-CM Codes**

N/A

**Noncovered Diagnosis**

N/A

**Coding Guidelines**

Continuing medical physics consultation (code 77336) is used to describe the ongoing medical physics assessment provided to all patients receiving radiation therapy. CPT code 77336 is a "weekly code" and is reported once for each week of external beam radiation treatments in which at least three fractions have been given, or once for each five treatments, in the event that more than one treatment is given per day. For radiation therapy treatment that is not administered in five weekly fractions (such as brachytherapy or stereotactic radiosurgery) or for a course

of radiation therapy consisting of one or two fractions, code 77336 may be reported.

77336 *Continuing medical physics consultation* and 77370 *Special medical radiation physics consultation* are distinct, separately identifiable procedures. A special medical radiation physics consult (code 77370) is generally required once per course of radiation therapy. However, additional medical physics work in support of a specific patient's treatment (e.g., total body irradiation, etc.) may require additional medical physics consultation.

**Documentation Requirements**

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

The request for a consultation from the attending physician or other appropriate source and the need for consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated in writing to the requesting physician or other appropriate source.

**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**

American Society for Therapeutic Radiology and Oncology (ASTRO) and the American College of Radiology (ACR). 2001. *Radiation oncology coding user's guide*. ASTRO/ACR Joint Economics Committee. Provides the indications and limitations of coverage, as well as the coding guidelines.

**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 include representatives from numerous societies.

**Start Date of Comment Period**

05/10/2002

**End Date of Comment Period**

06/24/2002

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number:	1
Start Date of Comment Period:	05/10/2002
Start Date of Notice Period:	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Revised Effective Date	09/23/2002
Explanation of Revision:	To provide further clarification regarding the indications and limitations of coverage, as well as appropriate coding guidelines, for these services. ❖

## 82607: Vitamin B-12 (Cyanocobalamin) Assay

*Revision Overview: The following sections of the policy have been revised to include frequency guidelines regarding vitamin B-12 assays: "Indications and Limitations of Coverage and/or Medical Necessity," "Type of Bill Code," and "Utilization Guidelines."*

### Policy Number

82607

### Contractor Name

First Coast Service Options, Inc.

### Contractor Number

090

### Contractor Type

Intermediary

### LMRP Title

Vitamin B-12 (Cyanocobalamin) Assay

### AMA CPT Copyright Statement

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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

03/15/2000

### Original Policy Ending Date

N/A

### Revision Effective Date

09/23/2002

### Revision Ending Date

09/22/2002

### LMRP Description

Vitamin B-12 (Cyanocobalamin), is a water soluble hematopoietic vitamin found in foods of animal origin. It is necessary for the metabolism of protein, fats and carbohydrates. It is essential for normal blood formation and normal neural function. Causes of vitamin B-12 deficiency usually include the absence of intrinsic factor, which is vital for the absorption of vitamin B-12 by the gastrointestinal tract. Since vitamin B-12 is present in all foods of animal origin, dietary B-12 deficiency is rare. It is usually only seen in Vegans (strict vegetarians). Deficiency of vitamin B-12 leads to macrocytic anemia. The normal adult daily intake of vitamin B-12 is between 2.0 ug and 5.0 ug.

The serum vitamin B-12 assay is intended to measure the serum vitamin B-12 level. The measurement is used to diagnose anemia due to gastrointestinal malabsorption and

inadequate dietary intake of vitamin B-12. The normal adult vitamin B-12 levels are between 150 pg/mL and 350 pg/mL.

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

Florida Medicare will consider a vitamin B-12 assay level medically necessary for the following indications:

- To initially evaluate a patient presenting with signs and symptoms suggestive of vitamin B-12 deficiency. These patients could present with a megaloblastic anemia determined by other lab indices, peripheral neuropathy, and/or altered cerebral functioning such as dementia.
- To evaluate a patient with a previously identified gastrointestinal disease such as malabsorption syndromes, sprue or a patient that has undergone gastric or ileal surgery and a vitamin B-12 deficiency is suspected.

Other than the initial vitamin B-12 assay, which is used to diagnose vitamin B-12 deficiency, it is not expected that the test would need to be repeated.

**Note: Sequential vitamin B-12 testing is not necessary for the purpose of monitoring the effectiveness of vitamin B-12 therapy. Since vitamin B-12 is administered as a treatment for anemia, the tests that are usually ordered for monitoring are the complete blood count (CBC), the hematocrit (HCT) and the hemoglobin (HGB).**

### CPT/HCPCS Section & Benefit Category

Pathology and Laboratory/Chemistry

### Type of Bill Code

Hospital – 12x, 13x, 14x  
 Skilled Nursing Facility – 21x, 22x, 23x  
 End Stage Renal Disease – 72x  
 Critical Access Hospital – 85x

### Revenue Code

301 Chemistry

### CPT/HCPCS Codes

82607 *Cyanocobalamin (Vitamin B-12);*  
 82608 *unsaturated binding capacity*

### Not Otherwise Classified Codes (NOC)

N/A

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

266.2	Other B-complex deficiencies
281.0	Pernicious anemia
281.1	Other vitamin B-12 deficiency anemia
281.3	Other specified megaloblastic anemias not elsewhere classified
285.8	Other specified anemias
285.9	Anemia, unspecified
294.8	Other specified organic brain syndromes (chronic)

**82607: Vitamin B-12 (Cyanocobalamin) Assay (continued)**

298.9	Unspecified psychosis
311	Depressive disorder, not elsewhere classified
357.4	Polyneuropathy in other diseases classified elsewhere
555.9	Regional enteritis, unspecified site
558.3	Allergic gastroenteritis and colitis
558.9	Other and unspecified noninfectious gastroenteritis and colitis
579.0	Celiac disease
579.1	Tropical sprue
579.2	Blind loop syndrome
579.3	Other and unspecified postsurgical nonabsorption
579.9	Unspecified intestinal malabsorption

**Diagnoses that Support Medical Necessity**  
N/A

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

**Diagnoses that DO NOT Support Medical Necessity**  
N/A

**Reasons for Denials**

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

**Noncovered ICD-9-CM Codes**

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

**Noncovered Diagnosis**  
N/A

**Coding Guidelines**  
N/A

**Documentation Requirements**

Medical record documentation (e.g., history and physical, progress notes) maintained by the ordering physician/referring physician must indicate the medical necessity for performing a vitamin B-12 assay. Additionally, a copy of the lab results should be maintained in the medical records.

If the provider of the services is other than the ordering/referring physician, that provider must maintain hard copy documentation of the lab results, along with copies of the ordering/referring physician’s order for the vitamin B-12 level. The physician must state the clinical indication/medical necessity for the vitamin B-12 level in the order for the test.

**Utilization Guidelines**

The vitamin B-12 assay is used to diagnose vitamin B-12 deficiency. Since the assay is not used to monitor the effects of vitamin B-12 therapy, it is not expected to see repeated vitamin B-12 assays.

**Other Comments**  
N/A

**Sources of Information and Basis for Decision**

Anderson, K., Anderson, L., & Glanze, W., et.al. (1994). *Mosby’s medical dictionary* (4th ed.). St. Louis, MO.: W.B. Saunders Co.  
 Braunwald, E., Fauci, A., & Isselbacher, K., et. al. (1998). *Harrison’s principles of internal medicine* (14th ed.). New York: McGraw-Hill.  
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 Demott, W., Finley, P., Horvat, R., Jacobs, D., Kasten, B., & Tizler, L., et. al. (1994). *Laboratory test handbook* (3rd ed.). Cleveland, OH.: Lexi-Comp. Inc.  
 Henry, J. (1991). *Clinical diagnosis & management by laboratory methods* (18th ed.). Philadelphia: W.B. Saunders Co.  
 McPhee, S., Tierney, L., & Papadakis, M. (1998). *Current medical diagnosis & treatment* (37th ed.). Stamford, CT.: Appleton & Lange.

**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 include representatives from numerous societies.

**Start Date of Comment Period**  
08/17/2001

**End Date of Comment Period**  
10/01/2001

**Start Date of Notice Period**  
08/01/2002

**Revision History**

Revision Number:	2
Start Date of Comment Period	08/17/2001
Start Date of Notice Period	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Revised Effective Date:	09/23/2002
Explanation of Revision:	A request was made to enhance the policy to include frequency guidelines regarding vitamin B-12 assays.
Revision Number:	1
Start Date of Comment Period	N/A
Start Date of Notice Period	10/01/2000
	Oct/Nov 2000 <i>Bulletin</i>
Revised Effective Date:	10/01/2000
Explanation of Revision:	Annual ICD-9-CM Update
Revision Number	Original
Start Date of Comment Period:	08/13/1999
Start Date of Notice Period:	02/2000
	Feb/Mar 2000 <i>Bulletin</i>
Original Effective Date	03/15/2000 ❖



**84100: Serum Phosphorus**

*Revision Overview: "ICD-9-CM Codes that Support Medical Necessity" section of the policy has been revised to incorporate multiple diagnosis ranges that were inadvertently left off from the previous revision. Type of bill 71x has been removed from the policy.*

**Policy Number**

84100

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Serum Phosphorus

**AMA CPT Copyright Statement**

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**CMS National Coverage Policy**

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

**Primary Geographic Jurisdiction**

Florida

**Secondary Geographic Jurisdiction**

N/A

**CMS Region**

Region IV

**CMS Consortium**

Southern

**Original Policy Effective Date**

01/01/2001

**Original Policy Ending Date**

N/A

**Revision Effective Date**

04/18/2002

**Revision Ending Date**

04/17/2002

**LMRP Description**

Phosphorus is a non-metallic chemical element. Most of the body's phosphorus is combined with calcium within the skeleton; however, approximately 15% of phosphorus exists in the blood as a phosphate salt. Phosphates help store and utilize body energy. Additionally, they help regulate calcium levels, carbohydrate and lipid metabolism, and acid-base balance. Vitamin D is important in the absorption and metabolism of phosphorus. Phosphorus levels are determined by calcium metabolism, parathyroid hormone, and to a lesser degree by intestinal absorption. Normal serum phosphorus is 2.5-4.5mg/dl. Serum phosphate levels help to detect endocrine, skeletal, and calcium disorders, and aid in the diagnosis of renal disorders and acid-base imbalance.

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

Florida Medicare will consider serum phosphorus testing medically reasonable and necessary under either of the two following circumstances:

1. Evaluation of patients with signs and symptoms of hypophosphatemia. Patients with mild hypophosphatemia usually have no clinical manifestations. Clinical findings below usually occur when the phosphate deficit is severe:

anorexia	hypercaliuria
nausea	osteomalacia
muscle weakness and soreness	rhabdomyolysis
bone pain	encephalopathy
apprehension	seizures
confusion	hemolysis
paresthesias	platelet dysfunction
mental obtundation	thrombocytopenia

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

- Decreased phosphate ingestion or absorption:
  - Malnutrition: alcoholism, starvation
  - Vitamin D deficiency
  - Malabsorption syndromes
  - Hyperalimentation without phosphate supplements
- Increased utilization or consequence of metabolism:
  - Pregnancy
  - Recovery from malnutrition or diabetic ketoacidosis: insulin and glucose therapy
  - Respiratory alkalosis: salicylate poisoning, gram-negative bacteremia
  - Lactate, sodium bicarbonate, or sodium chloride infusions
  - Absorption by bone following parathyroidectomy
- Excess losses of phosphate:
  - Dialysis
  - Diuretic therapy
  - Primary hyperparathyroidism
  - Renal tubular defects: congenital, after renal transplant, toxic, and diuretic phase following acute renal failure or burns
  - Oral antacid therapy
  - Hypomagnesemia

2. Evaluation of patients with hyperphosphatemia. Patients with hyperphosphatemia usually have no clinical symptoms per se. Symptoms may arise, however, from underlying conditions. Some signs of hyperphosphatemia can include, but are not limited to, the following:

**84100: Serum Phosphorus (continued)**

serum phosphorus level greater than 4.5mg/dl on two fasting blood levels  
skeletal lesions on X-ray  
elevation of serum creatinine and alkaline phosphatase

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

- Excess phosphate from exogenous sources:
  - Ingestion of dairy products
  - Ingestion of phosphate salts or use of phosphate enemas in patients with renal disease
  - Hypervitaminosis D
  - Sarcoidosis
- Excess phosphate from endogenous sources:
  - Metabolic or respiratory acidosis
  - Skeletal lesion, local: myeloma, Paget's disease, and metastatic carcinoma
  - Skeletal lesion, diffuse: prolonged skeletal immobilization, severe hyperparathyroidism secondary to renal disease
  - Phosphate release from tissue destruction or ischemia: irradiation or chemotherapy hemolysis, lactic acidosis
- Impaired excretion of phosphate: renal disease, hypoparathyroidism

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

Tests useful in the differential diagnosis include repeat serum phosphorus, alkaline phosphatase, calcium, parathyroid hormone, and skeletal X-ray.

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

**CPT/HCPCS Section & Benefit Category**

Pathology and Laboratory/Chemistry

**Type of Bill Code**

Hospital – 12x, 13x, 14x  
Skilled Nursing Facility – 21x, 22x, 23x  
End Stage Renal Disease – 72x  
Critical Access Hospital – 85x

**Revenue Code**

301 Laboratory, Chemistry

**CPT/HCPCS Codes**

84100 Phosphorus inorganic (phosphate)

**Not Otherwise Classified Codes (NOC)**

N/A

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

135	Sarcoidosis
170.0-170.9	Malignant neoplasm of bone and articular cartilage
198.5	Secondary malignant neoplasm of bone and bone marrow
203.00-203.01	Multiple myeloma
238.6	Neoplasm of uncertain behavior of plasma cells (solitary myeloma)
252.0	Hyperparathyroidism
260-263.9	Nutritional deficiencies
268.0-268.9	Vitamin D deficiency
275.2	Disorders of magnesium metabolism (hypomagnesemia)
275.3	Disorders of phosphorus metabolism
275.40-275.49	Disorders of calcium metabolism
276.0-276.9	Disorders of fluid, electrolyte, and acid-base balance
278.4	Hypervitaminosis D
278.8	Other metabolic disorders due to hyperalimentation (excess phosphate)
287.0-287.9	Purpura and other hemorrhagic conditions
293.0-293.1	Acute and subacute delirium (confusion)
298.9	Unspecified psychosis (mental obtundation)
348.3	Encephalopathy, unspecified
403.01	Malignant hypertensive renal disease with renal failure
403.11	Benign hypertensive renal disease with renal failure
404.02	Malignant hypertensive heart and renal disease with renal failure
404.03	Malignant hypertensive heart and renal disease with congestive heart failure and renal failure
404.12	Benign hypertensive heart and renal disease with renal failure
404.13	Benign hypertensive heart and renal disease with congestive heart failure and renal failure
579.0-579.9	Intestinal malabsorption
580.0-588.9	Nephritis, nephritic syndrome, and nephrosis
728.89	Other disorders of muscle, ligament, and fascia (rhabdomyolysis)
728.9	Unspecified disorder of muscle, ligament, and fascia (muscle weakness and soreness)
729.1	Myalgia and myositis, unspecified
731.0	Osteitis deformans without mention of bone tumor
733.90	Disorder of bone and cartilage, unspecified (bone pain)
753.9	Unspecified anomaly of urinary system (congenital renal tubular defects)
780.39	Other convulsions
782.0	Disturbance of skin sensation (paresthesias)
783.0	Anorexia
787.02	Nausea alone
790.6	Other abnormal blood chemistry

**84100: Serum Phosphorus (continued)**

790.7	Bacteremia
793.0	Nonspecific abnormal findings on radiological examination of skull and head (skeletal lesions)
793.7	Nonspecific abnormal findings on radiological examination of musculoskeletal system (skeletal lesions)
799.2	Nervousness (apprehension)
965.1	Poisoning by salicylates
990	Effects of radiation, unspecified (phosphate release from tissue destruction or ischemia)
995.84	Adult neglect (nutritional)
E858.5	Accidental poisoning by water, mineral, and uric acid metabolism drugs
E933.3	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, alkalinizing agents
E943.0	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antacids and antigastric secretion drugs
E944.0-E944.5	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, water, mineral, and uric acid metabolism drugs
V45.89	Other postsurgical status (absorption by bone following parathyroidectomy)

**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**

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

**Documentation Requirements**

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

If the provider of the service is other than the ordering/referring physician, that provider must maintain hard copy documentation of 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**

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

**Other Comments**  
N/A

**Sources of Information 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](http://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 include representatives from numerous societies.

**Start Date of Comment Period**  
N/A

**End Date of Comment Period**  
N/A

**Start Date of Notice Period**  
N/A

**Revision History**

Revision Number	3
Start Date of Comment Period:	N/A
Start Date of Notice Period:	08/01/02 4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Revised Effective Date	04/18/2002
Explanation of Revision:	Multiple diagnosis ranges were inadvertently left off the previous revision, therefore, the applicable diagnoses were added back to the policy.
Revision Number	2
Start Date of Comment Period:	N/A
Start Date of Notice Period:	05/01/2002 3 <sup>rd</sup> Qtr 2002 <i>Bulletin</i>
Revised Effective Date	04/18/2002
Explanation of Revision:	According to the Coding Clinic guidelines, the combined diagnoses for patients with renal failure caused by hypertension should be billed with diagnosis codes in the 403 and 404 ranges. Therefore, the policy was revised to add the applicable diagnoses. ❖

**86706: Hepatitis B Surface Antibody and Surface Antigen**

*Revision Overview: "ICD-9-CM section of the policy has been updated to incorporate diagnosis ranges for 403 and 404 to cover the combined diagnosis guidelines for patients with renal failure caused by hypertension.*

**Policy Number**

86706

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Hepatitis B Surface Antibody and Surface Antigen

**AMA CPT Copyright Statement**

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**CMS National Coverage Policy**

Coverage Issues Manual, Section 50-17  
Hospital Manual, Sections 160B12, E205.  
Intermediary Manual, Section 3157  
Renal Dialysis Facility Manual, Section 207.3  
Skilled Nursing Facility Manual, Section 260.7

**Primary Geographic Jurisdiction**

Florida

**Secondary Geographic Jurisdiction**

N/A

**CMS Region**

Region IV

**CMS Consortium**

Southern

**Original Policy Effective Date**

11/15/1999

**Original Policy Ending Date**

N/A

**Revision Effective Date**

06/21/2002

**Revision Ending Date**

06/20/2002

**LMRP Description**

Hepatitis refers to inflammation of the liver. Approximately 50 percent of all acute viral hepatitis cases in the United States are type B. Hepatitis B is caused by the hepatitis B virus (HBV), which is spread by blood and serum-derived fluids through direct contact with these body fluids (such as transmission through parenteral, sexual and perinatal modes). The incubation period for hepatitis B can be six weeks to six months with a slow onset. The most frequent presenting symptoms of acute viral hepatitis are low-grade fever, anorexia, fatigue, myalgia, and nausea followed one to two weeks later by jaundice. Dark urine and clay colored stools present several days before jaundice. After the onset of jaundice, the liver enlarges and

becomes tender. About five percent of patients infected with the hepatitis B virus develop what is coined the "serum-sickness syndrome". The syndrome includes the symptoms of jaundice, fever, rash and arthralgia. Hepatitis B may be quite mild, while a few patients could rapidly progress to death suffering from acute necrosis of the liver. Some patients with hepatitis B (approximately 6%-10%) may progress to a persistent carrier status confirmed by the consistently present hepatitis B surface antigen in their blood. These patients are highly likely to transmit hepatitis B. Each case of hepatitis B is treated symptomatically.

Hepatitis B surface antigen (HBsAg) is the earliest indicator of an acute hepatitis B infection. It can be detected one to seven weeks before liver enzyme elevation or the onset of clinical symptoms. The serology of 50% of affected patients will be positive three weeks after acute onset, while at the seventeen week mark only 10% will remain positive. There is evidence of a "window" stage where the hepatitis B surface antigen has become negative and the patient has not yet developed the hepatitis B surface antibody. The chronic carrier state is indicated by the persistence of hepatitis B surface antigen over six months and longer (even years) while never seroconverting to hepatitis B surface antibody. The reference range is negative. The detection of the hepatitis B surface antigen establishes the presence of infection and implies infectivity.

Hepatitis B surface antibody (HbsAb or anti-HBs) is present in the serum of patients who have resolved a previous hepatitis B infection or have been vaccinated against hepatitis B. The disappearance of hepatitis B antigen with the appearance of hepatitis B antibody signals recovery from the hepatitis B infection, the status of noninfectivity and protection from recurrent hepatitis B infection. Hepatitis B surface antibody can be detected several weeks to several years after Hepatitis B antigen can no longer be detected. It may persist for life after the acute infection has been resolved. Since there are different serologic subtypes of the hepatitis B virus, it is possible for a patient to have an antibody for one subtype and be infected with another. Transfused individuals or hemophiliacs receiving plasma components may have false positive tests. Individuals vaccinated with HBV vaccine will have antibodies. The appearance of the hepatitis B antibody following vaccination signals successful vaccination against hepatitis B. The detection of hepatitis B surface antibody in the patient's serum can be performed by either the radioimmunoassay (RIA) or enzyme immunoassay (EIA) method. The reference range varies with the clinical circumstance.

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

**Hepatitis B Surface Antibody**

Florida Medicare will consider coverage for the Hepatitis B surface antibody (86706) for any of the following indications:

- I. To confirm the resolution of a recent hepatitis B infection. The HBsAb is drawn one month after the diagnosis of acute hepatitis B is made. This test may



86706: Hepatitis B Surface Antibody and Surface Antigen (continued)

be repeated monthly while seeking the disappearance of HBsAg and the appearance of HBsAb indicating immunity and recovery. If the HBsAg is still evident at the end of six months of testing, the patient is considered a persistent hepatitis B carrier. No further HBsAb would be considered reasonable and necessary.

- II. After percutaneous or mucosal exposure to blood and/or serum-derived fluids when the SOURCE is HBsAg-positive **and** the previously vaccinated exposed person is either a known responder or the response to vaccination is unknown, in order to determine adequate antibody response. One test would be sufficient to make this determination. EXCEPTION- Vaccinated persons who have not been tested within the past 24 months should undergo testing to determine immunity.
- III. After percutaneous or mucosal exposure to blood and/or serum-derived fluids when the SOURCE is not tested or unknown **and** the previously vaccinated exposed person's response to the vaccination is unknown, in order to determine adequate antibody response. One test would be sufficient to make this determination.
- IV. Following the administration of the Hepatitis B vaccine series in order to determine adequate antibody response. Coverage for this indication is limited to two instances.
  - 1. To determine the antibody response of vaccination due to prophylaxis treatment following percutaneous and/or mucosal exposure, or
  - 2. To determine the antibody response of vaccination following a Medicare reimbursed vaccination furnished to a beneficiary who is at high or intermediate risk of contracting hepatitis B. See Intermediary Manual section 3157 for more information regarding this benefit.

It is recommended this testing occur between one to six months following the completion of the series. If the patient was given Hepatitis B immunoglobulin (HBIG) during this time period, the testing should be delayed until four to six months after the HBIG administration. Those beneficiaries who do not respond to the initial vaccination series, can receive up to three additional doses of vaccine at one to two month intervals. Serologic testing can occur following each dose.

- V. To determine the serological status of a hemodialysis, intermittent peritoneal dialysis, or continuous cycling peritoneal dialysis patient upon entry into a Medicare dialysis facility in accordance with CMS National coverage policy. Further testing is dependent upon the initial result and the vaccination status. Please refer to the following table from the Coverage Issues Manual, section 50-17.

Vaccination and Serologic Status	Freq. of HBsAb Surveillance
<b>Unvaccinated</b>	
Susceptible	Semiannually
HBsAg Carrier	None
HBsAb positive (*)	Annually

**Vaccinated**

HBsAb positive (*)	Annually
HBsAb of 9 or less SRUs by RIA	Semiannually

\* At least 10 sample ratio units (SRUs) by radioimmunoassay or positive by enzyme immunoassay. Antibody titers 10 mIU/ml are recognized as conferring protection against hepatitis.

ESRD patients who are in the process of receiving the hepatitis B vaccine, but have not completed the series, should be followed as susceptible. Between one and six months following the final vaccine dose, all patients should be tested for HBsAb response to the vaccine. Once the response is confirmed as positive, there is no further need to perform semiannual HBsAb tests. If, during future annual HBsAb testing, it is determined that the SRUs drop below 10 or the result by EIA is negative, a booster dose of hepatitis B vaccine should be given. A booster dose, otherwise known as re-vaccination, requires the complete three-injection-series be repeated. Once again, between one and six months following the final vaccine dose, all patients should be tested for HBsAb response to the vaccine.

**Hepatitis B Surface Antigen**

Florida Medicare will consider coverage for the Hepatitis B surface antigen (87340) for any of the following indications:

- I. To aid in the differential diagnosis of hepatitis when the patient presents with signs and symptoms of acute viral infection. If the initial HBsAg test is positive **with the Anti-HBc-IgM being negative**, both of these tests are repeated in two weeks. The results of the repeat tests aid in the differential diagnosis of acute HBV infection vs. chronic HBV carrier status. If the initial HBsAg test is positive **with the Anti-HBc-IgM being positive**, HBV infection is confirmed. The hepatitis B surface antigen test can be repeated monthly until negative. If, at the end of six months, the hepatitis B surface antigen remains positive, the beneficiary is diagnosed as a chronic HBV carrier and further hepatitis B surface antigen testing would not be reasonable or necessary.
- II. To evaluate patients with chronic elevations (6 months or longer) of the following serum liver enzyme levels: alanine aminotransferase (ALT) and aspartate aminotransferase (AST) to rule out the diagnosis of Hepatitis B. It is expected that only one HBsAg test will be required in this clinical situation (ICD-9-CM code 790.4).
- III. To evaluate patients with polyarteritis nodosa to determine if the illness is associated with replicating hepatitis B. In this instance HBsAg and HBeAg would be evaluated. It is expected that only one HBsAg test will be required (ICD-9-CM code 446.0)
- IV. To determine the serological status of a hemodialysis, intermittent peritoneal dialysis, or continuous cycling peritoneal dialysis patient upon entry into a Medicare dialysis facility in accordance with CMS National coverage policy. Further testing is dependent upon the

**86706: Hepatitis B Surface Antibody and Surface Antigen (continued)**

initial result as well as the vaccination status. Please refer to the following table from the Coverage Issue Manual, section 50-17.	403.01	Malignant hypertensive renal disease with renal failure
	403.11	Benign hypertensive renal disease with renal failure
Vaccination and Serologic Status	Freq. of HBsAb Surveillance	404.02
<b>Unvaccinated</b>		404.03
Susceptible	Monthly	404.03
HbsAg Carrier	Annually	404.12
HbsAb positive (*)	None	404.12
<b>Vaccinated</b>		404.13
HbsAb positive (*)	None	404.13
HbsAb of 9 or less SRUs by RIA	Monthly	404.13
* At least 10 sample ratio units (SRUs) by radioimmunoassay or positive by enzyme immunoassay. Antibody titers 10 mIU/ml are recognized as conferring protection against hepatitis B.	585	Chronic renal failure
ESRD patients who are in the process of receiving the hepatitis B vaccine, but have not completed the series, should be followed as susceptible. Between one and six months following the final vaccine dose, all patients should be tested for HbsAb response to the vaccine. Once the response is confirmed, there is no further need to perform monthly HbsAg tests. If, during future annual HbsAb testing, it is determined that the SRUs drop below 10 or the result by EIA is negative, a booster dose of hepatitis B vaccine should be given. Monthly HbsAg can resume while awaiting the antibody response to this booster. Once the antibody titer confirms protection, no further HbsAg testing would be necessary.	V01.7	Contact with or exposure to other viral diseases (viral hepatitis)
	V05.3	Need for other prophylactic vaccination and inoculation against single diseases, Viral hepatitis
	V45.1	Renal dialysis status
	V67.59	Follow-up examination, other treatment [Hepatitis B Vaccination]
	<b>Note:</b>	Billing for Hepatitis B Surface Antigen for ESRD beneficiaries requires dual diagnoses. Please submit codes 403.01, 403.11, 404.02, 404.03, 404.12, 404.13, or 585 and V45.1 to report the approved indication.
		For procedure code 87340 (Hepatitis B surface antigen)
<b>CPT/HCPCS Section &amp; Benefit Category</b>	070.20-070.23	Viral hepatitis B with hepatic coma
Pathology and Laboratory/Immunology	070.30-070.33	Viral hepatitis B without mention of hepatic coma
Pathology and Laboratory/Microbiology	070.6	Unspecified viral hepatitis with hepatic coma
<b>Type of Bill Code</b>	070.9	Unspecified viral hepatitis without mention of hepatic coma (fulminant hepatic failure)
Hospital – 12x, 13x, 14x	403.01	Malignant hypertensive renal disease with renal failure
Skilled Nursing Facility – 21x, 22x, 23x	403.11	Benign hypertensive renal disease with renal failure
End Stage Renal Dialysis Facility – 72x	404.02	Malignant hypertensive heart and renal disease with renal failure
Critical Access Hospital – 85x	404.03	Malignant hypertensive heart and renal disease with congestive heart failure and renal failure
<b>Revenue Codes</b>	404.12	Benign hypertensive heart and renal disease with renal failure
302 Laboratory Immunology (Hepatitis B surface antibody)	404.13	Benign hypertensive heart and renal disease with congestive heart failure and renal failure
306 Laboratory Microbiology (Hepatitis B surface antigen)	446.0	Polyarteritis nodosa
<b>CPT/HCPCS Codes</b>	570	Acute and subacute necrosis of liver
86706 Hepatitis B surface antibody (HbsAb)	573.1	Hepatitis in viral diseases classified elsewhere
87340 Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; hepatitis B surface antigen (HbsAg)	573.2	Hepatitis in other infectious diseases classified elsewhere
<b>Not Otherwise Classified Codes (NOC)</b>	573.3	Hepatitis, unspecified
N/A	585	Chronic renal failure
<b>ICD-9-CM Codes that Support Medical Necessity</b>		
For procedure code 86706 (Hepatitis B surface antibody)		
070.20-070.23 Viral hepatitis B with hepatic coma		
070.30-070.33 Viral hepatitis B without mention of hepatic coma		

**86706: Hepatitis B Surface Antibody and Surface Antigen (continued)**

719.40-719.49	Pain in joint (arthralgia)
729.1	Myalgia and myositis, unspecified
774.4	Perinatal jaundice due to hepatocellular damage
780.6	Fever (of unknown origin)
780.79	Other malaise and fatigue
782.1	Rash and other nonspecific skin eruption
782.4	Jaundice, unspecified, not of newborn
783.0	Anorexia
787.02	Nausea alone
789.1	Hepatomegaly
790.4	Nonspecific elevation of levels of transaminase or lactic acid dehydrogenase [LDH]
791.9	Other nonspecific findings on examination of urine (urobilin or urochrome)
792.1	Nonspecific abnormal findings in stool contents
V01.7	Contact with or exposure to other viral diseases (viral hepatitis)
V02.61	Hepatitis B carrier
V45.1	Renal dialysis status

**Note:** Billing for Hepatitis B Surface Antigen for ESRD beneficiaries requires dual diagnoses. Please submit codes 403.01, 403.11, 404.02, 404.03, 404.12, 404.13, or 585 and V45.1 to report the approved indication.

**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**

Hepatitis B surface antigen and antibody tests are separately billable lab tests for hemodialysis, intermittent peritoneal dialysis and continuous cycling peritoneal dialysis patients. Payment for these tests is not part of the composite rate of reimbursement.

To identify end-stage renal dialysis patients, bill **both** 403.01, 403.11, 404.02, 404.03, 404.12, 404.13, or 585 and V45.1 on the Medicare claim form. If both ICD-9-CM codes are not on the claim, the services will be denied as lacking medical necessity.

**Documentation Requirements**

For someone suspected of having been recently exposed to the hepatitis B virus, the medical record documentation must contain information regarding the beneficiary’s vaccination status, and the suspected incident including an assessment of current signs and symptoms. It is expected that the initial and, if needed, subsequent hepatitis B lab test results (e.g., HBsAg, HBsAb, and/or Anti-HBc-IgM) be contained within the medical record. This information is usually found in the history and physical, office notes, test results, and/or progress notes.

Medical record documentation for ESRD beneficiaries receiving services through Medicare dialysis facilities must contain information regarding the method of dialysis, their hepatitis B vaccination status and the results of their initial admission serology testing and all subsequent hepatitis B surface antigen and antibody tests.

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

**Utilization Guidelines**

It is expected that these services would be performed as indicated in the “Indications and Limitations of Coverage and/or Medical Necessity” section of this policy. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

**Other Comments**

**Terms defined:**

*Chronic hepatitis* – persistently abnormal liver enzymes for at least six months duration.

*End-stage renal disease (ESRD)* – the term as defined by CMS reads the “stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life.”

*Person infected with HBV* – the blood of this individual contains the hepatitis B surface antigen.

*Person immune to HBV* – the blood of this individual contains the hepatitis B antibody.

*Person susceptible to HBV* – the blood of this individual contains neither hepatitis B surface antigen nor antibody.

**Sources of Information and Basis for Decision**

Agency for Health Care Policy and Research (1994).

*Health Technology Assessment: Laboratory Tests in End-Stage Renal Disease Patients Undergoing Dialysis* (AHCPR Pub. No. 94-0053). Rockville, MD: Agency for Health Care Policy and Research.

American Medical Association Advisory Group on Prevention, Diagnosis, and Management of Viral Hepatitis. (1995). *Prevention, Diagnosis, and Management of Viral Hepatitis: A Guide for Primary Care Physicians. Abstracts of Clinical Care Guidelines*, 7: 1-8.

Bacon, B. (1991). Managing chronic hepatitis: recent advances in diagnosis and treatment. *Postgraduate Medicine*, 90 (5) 103-104, 107-108, 111-112.

**86706: Hepatitis B Surface Antibody and Surface Antigen (continued)**

*Drug Facts and Comparisons*, St. Louis, MO :Facts and Comparisons, Inc.  
 Jacobs, D., Demott, W., Grady, H., Horvat, R., Huestis, D., Kasten, B. (1996). *Laboratory Test Handbook* (4th ed.). Ohio: Lexi-Corp.  
 Thomas, C.L. (1993). *Taber's Cyclopedic Medical Dictionary* (17th ed.). Philadelphia: F.A. Davis Company.  
 Tierney, L., McPhee, S., Papadakis, M. (1998). *Current Medical Diagnosis and Treatment* (37th ed.). Stamford: Appleton and Lange.

**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 include representatives from from the Florida Gastroenterologic Society, Florida Society of Nephrology and the Clinical Laboratory Management Association.

**Start Date of Comment Period**

N/A

**End Date of Comment Period**

N/A

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number	1
Start Date of Comment Period	N/A
Start Date of Notice Period	08/01/2002 4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Revised Effective Date	06/21/2002
Explanation of Revision:	According to the Coding Clinic guidelines, the combined diagnoses for patients with renal failure caused by hypertension should be billed with diagnosis codes in the 403 and 404 ranges. Therefore, the policy was revised to add the applicable diagnoses.
Revision Number	Original
Start Date of Comment Period:	08/26/1998
Start Date of Notice Period:	10/01/1999 Oct/Nov 1999 <i>Bulletin</i>
Original Effective Date	11/15/1999 ❖



## 92567: Tympanometry

### Policy Number

92567

### Contractor Name

First Coast Service Options, Inc.

### Contractor Number

090

### Contractor Type

Intermediary

### LMRP Title

Tympanometry

### AMA CPT Copyright Statement

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### CMS National Coverage Policy

Social Security Act, Section 1861 (11)(3).  
Medicare Intermediary Manual, Section 3653

### Primary Geographic Jurisdiction

Florida

### Secondary Geographic Jurisdiction

N/A

### CMS Region

Region IV

### CMS Consortium

Southern

### Original Policy Effective Date

09/23/2002

### Original Policy Ending Date

N/A

### Revision Effective Date

N/A

### Revision Ending Date

N/A

### LMRP Description

Tympanometry is a test used to evaluate the condition of the middle ear system. The test determines the functionality of the tympanic membrane by observing its response to waves of pressure, and measuring the pressure of the middle ear. The test is used to measure parameters of the middle ear and eardrum in an effort to determine whether there are dysfunctions that could ultimately affect the hearing of the patient or put one at risk for repeated infections. Tympanometry is regarded as an objective technique for obtaining reproducible measurements of the compliance (also referred to as "admittance") or mobility of the tympanic membrane and the pressure within the middle ear system. The measurements assist in assessing Eustachian tube function and in determining the continuity and mobility of the ossicular chain.

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

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

- To evaluate middle ear abnormalities suspected by clinical otoscopy
- To evaluate Eustachian tube patency
- To evaluate conductive hearing loss
- To evaluate perforations of the tympanic membrane
- To evaluate suspected fixation of the ossicular chain
- To evaluate middle ear function
- To evaluate lack of contact between conduction of the bones of the middle ear
- To document or follow persistent middle ear effusions

Tympanometry (impedance testing) is covered when testing is for the purpose of determining the appropriate medical or surgical treatment for disorders.

### CPT/HCPCS Section & Benefit Category

Medicine/Special Otorhinolaryngologic Services

### Type of Bill Code

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

### Revenue Codes

470 Audiology, General Classification

### CPT/HCPCS Codes

92567 Tympanometry (impedance testing)

### Not Otherwise Classified Codes (NOC)

N/A

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

381.00-381.9	Nonsuppurative otitis media and Eustachian tube disorders
382.00-382.9	Suppurative and unspecified otitis media
383.00-383.9	Mastoiditis and related conditions
384.00-384.9	Other disorders of tympanic membrane
389.00-389.08*	Conductive hearing loss

\*Tests for the ICD-9-CM codes 389.00-389.08 are covered only for an initial evaluation of a hearing problem.

### 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.

92567: Tympanometry (continued)

**Noncovered ICD-9-CM Codes**

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

**Noncovered Diagnosis**

N/A

**Coding Guidelines**

For Medicare coverage of audiologists performing hearing tests, the audiologists must be “qualified audiologists” as defined in Section 1861 (11)(3) of the Social Security Act;

A qualified audiologist is an individual with a master’s or doctoral degree in audiology who:

- Is licensed as an audiologist by the state in which the individual furnishes such services; or
- In the case of an individual who furnishes services in a state which does not license audiologists, has
  - Successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience),
  - Performed not less than 9 months of supervised full-time audiology services after obtaining a master’s degree or doctoral degree in audiology or a related field, and
  - Successfully completed a national examination in audiology approved by the secretary.

If a physician refers a beneficiary to an audiologist for evaluation of signs or symptoms associated with hearing loss or ear injury, the audiologist’s diagnostic services should be covered, even if the only outcome is the prescription of a hearing aid. If a beneficiary undergoes diagnostic testing performed by an audiologist without a physician referral, then these tests are not covered, even if the audiologist discovers a pathologic condition.

**Documentation Requirements**

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

**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](http://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 include representatives from numerous societies.

**Start Date of Comment Period**

05/18/2001

**End Date of Comment Period**

07/02/2001

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number:	Original
Start Date of Comment Period:	05/18/2001
Start Date of Notice Period:	08/01/2002
	4th Qtr 2002 <i>Bulletin</i>
Original Effective Date	09/23/2002 ❖

**93000: Electrocardiography**

*Revision Overview: The following sections of the policy have been revised: "Indications and Limitations of Coverage and/or Medical Necessity," "Type of Bill Code," "ICD-9-CM that Support Medical Necessity" and "Coding Guidelines."*

**Policy Number**

93000

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Electrocardiography

**AMA CPT Copyright Statement**

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**CMS National Coverage Policy**

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

**Primary Geographic Jurisdiction**

Florida

**Secondary Geographic Jurisdiction**

N/A

**CMS Region**

Region IV

**CMS Consortium**

Southern

**Original Policy Effective Date**

11/18/1996

**Original Policy Ending Date**

N/A

**Revision Effective Date**

07/16/2002

**Revision Ending Date**

07/15/2002

**LMRP Description**

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

The normal EKG pattern is composed of waves arbitrarily designated by the letters P, Q, R, S, and T. Through the analysis of these wave forms and time intervals, valuable information about the heart may be obtained. The EKG is used primarily to identify abnormal heart rhythms (arrhythmias or dysrhythmias) and to diagnose acute myocardial defects, ventricular hypertrophy, and/or strain.

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

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

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

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

93000: *Electrocardiography (continued)*

7. Evaluation of patients after coronary artery revascularization by Coronary Artery Bypass Grafting (CABGs), Percutaneous Transluminal Coronary Angiography (PTCA), thrombolytic therapy (e.g., TPA, Streptokinase, Urokinase), and/or stent placement.	240.0-246.9 250.00-250.93 276.0-276.9	Disorders of thyroid gland Diabetes mellitus Disorders of fluid, electrolyte, and acid-base balance
8. Evaluation of patients presenting with symptoms of a Myocardial Infarction (MI).	277.00-277.01 277.3 337.0	Cystic fibrosis Amyloidosis Idiopathic peripheral autonomic neuropathy
9. Evaluation of other symptomatology which may indicate a cardiac origin especially in those patients who have a history of an MI, CABG surgery or PTCA or patients who are being treated medically after a positive stress test or cardiac catheterization.	337.9 390-429.9 435.9	Unspecified disorder of autonomic nervous system Diseases of the circulatory system Unspecified transient cerebral ischemia (Transient ischemic attack [TIA])
10. Pre-operative Evaluation of the patient when:	436	Acute, but ill-defined, cerebrovascular disease
- undergoing cardiac surgery such as CABGs, automatic implantable cardiac defibrillator, or pacemaker, or	440.0-448.9	Diseases of arteries, arterioles, and capillaries
- the patient has a medical condition associated with a significant risk of serious cardiac arrhythmia and/or myocardial ischemia such as Diabetes, history of MI, angina pectoris, aneurysm of heart wall, chronic ischemic heart disease, pericarditis, valvular disease or cardiomyopathy to name a few.	668.10-668.14 710.0-710.9 714.0-714.9	Cardiac complications Diffuse diseases of connective tissue Rheumatoid arthritis and other inflammatory polyarthropathies
11. Evaluation of a patient's response to the administration of an agent known to result in cardiac or EKG abnormalities (for patients with suspected, or at increased risk of developing, cardiovascular disease or dysfunction). Examples of these agents are antineoplastic drugs, lithium, tranquilizers, anticonvulsants, and antidepressant agents.	745.0-745.9 746.00-747.9	Bulbus cordis anomalies and anomalies of cardiac septal closure Other congenital anomalies of heart and circulatory system
12. When performed as a baseline evaluation prior to the initiation of an agent known to result in cardiac or EKG abnormalities. An example of such an agent is verapamil.	780.02 780.2 780.31-780.39 780.4 780.79 782.0 782.61-782.62 785.0 785.1 785.2 785.3 785.50-785.59 786.00 786.01 786.02 786.03-786.09 786.50-786.59 786.6 789.01 789.02 789.06 794.30-794.39	Transient alteration of awareness Syncope and collapse Convulsions Dizziness and giddiness Other malaise and fatigue Disturbance of skin sensation Pallor and flushing Tachycardia, unspecified Palpitations Undiagnosed cardiac murmurs Other abnormal heart sounds Shock without mention of trauma Respiratory abnormality, unspecified Hyperventilation Orthopnea Dyspnea and respiratory abnormalities Chest pain Swelling, mass, or lump in chest Abdominal pain, right upper quadrant Abdominal pain, left upper quadrant Abdominal pain, epigastric Nonspecific abnormal results of cardiovascular function study Asphyxia Respiratory arrest Traumatic pneumothorax and hemothorax Injury to heart and lung Injury of trunk Poisoning by agents primarily affecting the cardiovascular system Toxic effects of substances chiefly nonmedicinal as to source Certain adverse effects not elsewhere classified Mechanical complication of cardiac device, implant and graft
<b>CPT/HCPCS Section &amp; Benefit Category</b> Cardiovascular/Medicine		
<b>Type of Bill Code</b> Outpatient Hospital – 12x, 13x, 14x Skilled Nursing Facility – 21x, 22x, 23x Comprehensive Outpatient Rehabilitation Facility – 75x Critical Access Hospital – 85x		
<b>Revenue Codes</b> 730 Electrocardiogram, General Classification		
<b>CPT/HCPCS Codes</b> 93000 <i>Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report</i> 93005 <i>tracing only, without interpretation and report</i> 93010 <i>interpretation and report only</i>	799.0 799.1 860.0-860.5 861.00-861.32 959.1 972.0-972.9 980.0-989.9 995.0-995.89 996.00-996.09	
<b>Not Otherwise Classified Codes (NOC)</b> N/A		
<b>ICD-9-CM Codes that Support Medical Necessity</b> 079.0-079.99 Viral and chlamydial infection in conditions classified elsewhere and of unspecified site		



**93000: Electrocardiography (continued)**

996.80-996.89	Complications of transplanted organ
997.1	Cardiac complications
997.2	Peripheral vascular complications
997.3	Respiratory complications
E933.1	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antineoplastic drugs
E936.0-E936.3	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, anticonvulsant drugs
E939.0-E939.9	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, psychotropic agents
V45.01-V45.09	Other postsurgical states, cardiac pacemaker, automatic implantable cardiac defibrillator, and other specified cardiac device
V45.81-V45.82	Other postsurgical status, aortocoronary bypass status and percutaneous transluminal coronary angioplasty status
V58.69	Long-term (current) use of other medications
V58.83	Encounter for therapeutic drug monitoring
V72.81	Pre-operative cardiovascular examination

**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**

Outpatient hospitals, critical access hospitals and CORFS may use *only* code 93005 when billing for this service.

When billing subsequent electrocardiograms on the same day, use modifier 76 if repeated by the same provider or modifier 77 when repeated by a different provider.

**Documentation Requirements**

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

If the provider of the service is other than the ordering/referring physician, that provider must maintain hard copy

documentation of test results and interpretation, along with copies of the ordering/referring physician’s order for the studies. The physician must state the clinical indication/medical necessity for the study in the order for the test.

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

If an EKG is being performed to evaluate a patient’s response to the administration of an agent known to result in cardiac or EKG abnormalities for patients with suspected, or at increased risk of developing cardiovascular disease or dysfunction, then diagnosis code V58.69 or V58.83 should be used. The “E” diagnoses should be used when the patient is experiencing adverse effects to high risk medications.

**Utilization Guidelines**

N/A

**Other Comments**

N/A

**Sources of Information and Basis for Decision**

Jacobs, D., Demott, W., Finley, P., Horvat, R., Kasten, B. and Tilzer, L. (1994). *Laboratory Text Handbook* (3rd ed.) Hudson: Lexi-Comp, Inc.

Pagana, K., and Pagana, J. (1995). *Mosby’s Diagnostic and Laboratory Test Reference*. (2nd ed.). St. Louis: Mosby.

**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 include representatives from the Florida Chapter of the American College of Cardiology.

**Start Date of Comment Period**

N/A

**End Date of Comment Period**

N/A

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number	7
Start Date of Comment Period	N/A
Start Date of Notice Period	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Revised Effective Date	07/16/2002

Explanation of Revision: The deletion of the term Dressler’s syndrome and the addition of Diabetes to indication #10 in the “Indications and Limitations of Coverage and/or Medical Necessity” section of the policy. The expansion of coverage to allow an EKG to be performed as a baseline evaluation prior to the initiation of an agent known to result in cardiac or EKG abnormalities. Expansion of the Diabetes ICD-9-CM code range to 250.00-250.93. Deletion of Type of Bill 71x and 72x and addition of Type of Bill 85x. ❖

**93025: Microvolt T-wave Alternans**

**Policy Number**

93025

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Microvolt T-wave Alternans

**AMA CPT Copyright Statement**

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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**

09/23/2002

**Original Policy Ending Date**

N/A

**Revision Effective Date**

N/A

**Revision Ending Date**

N/A

**LMRP Description**

Microvolt T-wave alternans (TWA) is an every other beat variation in the T-wave that is predictive of ventricular tachyarrhythmias associated with sudden cardiac death. Microvolt TWA is measured through sensors and electrodes placed in the standard 12-lead configuration as well as additional vector positions during a routine exercise stress test, pharmacologic stress test or cardiac pacing. Sustained alternans with an onset of the heart rate less than 110 bpm for a minimum of 2.5 minutes with alternans voltage measured at > 1.9 microvolts and alternans ratio of >3 is considered a positive t-wave alternans.

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

Florida Medicare will consider microvolt TWA medically reasonable and necessary when performed for a clinical condition associated with a high risk of ventricular tachyarrhythmias (e.g., ischemic cardiomyopathy, unexplained syncope with suspected or known heart disease,

etc.) only when the results of the test will be used in the management of the patient. For example, the results of the microvolt TWA will determine whether a patient will undergo an invasive electrophysiological study or treatment with antiarrhythmics when the results are positive.

Microvolt TWA is not covered for the general assessment of a patient with atherosclerotic heart disease, pre-surgical evaluation or other circumstances where the index of suspicion of ventricular tachycardia/fibrillation is low, or the knowledge of possible ventricular tachycardia/fibrillation will not alter the management of the patient. Also, the routine use of microvolt TWA as an add-on service to other cardiac evaluation tests such as electrocardiograms, stress testing, and electrophysiologic studies is not covered.

**CPT/HCPCS Section & Benefit Category**

Medicine/Cardiovascular

**Type of Bill Code**

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

**Revenue Codes**

730 EKG/ECG (Electrocardiogram), General Classification  
 920 Other Diagnostic Services, General Classification

**CPT/HCPCS Codes**

93025 *Microvolt T-wave alternans for assessment of ventricular arrhythmias*

**Not Otherwise Classified Codes (NOC)**

N/A

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

414.8 Other specified forms of chronic ischemic disease (Ischemic cardiomyopathy)  
 425.0-425.9 Cardiomyopathy  
 427.1 Paroxysmal ventricular tachycardia  
 427.41 Ventricular fibrillation  
 427.5 Cardiac arrest  
 428.1 Left heart failure  
 780.2 Syncope and collapse

**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.

**93025: Microvolt T-wave Alternans (continued)**

**Noncovered ICD-9-CM Codes**

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

**Noncovered Diagnosis**

N/A

**Coding Guidelines**

The following services are considered bundled into the reimbursement of microvolt TWA, and therefore, are not to be billed separately: Electrocardiogram/Rhythm electrocardiogram (procedure codes 93000-93010, 93040-93042), and the sensors/electrodes (procedure code 99070) used in the performance of the test.

**Documentation Requirements**

Medical record documentation must clearly indicate the medical necessity of the service(s) being billed and that the results of the test are being used in the management of the patient. In addition, the documentation must support that the procedure was performed. This information is normally found in the office/progress notes, hospital records, and test results.

**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](http://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 include representatives from the Florida Chapter of the American College of Cardiology.

**Start Date of Comment Period**

01/18/2002

**End Date of Comment Period**

03/04/2002

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number	Original
Start Date of Comment Period:	01/18/2002
Start Date of Notice Period:	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Original Effective Date	09/23/2002 ❖

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

*Revision Overview: Policy has been revised to incorporate coverage of transtelephonic monitoring of pacer cardioverter-defibrillators and noncoverage statements have been removed from the policy.*

**Policy Number**

93724

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator

**AMA CPT Copyright Statement**

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**CMS National Coverage Policy**

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

**Primary Geographic Jurisdiction**

Florida

**Secondary Geographic Jurisdiction**

N/A

**CMS Region**

Region IV

**CMS Consortium**

Southern

**Original Policy Effective Date**

03/15/2001

**Original Policy Ending Date**

N/A

**Revision Effective Date**

06/20/2002

**Revision Ending Date**

06/19/2002

**LMRP Description**

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

components; and ensure timely intervention for clinical problems.

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

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

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

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

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

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

**National Medicare Frequency Guidelines**

Frequency guidelines for transtelephonic monitoring (procedure codes 93733 and 93736) are divided into two categories: Guideline I which applies to the majority of pacemakers now in use and Guideline II which applies to pacemaker systems for which sufficient long-term clinical information exists to assure that they meet the standards of the Intersociety Commission for Heart Disease Resources (ICHD) for longevity and end-of-life decay. The two



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

groups of guidelines are further divided into single and dual-chamber pacemakers. The frequency guidelines identified below represent the maximum frequency of transtelephonic monitoring that is expected to occur under routine follow-up. The frequency with which a patient is monitored may be changed for a number of reasons, such as a change in the patient's overall condition, a reprogramming of the patient's pacemaker, and the development of better information on the pacemaker's longevity or failure mode.

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

**Pacemaker Clinic Services**

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

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

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

**Local Medicare Frequency Guidelines**

Electronic analysis of a pacing cardioverter-defibrillator (procedure codes 93741-93744) is performed in an office or outpatient hospital setting. Procedure codes 93741-93744 involve the interrogation and evaluation of the pulse generator status in addition to evaluation of the programmable parameters, analysis of event markers and device response during periods of rest and activity. The monitoring of these complex devices requires more

frequent monitoring than a single or dual chamber pacemaker. Therefore, Florida Medicare will allow routine electronic analysis of a pacing cardioverter-defibrillator (single and dual chamber) at one month following implantation and then every three months thereafter. More frequent testing may be necessary to evaluate patient symptomatology suggestive of pacing cardioverter-defibrillator involvement/origin. Transtelephonic monitoring of a pacer cardioverter-defibrillator is covered and should be billed with procedure code 93799 (Unlisted cardiovascular service or procedure).

The frequency of transtelephonic monitoring of a pacer cardioverter-defibrillator for asymptomatic patients is as follows: 1<sup>st</sup> month – every 2 weeks and every 4 weeks thereafter. More frequent testing may be necessary to evaluate patient symptomatology suggestive of pacing cardioverter-defibrillator involvement/origin.

**CPT/HCPCS Section & Benefit Category**

Medicine/Cardiovascular

**Type of Bill Code**

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

**Revenue Code**

480 Cardiology, General Classification

**CPT/HCPCS Codes**

- 93724 *Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)*
- 93731 *Electronic analysis of dual-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming*
- 93732 *with reprogramming*
- 93733 *Electronic analysis of dual chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker), telephonic analysis*
- 93734 *Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming*
- 93735 *with reprogramming*
- 93736 *Electronic analysis of single chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker), telephonic analysis*

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

- 93741 *Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber, without reprogramming*
- 93742 *single chamber, with reprogramming*
- 93743 *dual chamber, without reprogramming*
- 93744 *dual chamber, with reprogramming*

**Not Otherwise Classified Codes (NOC)**

- 93799 *Unlisted cardiovascular service or procedure (transtelephonic monitoring of implantable cardioverter-defibrillator)*

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

- 426.0-426.9 Conduction disorders
- 427.0-427.9 Cardiac dysrhythmias
- 429.4 Functional disturbances following cardiac surgery (pacemaker, automatic implantable cardiac defibrillator)
- 780.2 Syncope and collapse
- 785.1 Palpitations
- 996.01 Mechanical complication due to cardiac pacemaker (electrode)
- 996.04 Mechanical complication due to automatic implantable cardiac defibrillator
- 996.09 Mechanical complication of other cardiac device, implant, and graft
- V45.01 Other postsurgical states, cardiac pacemaker
- V45.02 Other postsurgical states, automatic implantable cardiac defibrillator
- V53.31 Fitting and adjustment of other device, cardiac pacemaker (reprogramming)
- V53.32 Fitting and adjustment of other device, automatic implantable cardiac defibrillator (reprogramming)
- V53.39 Fitting and adjustment of other device, other cardiac device (reprogramming)
- V67.9 Unspecified follow-up examination

**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.

Transtelephonic monitoring of a pacer cardioverter-defibrillator is noncovered.

**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**

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

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

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

**Documentation Requirements**

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

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

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

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

**Utilization Guidelines**

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

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

Local frequency guidelines for pacing cardioverter-defibrillators are identified in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

**Other Comments**

N/A

**Sources of Information and Basis for Decision**

American College of Cardiology/American Heart Association. (1998). ACC/AHA guidelines for implantation of cardiac pacemakers and antiarrhythmia devices. *Journal of the American College of Cardiology*, 31 (5), 1175-1209. Supports post-implantation monitoring and diagnosis supporting reason for implantation and monitoring.

American Medical Association (1998). Coding consultation. *cpt Assistant*, 8 (2), 11. Supports coding guideline information.

American Medical Association (1999). Pacemaker or pacing cardioverter-defibrillator. *cpt Assistant*, 9 (11), 50-51. Supports components of an analysis.

Bernstein, A. D., Irwin, M. E., Parsonnet, V., Wilkoff, B. L., Black, W. R., Buckingham, T. A., Maloney, J. D., Reynolds, D. D., Saksena, S., Singer, I., Nickelson, D. E., & Schurig, L. (1994). Report of the NASPE policy conference on antibradycardia pacemaker follow-up: Effectiveness, needs, and resources. *PACE*, 17 (Part I), 1714-1727. Supports post-implantation monitoring.

Winters, S., Packer, D., Marchlinski, F., Lazzara, R., Cannom, D., Breithardt, G., Wilber, D., Camm, A., & Ruskin, J. (2001). NASPE Policy Statement. Consensus statement on indications, guidelines for use, and recommendations for follow-up of implantable cardioverter defibrillators. *Journal of Pacing and Clinical Electrophysiology*, 24(2), 262-269. Supports indications for ICD-therapy and chronic assessment frequency for ICDs.

**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 include representatives from the Florida Chapter of the American College of Cardiology.

**Start Date of Comment Period**

N/A

**End Date of Comment Period**

N/A

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number:	3
Start Date of Comment Period	N/A
Start Date of Notice Period	08/01/2002 4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Revised Effective Date:	06/20/2002
Explanation of Revision:	Current information supports monitoring of pacer cardioverter-defibrillators transtelephonically, therefore, the noncoverage statements were deleted.
Revision Number:	2
Start Date of Comment Period	N/A
Start Date of Notice Period	05/01/2002 3 <sup>rd</sup> Qtr 2002 <i>Bulletin</i>
Revised Effective Date:	03/29/2002
Explanation of Revision:	Type of Bill codes 12x, 14x, 21x and 85x were added.
Revision Number:	1
Start Date of Comment Period	N/A
Start Date of Notice Period	02/01/2002 2 <sup>nd</sup> Qtr 2002 <i>Bulletin</i>
Revised Effective Date:	01/01/2002
Explanation of Revision:	Annual 2002 HCPCS Update
Revision Number:	Original
Start Date of Comment Period	11/15/2000
Start Date of Notice Period	02/01/2001 2 <sup>nd</sup> Qtr 2001 <i>Bulletin</i>
Original Effective Date:	03/15/2001 ❖

**93784: Ambulatory Blood Pressure Monitoring (ABPM)**

**Policy Number**

93784

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Ambulatory Blood Pressure Monitoring (ABPM)

**AMA CPT Copyright Statement**

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**CMS National Coverage Policy**

Coverage Issues Manual, Section 50-42  
Program Memorandum Transmittal AB-01-188  
(Change Request 1985, dated December 18, 2001)

**Primary Geographic Jurisdiction**

Florida

**Secondary Geographic Jurisdiction**

N/A

**CMS Region**

Region IV

**CMS Consortium**

Southern

**Original Policy Effective Date**

09/23/2002

**Original Policy Ending Date**

N/A

**Revision Effective Date**

N/A

**Revision Ending Date**

N/A

**LMRP Description**

Ambulatory Blood Pressure Monitoring (ABPM) involves the use of a FDA approved, non-invasive device, which is used to measure blood pressure in 24-hour cycles. These 24-hour measurements are stored in the device and are later interpreted at the physician's office. ABPM must be performed for 24 hours to meet coverage criteria.

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

Ambulatory blood pressure monitoring is covered by Medicare (effective for services furnished on or after April 1, 2002) for beneficiaries with suspected "white coat hypertension".

"White coat hypertension" is defined as:

- Office blood pressure >140/90 mmHg on at least three separate clinic/office visits with two separate measurements made at each visit;

- At least two documented separate blood pressure measurements taken outside the office which are <140/90 mmHg; and
- No evidence of end-organ damage.

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

**CPT/HCPCS Section & Benefit Category**

Medicine/Cardiovascular

**Type of Bill Code**

Hospital – 13x, 14x

Skilled Nursing Facility – 23x

Comprehensive Outpatient Rehabilitation Facility – 75x

Critical Access Hospital – 85x

**Revenue Codes**

920

Other Diagnostic Services

96x, 97x, 98x

Professional Fees

**CPT/HCPCS Codes**

- 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report*
- 93786 *recording only*
- 93788\* *scanning analysis with report*
- 93790 *physician review with interpretation and report*

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

**Not Otherwise Classified Codes (NOC)**

N/A

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

796.2 Elevated blood pressure reading without diagnosis of hypertension ("white coat hypertension")

**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.

Testing on an institutionalized beneficiary will be denied.

Any testing period less than 24 hours will be denied.

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



93784: Ambulatory Blood Pressure Monitoring (ABPM) (continued)

**Noncovered ICD-9-CM Codes**

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

**Noncovered Diagnosis**

N/A

**Coding Guidelines**

The applicable revenue code for the test procedure is 920 except for Critical Access Hospitals (CAHs). CAHs report these procedures under revenue codes 96x, 97x or 98x.

**Documentation Requirements**

Medical record documentation (e.g., office/progress notes) maintained by the ordering/referring physician must indicate the medical necessity for assessment of suspected “white coat hypertension”.

This includes documentation of:

1. Office blood pressure >140/90 on at least three separate clinic/office visits **with two separate measurements made at each visit**;
2. At least two documented separate blood pressure measurements taken **outside the office** which are <140/90 mmHg; and
3. No evidence of end-organ damage (e.g., central nervous system, renal, cardiac)

Additionally, a copy of the Ambulatory Blood Pressure Monitoring report, with the physician’s signature, must be maintained in the medical record.

**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**

Owens, P. Atkins, N, O’Brien, E., (1999). Diagnosis of white coat hypertension by ambulatory blood pressure monitoring. *Hypertension*, 34 (2), 267-272. This source was used to support the indications for this service.

**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 include representatives from numerous societies.

**Start Date of Comment Period**

05/10/2002

**End Date of Comment Period**

06/24/2002

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number:	Original
Start Date of Comment Period:	05/10/2002
Start Date of Notice Period:	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Original Effective Date	09/23/2002 ❖

**95250: Continuous Glucose Monitoring System (CGMS)**

**Policy Number**

95250

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Continuous Glucose Monitoring System (CGMS)

**AMA CPT Copyright Statement**

CPT codes, descriptions, and other data only are copyright 2001 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply.

**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**

09/23/2002

**Original Policy Ending Date**

N/A

**Revision Effective Date**

N/A

**Revision Ending Date**

N/A

**LMRP Description**

The Continuous Glucose Monitoring System (CGMS) is a sensor system that is designed to continuously and automatically monitor interstitial glucose values in subcutaneous tissue. This information is intended to supplement, not replace blood glucose information obtained using standard home glucose monitoring devices. The monitor records glucose values every five minutes, and should be worn for a maximum of three days. The information is downloaded and may be reviewed in both graphical and tabular formats. This information allows identification of patterns of glucose level excursions above or below the desired range, facilitating therapy adjustments, which may minimize these excursions.

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

Florida Medicare will cover the CGMS for the following patients:

Type I or Type II diabetics who have:

- Been instructed by a health care professional in the management of diabetes, and
- Documented frequency of glucose self-testing an average of at least 4 times per day during the previous month, and
- Been on a program of multiple daily injections of insulin (at least 2 injections per day) with self-adjustment of their insulin dose based on self-testing results, and
- Met one or more of the following criteria while on the multiple daily injection regime:
  - Glycated hemoglobin (Hgb A1C) values <4 or >9
  - Unexplained large fluctuations in daily glucose values before meals
  - Unexplained frequent hypoglycemic attacks
  - Episodes of ketoacidosis or hospitalizations for uncontrolled glucose levels.

Type I diabetics with an implanted insulin pump who have:

- Been instructed by a health care professional in the management of diabetes, and
- Documented frequency of glucose self-testing an average of at least 4 times per day during the previous month, and
- Met one or more of the following criteria since enrollment in the Medicare Program:
  - Glycated hemoglobin (Hgb A1C) values <4 or >9
  - Unexplained large fluctuations in daily glucose values before meals
  - Unexplained frequent hypoglycemic attacks
  - Episodes of ketoacidosis or hospitalizations for uncontrolled glucose levels.

Type I or Type II diabetic woman who is newly pregnant or a woman who has developed gestational diabetes that requires insulin therapy.

For Medicare purposes, continuous glucose monitoring must be performed for a minimum of 24 hours to effectively show glucose trends. The recommended monitoring period is 72 hours. Monitoring for less than 24 hours is not considered medically reasonable or necessary.

**CPT/HCPCS Section & Benefit Category**

Medicine/Endocrinology

**Type of Bill Code**

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

**Revenue Codes**

30x Laboratory

**CPT/HCPCS Codes**

95250 *Glucose monitoring for up to 72 hours by continuous recording and storage of glucose values from interstitial tissue fluid via a subcutaneous sensor (includes hook-up,*

**95250: Continuous Glucose Monitoring System (CGMS) (continued)**

*calibration, patient initiation and training, recording, disconnection, downloading with printout of data)*

250.82

Diabetes with other specified manifestations, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled

**Not Otherwise Classified Codes (NOC)**

N/A

250.83

Diabetes with other specified manifestations, type I [insulin dependent type] [IDDM] [juvenile type], uncontrolled

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

648.03

Diabetes mellitus in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication

250.02 Diabetes mellitus without mention of complication, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled

648.83

Abnormal glucose tolerance in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication (gestational diabetes)

250.03 Diabetes mellitus without mention of complication, type I [insulin dependent type] [IDDM] [juvenile type], uncontrolled

250.12 Diabetes with ketoacidosis, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled

**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

250.13 Diabetes with ketoacidosis, type I [insulin dependent type] [IDDM] [juvenile type], uncontrolled

250.22 Diabetes with hyperosmolarity, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled

**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.

The use of this code is intended for one-time or occasional use. Frequent use of continuous glucose monitoring will be denied as not reasonable and necessary.

Monitoring for less than 24 hours is not considered medically reasonable or necessary and therefore, will be denied.

250.23 Diabetes with hyperosmolarity, type I [insulin dependent type] [IDDM] [juvenile type], uncontrolled

250.42 Diabetes with renal manifestations, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled

**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**

Procedure code 95250 does not include reimbursement for data interpretation. The interpretation of this testing should be included in the evaluation and management services rendered to the patient at the time that the results are presented and the treatment options are discussed.

It is not appropriate to report code 95250 in conjunction with 99091 (Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time).

250.43 Diabetes with renal manifestations, type I [insulin dependent type] [IDDM] [juvenile type], uncontrolled

250.52 Diabetes with ophthalmic manifestations, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled

250.53 Diabetes with ophthalmic manifestations, type I [insulin dependent type] [IDDM] [juvenile type], uncontrolled

250.62 Diabetes with neurological manifestations, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled

250.63 Diabetes with neurological manifestations, type I [insulin dependent type] [IDDM] [juvenile type], uncontrolled

250.72 Diabetes with peripheral circulatory disorders, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled

250.73 Diabetes with peripheral circulatory disorders, type I [insulin dependent type] [IDDM] [juvenile type], uncontrolled

95250: Continuous Glucose Monitoring System (CGMS) (continued)

**Documentation Requirements**

Medical record documentation must substantiate the criteria listed in the “Indications and Limitations of Coverage and/or Medical Necessity” section of this policy. This information may be included in the office progress notes, hospital records and/or lab results section of the medical record.

**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**

The CGMS is intended for occasional rather than everyday use, and is to be used as a supplement to, and not a replacement for standard invasive measurements.

Testing must be performed on a device that is FDA approved for continuous glucose monitoring

**Sources of Information and Basis for Decision**

American Medical Association. (2001). *CPT® 2002 changes: An insider’s view*. Chicago: American Medical Association. This reference further explains procedure code 95250.

Bolinder, J., & Ungerstedt, U. (1993). Long-term continuous glucose monitoring with microdialysis in ambulatory insulin-dependent diabetic patients. *Lancet*, 342(8879), 1080-1086. This study verified the efficacy of continuous ambulatory glucose monitoring.

Boland, E., Monsod, T., Delucia, M., Brandt, C., Fernando, S., & Tamborlane, W. (2001). Limitations of conventional methods of self-monitoring of blood glucose. *Diabetes Care*, 24(11), 1858-1862. This article supports the use of this device in diabetic regimens.

Food and Drug Administration. (February 26, 1999). Summary Minutes of the Clinical Chemistry and Clinical Toxicology Devices Panel Meeting, Open Session. Retrieved March 20, 2002 from the World Wide Web: *www.fda.gov*. These document summarized the approval process for the device.

Food and Drug Administration. (February 26, 1999). Summary of Safety and Effectiveness Data. Retrieved March 20, 2002 from the World Wide Web: *www.fda.gov*. These document summarized the indications for use.

Jungheim, K., Koschinsky, T., Wientjes, K., Schoonen, A., Heinemann, L., & Lodwig, V. (2001). Subcutaneous continuous glucose monitoring. *Diabetes Care*, 46(9), 1696-1697. This article supports the efficacy of the device.

Kaufman, F. R., Gibson, L.C., Halvorson, M., Carpenter, S., Fisher, L.K., & Pitukcheewanont, P. (2001). A pilot study of the continuous glucose monitoring system. *Diabetes Care*, 24(12), 2030-2035. This article supports the use of this device to impact glycemic outcomes.

MiniMed®, Inc. (1999). Minimed® Continuous Glucose Monitoring System, Monitor Instructions For Use. Sylmar, CA. This information provided a description of the device and outlined the capabilities of the system.

**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 include representatives from numerous societies.

**Start Date of Comment Period**

05/10/2002

**End Date of Comment Period**

06/24/2002

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number:	Original
Start Date of Comment Period:	05/10/2002
Start Date of Notice Period:	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Original Effective Date	09/23/2002 ❖



**A0425: Ground Ambulance Services**

*Revision Overview: Several sections of the policy have been revised to incorporate guideline changes based on the ambulance initiative effective April 1, 2002.*

**Policy Number**

A0425

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Ground Ambulance Services

**AMA CPT Copyright Statement**

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**CMS National Coverage Policy**

Medicare Hospital Manual, Sections 236, 279, 433  
Intermediary Manual, Sections 3114, 3322, 3660.1  
Skilled Nursing Facility Manual, Section 539  
Program Memorandum B-00-09 (Change Request 1065)  
Program Memorandum, AB-01-165 (Change Request 1555)  
Program Memorandum, AB-02-036 (Change Request 2047)

**Primary Geographic Jurisdiction**

Florida

**Secondary Geographic Jurisdiction**

N/A

**CMS Region**

Region IV

**CMS Consortium**

Southern

**Original Policy Effective Date**

07/17/2000

**Original Policy Ending Date**

N/A

**Revision Effective Date**

04/01/2002

**Revision Ending Date**

03/31/2002

**LMRP Description**

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

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

The transportation must be medically reasonable and necessary as outlined in the Medicare Intermediary Manual. This requires that other means of transportation be medically contraindicated, in other words, that the patient cannot be safely transported by any other means.

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

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

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

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

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

- The patient’s condition necessitated emergency care and resulted from an acute injury or illness in which the patient was left in an unstable condition. Examples include a patient that has had a major bone compound fracture where bleeding and signs of shock are present, a patient who has suffered a serious cardiac event where blood pressure and pulse are unstable, and a patient who has suffered multiple trauma, and a spinal cord injury is suspected.
- The patient needed to be restrained to prevent injury to himself or others (e.g., combative, abusive, convulsive).
- The patient was unconscious, unable to respond to stimuli.
- The patient was in shock as evidenced by some of the following signs and symptoms secondary to the patient’s condition: blood pressure of less than 90/60, pulse >100 or <45, respirations greater than 24, significant changes in mental status, cold and/or cyanotic skin, excessive perspiration.
- Emergency measures or treatment were required (e.g., administration of emergency drugs, cardiopulmonary resuscitation, continuous cardiac monitoring).

**A0425: Ground Ambulance Services (continued)**

- The patient required IV fluids to maintain adequate blood pressure (e.g., dehydration, bleeding, cardiac arrhythmias, etc.) or an access line was established to administer emergency medication(s).
- The patient's acute condition required oxygen as part of the emergency treatment procedures enroute to destination (this does not include patients who already require oxygen therapy on an ongoing basis to manage an existing condition).
- The patient required immobilization to prevent further injury of a fracture or possible fracture or was in a condition that movement by any other means of transportation would potentially make the condition worse.
- The patient has sustained an acute stroke or myocardial infarction (this does not include patients who have a history of stroke or myocardial infarction and are able to be transported by other means because no acute medical condition exists).
- The patient was experiencing symptoms indicative of a possible myocardial infarction or stroke.
- The patient has or was experiencing a severe hemorrhage.
- The patient is bed confined (definition of bed confined must be met).

**Bed Confined**

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

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

**Certification**

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

**CPT/HCPCS Section & Benefit Category**

Ambulance

**Type of Bill Code**

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

**Revenue Codes**

540 Ambulance, General Classification

**CPT/HCPCS Codes**

- A0425 Ground mileage, per statute mile
- A0426 Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)
- A0427 Ambulance service, advanced life support, emergency transport, level 1 (ALS 1-emergency)
- A0428 Ambulance service, basic life support, non-emergency transport (BLS)
- A0429 Ambulance service, basic life support, emergency transport (BLS-emergency)
- A0433 Advanced life support, level 2 (ALS 2)
- A0434 Specialty care transport (SCT)
- Q3019 Ambulance service, advance life support (ALS) vehicle used, emergency transport, no ALS level service furnished
- Q3020 Ambulance service, advance life support (ALS) vehicle used, non-emergency transport, no ALS level service furnished

**Not Otherwise Classified Codes (NOC)**

N/A

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

- 250.20-250.23 Diabetes with hyperosmolarity (severe diabetic complication)
- 250.30-250.33 Diabetes with other coma
- 251.0 Hypoglycemic coma
- 255.4 Corticoadrenal insufficiency
- 293.0 Acute delirium
- 298.8 Other and unspecified reactive psychosis (psychosis requiring restraints)
- 345.3 Grand mal status
- 410.00-410.92 Acute myocardial infarction
- 411.0-411.89 Other acute and subacute forms of ischemic heart disease
- 413.0-413.9 Angina pectoris
- 414.10-414.19 Aneurysm of heart
- 415.11-415.19 Pulmonary embolism and infarction
- 426.0-426.9 Conduction disorders
- 427.0-427.9 Cardiac dysrhythmias
- 428.0-428.9 Heart failure (severe)
- 430-434.91, 436 Cerebrovascular disease (severe cerebral vascular problems)
- 441.00-441.9 Aortic aneurysm and dissection
- 442.0-442.9 Other aneurysm
- 493.01, 493.11, 493.21, 493.91 Asthma with status asthmaticus
- 518.0 Pulmonary collapse
- 518.4 Acute edema of lung, unspecified
- 518.5 Pulmonary insufficiency following trauma and surgery
- 518.81 Acute respiratory failure

**A0425: Ground Ambulance Services (continued)**

518.82 Other pulmonary insufficiency, not elsewhere classified

519.00-519.09 Tracheostomy complications

531.00-531.21, Diseases of esophagus, stomach, and duodenum (severe gastrointestinal complication)

531.40-531.61, 532.00-532.21, 532.40-532.61, 533.00-533.21, 533.40-533.61, 534.00-534.21, 534.40-534.61, 535.01, 535.11, 535.21, 535.31, 535.41, 535.51, 535.61

578.9 Hemorrhage of gastrointestinal tract, unspecified

669.10-669.14 Shock during or following labor and delivery

669.90-669.94 Unspecified complication of labor and delivery

719.49 Pain in joint, multiple sites (severe joint pain causing immobility)

780.01 Coma

780.2 Syncope and collapse

780.31-780.39 Convulsions

785.50-785.59 Shock without mention of trauma

786.09 Other symptoms involving respiratory system and other chest symptoms (severe respiratory distress)

786.50-786.59 Chest pain

789.00-789.09 Abdominal pain (severe)

799.0 Asphyxia

799.1 Respiratory arrest

800.00-804.99 Fracture of skull

805.00-809.1 Fracture of neck and trunk

820.00-823.92 Fracture of femur, patella, tibia, and fibula

835.00-835.13 Dislocation of hip

850.1-854.19 Intracranial injury, excluding those with skull fracture

860.0-869.1 Internal injury of thorax, abdomen, and pelvis

871.0-871.9 Open wound of eyeball

925.1-929.9 Crushing injury

948.00-948.99 Burns classified according to extent of body surface involved

952.00-952.9 Spinal cord injury without evidence of spinal bone injury

958.4 Traumatic shock

959.01-959.3, 959.6-959.8 Injury, other and unspecified (severe injuries to include those with open fractures, unstable fractures where movement could result in further injury, moderate to heavy bleeding, traumatic amputations, incapacitating pain)

960.0-979.9 Poisoning by drugs, medicinal, and biological substances

980.0-989.9 Toxic effects of substances chiefly nonmedicinal as to source

991.6 Hypothermia (severe with decreased level of consciousness)

993.3 Caisson disease

994.0 Effects of lightening

994.1 Drowning and nonfatal submersion

994.7 Asphyxiation and strangulation

994.8 Electrocution and nonfatal effects of electric current

995.0 Other anaphylactic shock

995.60-995.69 Anaphylactic shock due to adverse food reaction

999.4 Anaphylactic shock due to serum

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

**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**

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

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**

Origin and destination modifiers are to be used with codes A0425-A0434 and Q3019-Q3020. The first position alpha code equals origin and the second position alpha code equals destination. The origin and destination codes are:

**A0425: Ground Ambulance Services (continued)**

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

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

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

The charges for mileage must be coded on a “loaded” basis (i.e. from the pick up of the patient to his/her destination). Separate charges for “unloaded” mileage should not be coded. Charges for unloaded mileage will be denied.

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

**Documentation Requirements**

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

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

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

**Utilization Guidelines**

N/A

**Other Comments**

**Terms defined:**

**Basic Life Support (BLS)** – Basic life support (BLS) means transportation by ground ambulance vehicle and

medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician-basic (EMT-Basic). These laws may vary from State to State. For example, only in some States is an EMT-Basic permitted to operate limited equipment on board the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral intravenous (IV) line.

**Basic Life Support (BLS)** – Emergency – The Basic Life Support – Emergency category is the provision of BLS services, as specified above, in the context of an emergency response.

Emergency response means responding immediately at the BLS or ALS 1 level of service to a 911 call or the equivalent in areas without a 911-call system. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

**Advanced Life Support, Level 1 (ALS 1)** – Advanced life support, level 1, (ALS 1) means transportation by ground ambulance, medically necessary supplies and services and an ALS assessment by ALS personnel or the provision of at least one ALS intervention.

Advanced life support assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient’s reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires and ALS level of service.

Advanced life support intervention means a procedure that is, in accordance with State and local laws, beyond the scope of authority of an emergency medical technician-basic (EMT-Basic).

Advanced life support personnel means an individual trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic. The EMT-Intermediate is defined as an individual who is qualified, in accordance with State and local laws, as an EMT-Basic and who is also qualified in accordance with State and local laws to perform essential advanced techniques and to administer a limited number of medications. The EMT-Paramedic is defined as possessing the qualifications of the EMT-Intermediate and also, in accordance with State and local laws, as having enhanced skills that include being able to administer additional interventions and medications.

**Advanced Life Support, Level 1 (ALS 1)** – Emergency – The Advanced Life Support, Level 1 – Emergency Response category is defined as the provision of ALS 1 services as specified above, in the context of an emergency response.

Emergency response means responding immediately at the BLS or ALS 1 level of service to a 911 call or the equivalent in areas without a 911 system. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.



**A0425: Ground Ambulance Services (continued)**

**Advanced Life Support, Level 2 (ALS 2)** – The Advanced Life Support, Level 2 category is:

1. Three or more different administrations of medications by intravenous push/bolus or by continuous infusion excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer’s Lactate), and transportation, medically necessary supplies and services, or
2. The provision of at least one of the following ALS procedures:
  - Manual defibrillation/cardioversion
  - Endotracheal intubation
  - Central venous line
  - Cardiac pacing
  - Chest decompression
  - Surgical airway
  - Intraosseous line.

**Specialty Care Transport (SCT)** – When medically necessary, for a critically injured or ill beneficiary, a level of inter-facility service provided by a ground ambulance vehicle, including medically necessary supplies, that is at a level of service beyond the scope of the EMT-paramedic. SCT is necessary when a beneficiary’s condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area (for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training).

**Sources of Information and Basis for Decision**

N/A

**Advisory Committee Notes**

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

**Start Date of Comment Period**

N/A

**End Date of Comment Period**

N/A

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number	3
Start Date of Comment Period	N/A
Start Date of Notice Period	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Revised Effective Date	04/01/2002
Explanation of Revision:	This policy is being revised to reflect the information in Program Memorandums AB-01-165 and AB-02-036.
Revision Number	2
Start Date of Comment Period	N/A
Start Date of Notice Period	02/01/2001
	2 <sup>nd</sup> Qtr 2001 <i>Bulletin</i>
Revised Effective Date	01/01/2001
Explanation of Revision:	The information under “Documentation Requirements” regarding the submission of trip sheets or a narrative statement on an EMC claim does not apply to ambulance providers billing to the Intermediary. Therefore, the entire paragraph was deleted.
Revision Number	1
Start Date of Comment Period	N/A
Start Date of Notice Period	02/01/2001
	2 <sup>nd</sup> Qtr 2001 <i>Bulletin</i>
Revised Effective Date	01/01/2001
Explanation of Revision:	Based on Program Memorandum AB-00-88 and AB-00-118, new HCPCS codes replace existing codes, except the mileage codes which will be used until further notice. In addition, a revision was made to the certification required for ambulance providers.
Revision Number	Original
Start Date of Comment Period:	02/21/2000
Start Date of Notice Period:	06/01/2000
	June/July 2002 <i>Bulletin</i>
Original Effective Date	07/17/2000 ❖

**G0245: Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes**

**Policy Number**

G0245

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes

**AMA CPT Copyright Statement**

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**CMS National Coverage Policy**

Coverage Issues Manual, Section 50-8.1  
Memorandum AB-02-042, (Change Request 2060, dated April 01, 2002, and Change Request 2296, dated July 17, 2002)

**Primary Geographic Jurisdiction**

Florida

**Secondary Geographic Jurisdiction**

N/A

**CMS Region**

Region IV

**CMS Consortium**

Southern

**Original Policy Effective Date**

07/01/2002

**Original Policy Ending Date**

N/A

**Revision Effective Date**

N/A

**Revision Ending Date**

N/A

**LMRP Description**

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.

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

Peripheral neuropathy with LOPS, secondary to diabetes, is a localized illness of the feet. 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 01, 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 National Institute of Diabetes and Digestive and Kidney Diseases 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.

**CPT/HCPCS Section & Benefit Category**

Procedures / Professional Services

**Type of Bill Code**

Hospital – 13x  
Outpatient Rehab Facility – 74x  
Comprehensive Outpatient Rehabilitation Facility – 75x  
Critical Access Hospital – 85x

**Revenue Codes**

510 Clinic (General Classification)  
940 Other Therapeutic Services (General Classification)

**CPT/HCPCS Codes**

G0245 Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include:  
1. the diagnosis of LOPS;  
2. a patient history;  
3. a physical examination that consists of at least the following elements:  
(a) visual inspection of the forefoot, hindfoot, and toe web spaces,  
(b) evaluation of a protective sensation,  
(c) evaluation of foot structure and biomechanics,

**G0245: Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes (continued)**

- (d) evaluation of vascular status and skin integrity,
- (e) evaluation and recommendation of footwear, and
- 4. patient education.

- G0246 Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following:
1. a patient history;
  2. a physical examination that includes:
    - (a) visual inspection of the forefoot, hindfoot, and toe web spaces,
    - (b) evaluation of protective sensation,
    - (c) evaluation of foot structure and biomechanics,
    - (d) evaluation of vascular status and skin integrity,
    - (e) evaluation and recommendation of footwear, and
  3. patient education.
- G0247 Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include if present, at least the following:
- (1) local care of superficial wounds,
  - (2) debridement of corns and calluses, and
  - (3) trimming and debridement of nails.

**Not Otherwise Classified Codes (NOC)**

N/A

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

- |        |   |
|--------|---|
| 250.60 | Diabetes with neurological manifestations, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, not stated as uncontrolled |
| 250.61 | Diabetes with neurological manifestations, type I [insulin dependent type] [IDDM] [juvenile type], not stated as uncontrolled                                   |
| 250.62 | Diabetes with neurological manifestations, type II [non-insulin dependent type] [NIDDM type] [adult onset type] or unspecified type, uncontrolled               |
| 250.63 | Diabetes with neurological manifestations, type I [insulin dependent type] [IDDM] [juvenile type], uncontrolled   |
| 357.2  | Polyneuropathy in diabetes  |

**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**

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

The applicable revenue code is 940, except for hospitals. Hospitals should bill under revenue code 510.

**Documentation Requirements**

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

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

**Utilization Guidelines**

Each physician or physician group, of which that physician is a member, may only receive reimbursement once for G0245 for each beneficiary. However, should that beneficiary need to see a new physician, that new physician may also be reimbursed once for G0245 for that beneficiary as long as it has been at least six months from the last time G0245 or G0246 was paid for the beneficiary, regardless of who provided the service.

**Other Comments**

N/A

**Sources of Information and Basis for Decision**

N/A

**Advisory Committee Notes**

N/A

**Start Date of Comment Period**

N/A

**End Date of Comment Period**

N/A

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number	Original
Start Date of Comment Period:	N/A
Start Date of Notice Period:	08/01/2002
	4th Qtr 2002 <i>Bulletin</i>
Original Effective Date	07/01/2002 ❖

**G0248: Home Prothrombin Time International Normalized Ratio (INR)**

**Monitoring**

**Policy Number**

G0248

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Home Prothrombin Time International Normalized Ratio (INR) Monitoring

**AMA CPT Copyright Statement**

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**CMS National Coverage Policy**

Coverage Issues Manual, Section 50-56  
Program Memorandum AB-02-064 (Change Request 2071, dated 05/02/02)

**Primary Geographic Jurisdiction**

Florida

**Secondary Geographic Jurisdiction**

N/A

**CMS Region**

Region IV

**CMS Consortium**

Southern

**Original Policy Effective Date**

07/01/2002

**Original Policy Ending Date**

N/A

**Revision Effective Date**

N/A

**Revision Ending Date**

N/A

**LMRP Description**

Warfarin is the oral anticoagulant most frequently used to control and prevent thromboembolic disorders. The goal of anticoagulant therapy is to administer the lowest possible dose of anticoagulant to prevent clot formation or expansion. The required degree of anticoagulation continues to evolve as studies provide more information about the efficacy and safety of lower doses. The prothrombin time (PT) is the primary assay used in monitoring warfarin therapy. The standardized use of the International Normalized Ratio (INR) allows physicians to determine the level of anticoagulation in a patient independent of the laboratory reagents used. The INR is the ratio of the patient's population time compared to the mean prothrombin time for a group of normal individuals. The current therapeutic INR

goal for patients with mechanical prosthetic heart valves is 2.5-3.5.

The monitoring of patient's INR level to maintain patients within the therapeutic range is accomplished in a physician's office, anticoagulant clinics, or home monitoring. Patient self-testing and self-management through the use of a home INR monitor may be used to improve the time in therapeutic rate for a select group of patients. This policy addresses coverage of home monitoring of INR levels.

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

Effective for services performed on or after July 1, 2002, Medicare will cover the use of home prothrombin time INR monitoring for anticoagulation management for patients with mechanical heart valves on warfarin. The monitor and the home testing must be prescribed by a physician and the following patient requirements must be met:

- Must have been anticoagulated for at least three months prior to use of the home INR device;
- Must undergo an educational program on anticoagulation management and the use of the device prior to its use in the home; and
- Self-testing with the device is limited to a frequency of once per week.

**Note:** Porcine valves are not covered so Medicare will not make payment on home INR monitoring for patients with porcine valves.

**CPT/HCPCS Section & Benefit Category**

Pathology and Laboratory/Hematology and Coagulation

**Type of Bill Code**

Hospital – 13x  
Critical Access Hospital – 85x

**Revenue Codes**

920 Other Diagnostic Services, General Classification  
Revenue center where services are performed

**CPT/HCPCS Codes**

- G0248 Demonstration, at initial use, of home INR monitoring for patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician; includes: demonstration use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results and documentation of a patient ability to perform testing.
- G0249 Provision of test materials and equipment for home INR monitoring to patient with mechanical valve(s) who meets Medicare coverage criteria. Includes provision of materials for use in the home and reporting of test results to physician; per 4 tests.

**Not Otherwise Classified Codes (NOC)**

N/A



**G0248: Home Prothrombin Time International Normalized Ratio (INR) Monitoring (continued)**

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

V43.3 Organ or tissue replaced by other means, heart valve

**Diagnoses that Support Medical Necessity**  
N/A

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

**Diagnoses that DO NOT Support Medical Necessity**  
N/A

**Reasons for Denials**

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

**Noncovered ICD-9-CM Codes**

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

**Noncovered Diagnosis**  
N/A

**Coding Guidelines**

The cost of the device and supplies are included in the payment for G0249, therefore, are not separately billable to Medicare.

Hospitals may report these services under revenue code 920 or may report codes G0248 and G0249 under the revenue center where they are performed.

**Documentation Requirements**

Medical record documentation maintained in the patient’s file must support that the coverage requirements are met. In addition, the documentation must support that the procedure was performed. This information is normally found in the office/progress notes, hospital records, and test results.

**Utilization Guidelines**  
N/A

**Other Comments**  
N/A

**Sources of Information and Basis for Decision**

Horton, J. D., & Bushwick, B. M. (1999). Warfarin therapy: Evolving strategies in anticoagulation. *American Family Physician*, 59(3), 635-646. Used in the description of the service.

**Advisory Committee Notes**  
N/A

**Start Date of Comment Period**  
N/A

**End Date of Comment Period**  
N/A

**Start Date of Notice Period**  
08/01/2002

**Revision History**

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Original Effective Date	07/01/2002 ❖

**J0587: Botulinum Toxin Type B (Myobloc™)**

**Policy Number**

J0587

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Botulinum Toxin Type B (Myobloc™)

**AMA CPT Copyright Statement**

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**CMS National Coverage Policy**

Medicare Intermediary Manual, Sections 3101.3 and 3112.4

Program Memorandum A-02-026 (Change Request 2102, dated 03/28/2002)

**Primary Geographic Jurisdiction**

Florida

**Secondary Geographic Jurisdiction**

N/A

**CMS Region**

Region IV

**CMS Consortium**

Southern

**Original Policy Effective Date**

09/23/2002

**Original Policy Ending Date**

N/A

**Revision Effective Date**

N/A

**Revision Ending Date**

N/A

**LMRP Description**

Botulinum toxin type B (Myobloc™) is an injectable neurotoxin that is produced by fermentation of the bacterium *Clostridium botulinum* type B. Myobloc™ acts at the neuromuscular junction to produce flaccid paralysis, thereby reducing the severity of abnormal head position and neck pain associated with cervical dystonia.

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

Florida Medicare will consider botulinum toxin type B (Myobloc™) medically reasonable and necessary when provided for its Food and Drug Administration (FDA) approved use for treatment of cervical dystonia. Myobloc™ is indicated and approved to reduce the severity of abnormal head position and neck pain associated with cervical dystonia.

**CPT/HCPCS Section & Benefit Category**

Drugs and Biologicals

**Type of Bill Code**

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

**Revenue Codes**

636 Drugs Requiring Detailed Coding

**CPT/HCPCS Codes**

J0587 Botulinum Toxin Type B (Myobloc™), per 100 units

**Not Otherwise Classified Codes (NOC)**

N/A

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

333.83 Spasmodic torticollis (cervical dystonia)  
723.5 Torticollis, unspecified

**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.

Treatment of wrinkles using botulinum toxin type B (Myobloc™) is considered to be cosmetic and is not covered.

**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**

Botulinum Toxin Type B (Myobloc™) injection should be billed by the outpatient hospital with revenue code 636 and HCPCS code J0587.

When billing for injections of botulinum toxin type B (Myobloc™) for covered conditions/diagnoses, the following guidelines should be used. Failure to report this procedure according to these guidelines may result in a denial of a claim.

When reporting HCPCS code J0587, botulinum toxin type B (Myobloc™), a detailed description of the procedure must also be submitted with the claim before consideration for payment may be made.

To bill medically necessary electromyography guidance, in addition to botulinum toxin type B (Myobloc™), report the following procedure code(s):

J0587: *Botulinum Toxin Type B (Myobloc™)* (continued)

CPT Code	Descriptor	Corresponding Chemodenervation/Injection Code
95860	Needle electromyography, one extremity with or without related paraspinal areas	64614
95861	Needle electromyography, two extremities with or without related paraspinal areas	64614
95867	Needle electromyography, cranial nerve supplied muscles, unilateral	31513, 31570, 31571, 64612, 64613
95868	Needle electromyography, cranial nerve supplied muscles, bilateral	31513, 31570, 31571, 64612, 64613
95869	Needle electromyography; thoracic paraspinal muscles	64614
95870	Needle electromyography; limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters	64613, 64614, 64640

Due to the short shelf life of the botulinum toxin type B (Myobloc™), Medicare will reimburse the unused portion of this drug only when the vial is not split between patients. The exact dosage of the drug given and the exact amount of the discarded portion of the drug must be documented in the patient's medical record.

Scheduling of more than one patient is encouraged to prevent wastage of botulinum toxin type B (Myobloc™).

**Documentation Requirements**

Medical record documentation maintained by the ordering/referring physician must substantiate the medical need for the use of this drug by clearly indicating the condition for which this drug is being used. This documentation is usually found in the history and physical or in the office/progress notes.

**Utilization Guidelines**

N/A

**Other Comments**

N/A

**Sources of Information and Basis for Decision**

OBGYN net BOOKSTORE Website. (January 13, 2001). *Botulinum toxin type B injectable solution approved by FDA*. [On-line]. Available: <http://www.obgyn.net/newsrx/womens-health-Cervical-Dystonia-2001011.3-8.asp>. This article was used in the evaluation of the FDA approved indications as well as specifics about the drug. Myobloc™ Package Insert. (2001). Elan Pharmaceuticals, Inc. South San Francisco, CA This document was used in the description of indications, definitions, contraindications, dosages, and studies of the drug.

Scaife, M. (2000). *Product approval information*. [On-line]. Available: <http://www.fda.gov/cber/approvltr/botelan1208001.htm> This article was used in the evaluation of medical necessity and uses of the drug.  
 Schwartz, B.A. (2001). *First drug for cervical dystonia*. [On-line]. Available: <http://jama.ama-assn.org/issues/v285n6/ffull/jfd10001-3.html> This document was used in the definition of the FDA approved indication of the drug.  
 Sloop, R.R., Cole, B.A., Escutin, R.O. (1997). Human response to botulinum toxin injection: type B compared with type A. *American Academy of Neurology*, 49(7), 189-194. Lippincott & Williams: CA. This article was used to compare the two types of botulinum toxin drugs.

**Advisory Committee Notes**

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

**Start Date of Comment Period**

08/17/2001

**End Date of Comment Period**

10/01/2001

**Start Date of Notice Period**

08/01/2002

**Revision History**

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 Start Date of Comment Period: 08/17/2001  
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 4<sup>th</sup> Qtr 2002 *Bulletin*  
 Original Effective Date 09/23/2002 ❖

**J2820: Sargramostim (GM-CSF, Leukine®)**

**Policy Number**

J2820

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Sargramostim (GM-CSF, Leukine®)

**AMA CPT Copyright Statement**

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**CMS National Coverage Policy**

Medicare Intermediary Manual, Sections 3101.3, 3112.4, 3133.5, 3168, & 3660.11  
Skilled Nursing Facility Manual, Section 230.5

**Primary Geographic Jurisdiction**

Florida

**Secondary Geographic Jurisdiction**

N/A

**CMS Region**

Region IV

**CMS Consortium**

Southern

**Original Policy Effective Date**

09/23/2002

**Original Policy Ending Date**

N/A

**Revision Effective Date**

N/A

**Revision Ending Date**

N/A

**LMRP Description**

Granulocyte Macrophage Colony Stimulating Factor (GM-CSF) is an antineutropenic, hematopoietic growth factor, which supports survival, clonal expansion, and differentiation of hematopoietic progenitor cells. GM-CSF is also capable of activating mature granulocytes and macrophages. This drug is not a cancer chemotherapy agent.

The drug appears to elicit the pharmacologic effects usually produced by endogenous human GM-CSF. Endogenous GM-CSF is a multilineage colony-stimulating factor that principally affects the proliferation, differentiation, and activation of granulocytes and macrophages by inducing partially committed progenitor cells to divide and differentiate in the granulocyte-macrophage pathways.

Endogenous GM-CSF acts on various progenitor target cells by binding to GM-CSF specific receptors on their cell surfaces. Biosynthetic GM-CSF principally affects

cells in the granulocyte-macrophage lineage. In patients receiving low doses of biosynthetic GM-CSF, the leukocyte response is composed principally of neutrophils; at higher concentrations, the leukocyte response also involves proliferation of monocytes and eosinophils.

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

**Indications**

Florida Medicare will consider GM-CSF medically reasonable and necessary for the treatment of the following FDA approved indications when it is not self/caregiver administered:

- Promotion of myeloid engraftment following bone marrow transplant (BMT):
  - For acceleration of myeloid recovery in patients with non-Hodgkin’s lymphomas, acute lymphoblastic leukemia, and Hodgkin’s disease undergoing autologous BMT.
  - For acceleration of myeloid recovery in patients undergoing autologous or allogenic BMT following myeloablative chemotherapy for non-myeloid malignancies.
  - For acceleration of myeloid recovery in patients undergoing allogenic BMT following myeloablative chemotherapy for myeloid malignancies.
  - For treatment of failure or delay of myeloid engraftment following autologous or allogenic BMT, in the presence or absence of infection.
- Enhancement of peripheral blood progenitor cell (PBPC) collection when the bone marrow transplant procedure itself is a covered benefit.
- For acceleration of myeloid recovery in patients undergoing hematopoietic stem cell transplantation following myeloablative chemotherapy.
- To reduce the duration of neutropenia, following induction chemotherapy treatment of adults with acute myelocytic leukemia (AML).

Florida Medicare will consider GM-CSF medically reasonable and necessary for the treatment of the following off-label indications when it is not self/caregiver administered:

- Failure or delay of myeloid engraftment in patients who have undergone autologous or allogenic hematopoietic stem cell transplantation, in the presence or absence of infection.
- To decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe febrile neutropenia.
- Acquired immunodeficiency syndrome (AIDS)-associated neutropenia caused by the disease (AIDS) itself or infection with opportunistic organisms (such as cytomegalovirus), or antiretroviral agents (zidovudine, ganciclovir).
- Intermittent administration of GM-CSF for a subset of patients with Myelodysplastic syndromes (MDS) who have severe neutropenia and recurrent infections.



**J2820: Sargramostim (GM-CSF, Leukine®) (continued)**

**Limitations**

A physician is not to bill Florida Medicare for a supply of GM-CSF given to the patient for self-administration at home.

The following off-labeled uses of GM-CSF have not been shown to be safe and effective and are noncovered by Florida Medicare: aplastic anemia, hairy cell leukemia, severe chronic neutropenia which includes congenital (Kostmann’s syndrome), idiopathic and cyclic.

Treatment of drug-induced neutropenia, except when associated with the use of antiretroviral agents is an off-labeled indication and noncovered by Florida Medicare.

There is no evidence that GM-CSF is an important benefit in patients with refractory or relapsed myeloid leukemia.

Therapeutic initiation of GM-CSF does not add significantly to the antibiotic treatment outcome of established febrile neutropenia.

CSFs should not be routinely used as adjunct therapy for the treatment of uncomplicated fever and neutropenia. Uncomplicated fever and neutropenia are defined as follows:

- Fever of < 10 days in duration, and
- No evidence of pneumonia, cellulitis, abscess, sinusitis, hypotension, multi-organ dysfunction, or invasive fungal infection, *and*
- No uncontrolled malignancies.

There is inadequate data to support the use of GM-CSF for patients with afebrile neutropenia.

GM-CSF is contraindicated in patients with excessive leukemic myeloid blasts in the bone marrow or peripheral blood (> 10%).

In general, for previously untreated patients receiving a chemotherapy regimen, primary prophylactic administration of GM-CSF is not considered medically necessary.

Due to the potential sensitivity of rapidly dividing hematopoietic cells, GM-CSF should not be administered simultaneously with cytotoxic chemotherapy or radiotherapy or within 24 hours preceding or following chemotherapy or radiotherapy.

There is no evidence of benefit from the use of GM-CSF to increase chemotherapy dose-intensity.

**Dosage and Frequency**

The following is the recommended dosage and frequency when administering this drug:

Myelosuppressive chemotherapy - recommended dose is 250 mcg/m<sup>2</sup>/day. Administered no earlier than 24 hours after cytotoxic chemotherapy and not in the 24 hours before administration of chemotherapy.

PBPC - recommended dose is 250 mcg/m<sup>2</sup>/day. For the mobilization phase, this dosing should continue through the period of PBPC collection. For the post transplantation phase, begin the dose immediately and continue until an ANC > 1500 cells/mm<sup>3</sup> for 3 consecutive days is attained.

Myeloid Reconstitution after Autologous or Allogenic BMT - recommended dose following BMT is 250 mcg/m<sup>2</sup>/day. Patients should not receive the drug until the post marrow infusion ANC is less than 500 cells/mm<sup>3</sup>. The drug should be continued until an ANC >1500 cells/mm<sup>3</sup> for 3 consecutive days is attained.

BMT Failure or Engraftment Delay- recommended dose is 250 mcg/m<sup>2</sup>/day. Repeat dosage after 7 days off therapy if engraftment has not occurred. If engraftment still has not occurred, a third course of 500 mcg/ m<sup>2</sup>/day for 14 days may be tried after another 7 days off therapy. If there is still no improvement, it is unlikely that further dose escalation will be beneficial.

If the ANC exceeds 20,000 or the platelet count exceeds 500,000, GM-CSF treatment should be discontinued or the dose reduced by half. Excessive blood counts usually return to normal or baseline levels within 3 to 7 days following withdrawal of GM-CSF.

**CPT/HCPCS Section & Benefit Category**

Drugs and Biologicals

**Type of Bill Code**

Hospital - 13x  
 Skilled Nursing Facility - 21x  
 Critical Access Hospital - 85x

**Revenue Codes**

636 Drugs Requiring Detailed Coding

**CPT/HCPCS Codes**

J2820 Injection, sargramostim (GM-CSF), 50 mcg

**Not Otherwise Classified Codes (NOC)**

N/A

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

238.7	Neoplasm of uncertain behavior of other lymphatic and hematopoietic tissues
288.0	Agranulocytosis
V42.9	Unspecified organ or tissue replaced by transplant
V58.1	Encounter for other and unspecified procedures and aftercare, chemotherapy
V58.69	Long-term (current) use of other medications
V59.8	Donors, other specified organ or tissue

**Note:** Please refer to coding guidelines for specific requirements regarding the billing of each of these codes.

**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.

**J2820: Sargramostim (GM-CSF, Leukine®) (continued)**

**Noncovered Diagnosis**

N/A

**Coding Guidelines**

HCPCS code J2820 is subject to pass-through payment under the Outpatient Prospective Payment System (OPPS). Therefore, hospitals should use the “units” field to report multiples of the dosage identified in the code descriptor. Fractions of the dose specified in the code descriptor may be reported as 1 unit or one additional unit as appropriate.

Claims for GM-CSF should be billed using the following diagnosis codes:

- 238.7 (Neoplasm of uncertain behavior of other lymphatic and hematopoietic tissues) when GM-CSF is used for Myelodysplastic syndrome (MDS).
- 288.0 (Agranulocytosis) when GM-CSF is used for patients with AIDS-associated neutropenia.
- V42.9 (Unspecified organ or tissue replaced by transplant) when GM-CSF is given to stem cell recipients (e.g., BMT).
- V58.1 (Encounter for other and unspecified procedures and aftercare, chemotherapy) when GM-CSF is used for febrile neutropenia resulting from myelosuppressive chemotherapy or following induction or consolidation chemotherapy treatment of adults with AML.
- V58.69 (Long-term [current] use of other medications) when GM-CSF is used for a patient with AZT or Ganciclovir neutropenia.
- V59.8 (Donors, other specified organ or tissue) when GM-CSF is used in priming for autologous peripheral stem cells (e.g., PBPC), as an adjunct to allogeneic and autologous progenitor-cell transplantation, or for neutrophil engraftment failure.

**Documentation Requirements**

Medical record documentation maintained by the physician must clearly indicate:

- The patient’s current absolute neutrophil count (ANC);
- The patient’s weight in kilograms;
- The administration and dosage of the GM-CSF;
- The actual indication for which the drug was given and accompanying symptomology (e.g., fever); **and**
- The patient’s response to the treatment.

This information is usually found in the history and physical or the office/progress notes. The ANC may be reported in the patient’s laboratory report.

**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**

The package insert instructions for dosage and duration of treatment should not be exceeded.

The guidelines recommended for adults are generally applicable to the pediatric age group.

**Terms Defined:**

*Absolute neutrophil count (ANC)* – a lab test done on blood which counts the neutrophils within the blood specimen. It is represented by the total WBC x % segmented neutrophils and bands. Normal ANC is considered 3000-7000/mm<sup>3</sup>.

*Dose-intense chemotherapy* – treatment given at higher doses or on a more frequent schedule than is conventional in an attempt to induce either more complete remissions or a greater cure rate.

*Febrile neutropenia* – generally designated as a temperature of approximately 38.5°C (~101°F) or greater, sustained for more than one hour, and developing concurrently with an ANC < 500/mm<sup>3</sup>.

*GM-CSF primary administration* – the use of GM-CSF before any occurrence of neutropenia or febrile neutropenia that may result from chemotherapy (i.e., beginning in the first cycle of treatment).

*Myeloid* – pertaining to, derived from or resembling bone marrow.

*Neutropenia* – an abnormally small number of neutrophil cells in the blood (an ANC of < 1800/mm<sup>3</sup>).

*Progenitor-cell support* – refers to transplantation of hematopoietic cells derived from either bone marrow or the peripheral blood as a means to increase patient safety and tolerance of treatment when very high doses of chemotherapy are administered to increase remission rates and increase disease-free survival (DFS).

*Severe chronic neutropenia* – ANC less than 500/mm<sup>3</sup>.

**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](http://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 include representatives from numerous societies.

**Start Date of Comment Period**

01/11/2002

**End Date of Comment Period**

02/25/2002

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number:	Original
Start Date of Comment Period:	01/11/2002
Start Date of Notice Period:	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Original Effective Date	09/23/2002 ❖

**J3490: Zoledronic Acid (Zometa®)**

**Policy Number**

J3490

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

090

**Contractor Type**

Intermediary

**LMRP Title**

Zoledronic Acid (Zometa®)

**AMA CPT Copyright Statement**

CPT codes, descriptions, and other data only are copyright 2001 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply.

**CMS National Coverage Policy**

Medicare Hospital Manual, Section 442.7  
 Medicare Intermediary Manual, Sections 3101.3, 3112.4, 3133.5, 3627.9, and 3627.10  
 Rural Health Clinic and Federally Qualified Health Center Manual, Section 406.7  
 Skilled Nursing Facility Manual, Section 230.5

**Primary Geographic Jurisdiction**

Florida

**Secondary Geographic Jurisdiction**

N/A

**CMS Region**

Region IV

**CMS Consortium**

Southern

**Original Policy Effective Date**

09/23/2002

**Original Policy Ending Date**

N/A

**Revision Effective Date**

N/A

**Revision Ending Date**

N/A

**LMRP Description**

Zoledronic Acid (Zometa®) is a bisphosphonic acid, which is an inhibitor of osteoclastic bone resorption. This class of drug, also known as a bisphosphonate, binds to the bone matrix, which decreases osteoclastic activity, prevents bone resorption and skeletal calcium release induced by various stimulatory factors released by tumors. Osteoclastic hyperactivity resulting in excessive bone resorption is the underlying pathophysiologic derangement in hypercalcemia of malignancy and metastatic bone disease.

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

Florida Medicare will consider Zoledronic Acid (Zometa®) medically reasonable and necessary when provided to patients for the treatment of the following FDA approved indications:

- hypercalcemia of malignancy;
- multiple myeloma; and/or
- documented bone metastases from solid tumors in conjunction with standard antineoplastic therapy.

**Note:** Prostate cancer should have progressed after treatment with at least one hormonal therapy.

**CPT/HCPCS Section & Benefit Category**

Drugs Administered Other Than Oral Method

**Type of Bill Code**

Hospital - 13x  
 Skilled Nursing Facility - 21x, 23x  
 Critical Access Hospital - 85x

**Revenue Codes**

636 Drugs Requiring Detailed Coding

**CPT/HCPCS Codes**

C9115 Injection, zoledronic acid, per 2 mg

**Not Otherwise Classified Codes (NOC)**

J3490 Unclassified drugs

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

198.5 Secondary malignant neoplasm of bone and bone marrow  
 203.00-203.01 Multiple myeloma  
 275.42 Hypercalcemia (associated with malignancy)

**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.

The use of this drug for the treatment of osteoporosis is not FDA approved and is therefore not covered by Florida Medicare.

**Noncovered ICD-9-CM Codes**

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

**J3490: Zoledronic Acid (Zometa®) (continued)**

**Noncovered Diagnosis**

N/A

**Coding Guidelines**

When billing for Zoledronic Acid (Zometa®), hospital outpatient providers must report HCPCS code C9115 in accordance with Hospital Outpatient Prospective Payment System (OP PPS) implementation. All other providers use HCPCS code J3490 and include the name of the drug and the appropriate ICD-9-CM diagnosis code, which indicates the medical condition being treated.

When billing for the infusion of this drug, Infusion code Q0081 should be used and **not** chemotherapy administration code Q0084.

**Documentation Requirements**

Medical record documentation maintained by the ordering/referring provider must substantiate the medical need for the use of this drug by clearly indicating the condition for which this drug is being used. This documentation is usually found in the history and physical or in the office/progress notes.

**Utilization Guidelines**

N/A

**Other Comments**

N/A

**Sources of Information and Basis for Decision**

Berenson, J., Rosen, L., Howell, A., Porter, L., Coleman, R., Morley, W., Dreicer, R., Kurose, S., Lipton, A., & Seaman, J. (2001). Zoledronic acid reduces skeletal-related events in patients with osteolytic metastases. *Cancer*, 91(7), 1191-1200. This article supports the indications section of this policy.

Compendia-Based Drug Bulletin, Winter 2002 Update. (February 2002). The Association of Community Cancer Centers. Retrieved March 1, 2002. Available: <http://www.accc-cancer.org/publications/genericdrug1.asp>. This source supports appropriate ICD-9-CM codes that are used in policy.

Rosen, L.S., Gordon, D., Kaminski, M., Howell, A., Belch, A., Mackey, J., Apffelstaedt, J., Hussein, M., Coleman, R., Reitsma, D., Seaman, J., Chen, B., & Ambros, Y. (2001). Zoledronic acid versus Pamidronate in the treatment of skeletal metastases in patients with breast cancer or osteolytic lesions of multiple myeloma: A phase III, double-blind, comparative trial. *The Cancer Journal*, 7(5), 377-387. This article supports the indications section of this policy.

The United States Pharmacopeia Drug Information (USPDI). (2002). *Oncology drug information*. Maryland: The Association of Community Cancer Centers (ACCC). Retrieved March 1, 2002. Available: <http://www.accc-cancer.org/cgi-bin/nds/nvbcgfh.exe>. This source supports appropriate indications for this drug.

**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 include representatives from numerous societies.

**Start Date of Comment Period**

05/10/2002

**End Date of Comment Period**

06/24/2002

**Start Date of Notice Period**

08/01/2002

**Revision History**

Revision Number:	Original
Start Date of Comment Period:	05/10/2002
Start Date of Notice Period:	08/01/2002
	4 <sup>th</sup> Qtr 2002 <i>Bulletin</i>
Original Effective Date	09/23/2002 ❖



## 52282: Urethral Stents—Revision to Policy

The local medical review policy for Urethral Stents – 52282 was published in the August 26, 1998, *Medicare A Bulletin* G-346. To ensure accuracy of applicable types of bill for the services furnished, types of bill 13x and 85x have been added to the “Type of Bill Code” section of the policy, and types of bill 21x and 71x have been removed from the policy.

Additionally, the “Revenue Codes” section of the policy has been revised to reflect the change from the allowable revenue code 361 (minor surgery) to 36x (operating room services).

### Effective Date

These revisions are effective for services processed on or after July 30, 2002. ❖

## 82728: Serum Ferritin—Revision to Policy

The local medical review policy for Serum Ferritin – 82728 was published in the August/September 2000 *Medicare A Bulletin* (page 34). Since that time, the following diagnosis code has been added to the “ICD-9-CM Codes that Support Medical Necessity” section of the policy:

238.4 Polycythemia vera

In addition, critical access hospital – 85x has been added to the “Type of Bill Code” section of the policy, and rural health clinic – 71x has been removed from the policy.

### Effective Date

These revisions are effective for services processed on or after June 21, 2002. ❖

## 87086: Urine Bacterial Culture—Addition to Policy

The local medical review policy for Urine Bacterial Culture – 87086 was published in the December/January 2000 *Medicare A Bulletin* (pages 22-23). Since that time, ICD-9-CM diagnosis codes 791.0 (proteinuria) and 791.7 (other cells and casts in the urine) have been expanded to include diagnosis range 791.0-791.9. This has been added to the “ICD-9-CM Codes that Support Medical Necessity” section of the policy.

### Effective Date

These additions are effective for services processed on or after June 21, 2002. ❖

## 94010: Spirometry—Revision to Policy

The local medical review policy for Spirometry – 94010 was published in the First Quarter 2002 *Medicare A Bulletin* (pages 56-59). Since that time, types of bill 12x, 14x, and 71x have been removed from the “Type of Bill Code” section of the policy.

### Effective Date

These revisions are effective for services processed on or after June 27, 2002. ❖

## 71010: Chest X-ray—Revision to Policy

The local medical review policy for Chest X-ray – 71010 was published in the August/September 2000 *Medicare A Bulletin* (pages 24-31). Since that time, diagnosis code 236.9 has been updated for specificity to diagnosis code range 236.90-236.99.

Additionally, critical access hospital – 85x has been added to the “Type of Bill Code” section of the policy. Rural health clinic – 71x and end-stage renal disease clinic – 72x have been removed from the “Type of Bill Code” section of the policy.

### Effective Date

These revisions are effective for services processed on or after June 11, 2002. ❖

## 83540: Iron—Revision to Policy

The local medical review policy for Iron – 83540 was published in the October/November 2000 *Medicare A Bulletin* (page 28). Since that time, the following diagnosis code has been added to the “ICD-9-CM Codes that Support Medical Necessity” section of the policy:

238.4 Polycythemia vera

In addition, critical access hospital – 85x has been added to the “Type of Bill Code” section of the policy, and rural health clinic – 71x has been removed from the policy.

### Effective Date

These revisions are effective for services processed on or after June 21, 2002. ❖

## 93975: Duplex Scanning—Addition to Policy

The local medical review policy for Duplex Scanning – 93975 was published in the Second Quarter 2002 *Medicare A Bulletin* (pages 29-32). Since that time, an evaluation of scrotal contents as an indication for medical necessity has been included in the policy as follows:

Under the section “Indications and Limitations of Coverage and/or Medical Necessity” the following indication has been added:

To evaluate patients with pain or swelling of scrotal contents which may be as a result of suspected obstruction in arterial inflow or venous outflow to the testicles or related structures. The use of duplex scanning of scrotal contents should only be performed after conventional diagnostic test, such as ultrasound, have proven to be “non-definitive.”

Under the section “ICD-9-CM Codes that Support Medical Necessity” the following diagnosis codes have been added to CPT codes 93975 and 93976:

456.4 Scrotal varicities  
608.2 Torsion of testis  
608.83 Other specified disorders of male genital organ, vascular disorders

### Effective Date

These additions are effective for services processed on or after June 21, 2002. ❖

**94240: Functional Residual Capacity or Residual Volume—Revision to Policy**

The local medical review policy for Functional Residual Capacity or Residual Volume – 94240 was published in the First Quarter 2002 *Medicare A Bulletin* (pages 60-62). Since that time, types of bill 12x, 14x, and 71x have been removed from the “Type of Bill Code” section of the policy.

**Effective Date**

These revisions are effective for services processed on or after **June 27, 2002**. ❖

**94642: Aerosolized Pentamidine Isethionate—Revision to Policy**

The local medical review policy for Aerosolized Pentamidine Isethionate – 94642 was published in the August/September 2000 *Medicare A Bulletin* (page 41). Since that time, types of bill 23x and 85x have been added to the “Type of Bill Code” section of the policy and type of bill 71x has been removed from the policy.

Additionally, revenue code 46x has been removed from the “Revenue Codes” section of the policy.

**Effective Date**

These revisions are effective for services processed on or after **July 30, 2002**. ❖

**94760: Noninvasive Ear or Pulse Oximetry for Oxygen Saturation—Additions to Policy**

The local medical review policy for Noninvasive Ear or Pulse Oximetry for Oxygen Saturation – 94760 was published in the November/December 2000 *Medicare A Bulletin* (page 55). Since that time, the following ICD-9-CM diagnosis codes have been added to the policy for CPT codes 94760, 94761, and 94762:

391.8	398.91	402.01	402.11
402.91	404.01	404.03	404.11
404.13	404.91	404.93	428.1.

Additionally, type of bill 85x has been added to the “Type of Bill Code” section of the policy, and types of bill 12x, 14x, 22x, and 71x have been removed from the policy.

**Effective Date**

These additions are effective for services processed on or after **July 12, 2002**. ❖

**94620: Pulmonary Stress Test—Revision to Policy**

The local medical review policy for Pulmonary Stress Test – 94620 was published in the December 7, 1998 *Medicare A Bulletin* G-354. Since that time, type of bill 85x has been added to the “Type of Bill Code” section of the policy, and types of bill 12x, 14x, and 71x have been removed from the policy.

**Effective Date**

These revisions are effective for services processed on or after **July 11, 2002**. ❖

**94664: Diagnostic Aerosol or Vapor Inhalation—Revision to Policy**

The local medical review policy for Diagnostic Aerosol or Vapor Inhalation – 94664 was published in the December 1999/January 2000 *Medicare A Bulletin* (page 41). Since that time, type of bill 85x has been added to the “Type of Bill Code” section of the policy and types of bill 12x, 14x and 71x have been removed from the policy.

Additionally, revenue code 410 has been removed from the “Revenue Codes” section of the policy.

**Effective Date**

These revisions are effective for services processed on or after **July 30, 2002**. ❖

**95900: Nerve Conduction Studies—Revision to Policy**

The local medical review policy (LMRP) for Nerve Conduction Studies – 95900 was published in the Second Quarter 2002 *Medicare A Bulletin* (pages 35-37). Change Request 2153 (CMS transmittal AB-02-066) dated May 2, 2002, indicates that current perception sensory nerve conduction threshold (sNCT), HCPCS code G0255, is noncovered by Medicare, effective for dates of service on or after **October 1, 2002**. Therefore, the “Coding Guidelines” section of the policy has been revised to reflect this change. Please refer to the Web site [www.floridamedicare.com](http://www.floridamedicare.com) on or after October 1, 2002, for the latest revision to the 95900 LMRP. ❖

**J0635: Vitamin D Analogs in Chronic Renal Disease—Revision to Policy**

The local medical review policy for Vitamin D Analogs in Chronic Renal Disease – J0635 was published in the Third Quarter 2002 *Medicare A Bulletin* (pages 32-33). Since that time, approval was obtained to use the national temporary HCPCS code for paracalcitol , 1 mcg – W0237. Therefore, HCPCS code W0237 replaces the unlisted drug code J3490 indicated in the policy.

**Effective Date**

This revision is effective for services processed on or after **July 29, 2002**. ❖

**J1561: Intravenous Immune Globulin—Revision to Policy**

To provide clarification regarding coverage for HIV-associated thrombocytopenia, the “Indications and Limitations of Coverage and/or Medical Necessity” section of the local medical review policy for intravenous immune globulin has been revised. Please note the following changes:

**b) Idiopathic Thrombocytopenic Purpura (ITP) and HIV-associated Thrombocytopenia**

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.

ITP is the most common cause of thrombocytopenia in HIV disease, the mechanism of which is thought to be similar to individuals who are HIV negative. Antiretroviral therapy may be used for the initial long term management of HIV-associated thrombocytopenia for those individuals who do not meet the coverage criteria listed below. The use of IVIG for HIV-associated thrombocytopenia must meet the medical

necessity criteria set forth below and must be billed using ICD-9 code 287.5 (Thrombocytopenia, unspecified.)

IVIG is indicated for ITP and HIV-associated Thrombocytopenia 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.

**Note:** 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.

In addition, type of bill 72x has been removed from the “Type of Bill Code” section of the policy.

**Effective Date**

These additions are effective for services processed **on or after July 16, 2002.** ❖

**J9999: Antineoplastic Drugs—Additions to Policy**

The complete local medical review policy for Antineoplastic Drugs – J9999 was published in the First Quarter 2002 *Medicare A Bulletin* (pages 70-77). Since that time, four existing drugs have received additional indications based on literature evaluation and/or Compendia updates.

J9201	Gemcitabine	Malignant neoplasm of gallbladder (156.0-156.9)
J9206	Irinotecan	Malignant neoplasm of esophagus, stomach and pancreas (150.0-150.9, 151.0-151.9, and 157.0-157.9)
J9265	Paclitaxel	Malignant neoplasm of connective tissue and other soft tissue (171.0-171.9)
J9390	Vinorelbine	Malignant neoplasm of prostate (185)

**Effective Date**

These additions are effective for services processed **on or after July 9, 2002.** ❖

# SKILLED NURSING FACILITY SERVICES

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## Deactivation of Edits C7252 and C7256

On April 1, 2002, several common working file (CWF) crossover edits were implemented to prevent duplicate payment for Part B services furnished under consolidated billing (CB) requirements for skilled nursing facility (SNF) residents. Due to unanticipated results of these edits, the Centers for Medicare & Medicaid Services (CMS) has decided to deactivate CWF edits 7256 & 7252 for claims processed by Medicare fiscal intermediaries (FIs). These edits will remain deactivated until CMS is assured that there will be no unanticipated impact from activating the SNF CB and duplicate payment edits for FI processed claims.

### Action Required by Providers

Providers may adjust any claim that has a line item rejection as result of duplicate edits 7252 and 7256, processed on or after April 1, 2002. ❖

Source CMS Memorandum Dated May 14, 2002

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## Skilled Nursing Facility Prospective Payment System Update

The Centers for Medicare & Medicaid Services (MCS) has provided information on the updates to the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year 2003, as required by statute. Annual updates to the PPS rates are required by section 1888(e) of the Social Security Act, as amended by the Balanced Budget Refinement Act of 1999, and the Benefits Improvement and Protection Act of 2000, relating to Medicare payments and consolidated billing for SNFs.

On July 31, 2001, CMS published a final rule in the *Federal Register* (66 FR 39562) detailing the schedule of SNF PPS federal rates applicable for Medicare SNF payments in fiscal year 2002. SNF payment rates for FY 2003, that is October 1, 2002 through September 30, 2003, were published August 1, 2002 in the *Federal Register*.

The methodology used for the update is identical to that used in the previous year. The rates will reflect an adjustment required by the statute. The statute mandates an update to the federal rates using the latest SNF market basket minus 0.5-percentage point.

### Revised PRICER

CMS will release the new SNF PRICER software package by October 1, 2002, containing updated rates that are effective October 1, 2002 through September 30, 2003. ❖

Source: CMS Transmittal A-02-057, CR 2220



# HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

## July 2002 Update to the Hospital Outpatient Prospective Payment System

This notification provides new information to the July 2002 update and on the device category codes under the hospital outpatient prospective payment system (OPPS). Included in this article is a comprehensive list of current device category codes and their expiration dates, and a clarification of HCPCS code J9266 under the hospital OPPS.

### New HCPCS Codes Under the Hospital OPPS

The HCPCS codes listed in this section have been added to the outpatient code editor (OCE) effective July 1, 2002. The payment rate associated with each APC can be found in addendum A of the OPPS Final Rule that was published in a *Federal Register* notice dated March 1, 2002. Addendum A is available on the CMS Web site for downloading at [www.hcfa.gov/regs/hopps/ChangeF4CY2002.htm](http://www.hcfa.gov/regs/hopps/ChangeF4CY2002.htm).

HCPCS Code	APC	Descriptor
G0245	600	Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), which must include: <ol style="list-style-type: none"> <li>1. The diagnosis of LOPS</li> <li>2. A patient history</li> <li>3. A physical examination that consists of at least the following elements:                             <ol style="list-style-type: none"> <li>(a) Visual inspection of the forefoot, hindfoot, and toe web spaces</li> <li>(b) Evaluation of a protective sensation</li> <li>(c) Evaluation of foot structure and biomechanics</li> <li>(d) Evaluation of vascular status and skin integrity</li> <li>(e) Evaluation and recommendation of footwear</li> </ol> </li> <li>4. Patient education</li> </ol>
G0246	600	Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following: <ol style="list-style-type: none"> <li>1. A patient history</li> <li>2. A physical examination that consists of at least the following elements:                             <ol style="list-style-type: none"> <li>(a) Visual inspection of the forefoot, hindfoot, and toe web spaces</li> <li>(b) Evaluation of a protective sensation</li> <li>(c) Evaluation of foot structure and biomechanics</li> <li>(d) Evaluation of vascular status and skin integrity</li> <li>(e) Evaluation and recommendation of footwear</li> </ol> </li> <li>3. Patient education</li> </ol>
G0247	009	Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include if present, at least the following: <ol style="list-style-type: none"> <li>1. Local care of superficial wounds</li> <li>2. Debridement of corns and calluses</li> <li>3. Trimming and debridement of nails.</li> </ol> <p><b>Note:</b> Code G0247 must be billed on the same date of service with either G0245 or G0246 in order to be considered for payment.</p>
	707	Demonstration, at initial use, of home INR monitoring for patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician; includes: demonstration use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results and documentation of a patient ability to perform testing
G0249	707	Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meets Medicare coverage criteria. Includes provision of materials for use in the home and reporting of test results to physician; per 4 tests
G0250	0	Physician review; interpretation and patient management of home INR testing for a patient with mechanical heart valve(s) who meets other coverage criteria; per 4 tests (does not require face-to-face service)

## July 2002 Update to the Hospital Outpatient PPS (continued)

### New Pass-Through Device Category Codes

As of July 1, 2002, C-codes C1783, C1888, and C1900 will be reportable under the hospital OPPS. The C-codes and APCs will be in the July 2002 OCE and OPPS PRICER. However, fiscal intermediaries must add these C-codes to the HCPCS file in their internal claims processing systems.

HCPCS	APC	Descriptor
C1783	1783	Ocular implant, aqueous drainage assist device
C1888	1888	Catheter, ablation, non-cardiac, endovascular (implantable)
C1900	1900	Lead, coronary venous Lead, left ventricular coronary venous system

### Comprehensive List of Category Codes Currently in Effect

Section 402(a) of the Benefits Improvement and Protection Act of 2000 (BIPA), which was enacted on December 21, 2000, required the creation of categories for pass-through devices under the hospital OPPS. As a result of BIPA, new category codes were created for pass-through devices that became effective April 1, 2001.

Payment for pass-through devices is based on the charge on the individual bill, converted to cost by application of a provider specific cost-to-charge ratio, and subject (in some instances) to a reduction that offsets the cost of similar devices already included in the APC payment rate.

Effective April 1, 2002 through December 31, 2002, transitional pass-through payments for devices are subject to a 63.6 percent pro rata reduction. Please refer to Table 1 of the March 1, 2002 Final Rule, pp. 9557-9558, for a list of APCs that have device offsets applied to pass-through payments.

As indicated in section 1833(t)(6) of the Social Security Act, payments for pass-through devices are limited to at least two years but no more than three years.

While the category codes became effective April 1, 2001, many of the item-specific C-codes were approved for pass-through status before April 1, 2001. In determining the expiration dates for the pass-through device category codes listed in this section, Medicare has determined when item specific devices that are described by the categories were paid as pass-through devices prior to the creation of the categories, pursuant to the statute, section 1833(t)(6)(iii)(I). These dates are listed in the column below entitled "Date First Populated." Thus, many of the category codes that were made effective April 1, 2001, will expire on December 31, 2002. This section provides a list of the existing device category codes along with their expected expiration dates.

Although Medicare generally allows a 90-day grace period when a HCPCS code is discontinued, grace periods for these codes are not granted because they are transitional pass-through device category codes.

**Therefore, there will be no grace period allowed for the device category codes listed below which will expire after 12/31/02, and will no longer be reportable under the hospital OPPS for dates of service after 12/31/02.**

#	HCPCS Codes	Category Descriptor	Date First Populated	Expiration Date
1	C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable) 8/1/00	12/31/02	
2	C1765**	Adhesion barrier	10/01/00 – 3/31/01; 7/1/01	12/31/03
3	C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)	8/1/00	12/31/02
4	C1715	Brachytherapy needle	8/1/00	12/31/02
5	C1716	Brachytherapy seed, Gold 198	10/1/00	12/31/02
6	C1717	Brachytherapy seed, High Dose Rate Iridium 192	1/1/01	12/31/02
7	C1718	Brachytherapy seed, Iodine 125	8/1/00	12/31/02
8	C1719	Brachytherapy seed, Non-High Dose Rate Iridium 192	10/1/00	12/31/02
9	C1720	Brachytherapy seed, Palladium 103	8/1/00	12/31/02
10	C2616	Brachytherapy seed, Yttrium-90	1/1/01	12/31/02
11	C1721	Cardioverter-defibrillator, dual chamber (implantable)	8/1/00	12/31/02
12	C1882	Cardioverter-defibrillator, other than single or dual chamber (implantable)	8/1/00	12/31/02
13	C1722	Cardioverter-defibrillator, single chamber (implantable)	8/1/00	12/31/02
14	C1888	Catheter, ablation, non-cardiac, endovascular (implantable)	7/1/02	12/31/04
15	C1726	Catheter, balloon dilatation, non-vascular	8/1/00	12/31/02

*July 2002 Update to the Hospital Outpatient PPS (continued)*

#	HCPSC Codes	Category Descriptor	Date First Populated	Expiration Date
16	C1727	Catheter, balloon tissue dissector, non-vascular (insertable)	8/1/00	12/31/02
17	C1728	Catheter, brachytherapy seed administration	1/1/01	12/31/02
18	C1729	Catheter, drainage	10/1/00	12/31/02
19	C1730	Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes)	8/1/00	12/31/02
20	C1731	Catheter, electrophysiology, diagnostic, other than 3D mapping (20 or more electrodes)	8/1/00	12/31/02
21	C1732	Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping	8/1/00	12/31/02
22	C1733	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip	8/1/00	12/31/02
23	C2630	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip	10/1/00	12/31/02
24	C1887	Catheter, guiding (may include infusion/perfusion capability)	8/1/00	12/31/02
25	C1750*	Catheter, hemodialysis/ <b>peritoneal</b> , long-term	8/1/00	12/31/02
26	C1752*	Catheter, hemodialysis/ <b>peritoneal</b> , short-term	8/1/00	12/31/02
27	C1751	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)	8/1/00	12/31/02
28	C1759	Catheter, intracardiac echocardiography	8/1/00	12/31/02
29	C1754	Catheter, intradiscal	10/1/00	12/31/02
30	C1755	Catheter, intraspinal	8/1/00	12/31/02
31	C1753	Catheter, intravascular ultrasound	8/1/00	12/31/02
32	C2628	Catheter, occlusion	10/1/00	12/31/02
33	C1756	Catheter, pacing, transesophageal	10/1/00	12/31/02
34	C2627	Catheter, suprapubic/cystoscopic	10/1/00	12/31/02
35	C1757	Catheter, thrombectomy/embolectomy	8/1/00	12/31/02
36	C1885	Catheter, transluminal angioplasty, laser	10/1/00	12/31/02
37	C1725	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)	8/1/00	12/31/02
38	C1714	Catheter, transluminal atherectomy, directional 8/1/00	12/31/02	
39	C1724	Catheter, transluminal atherectomy, rotational	8/1/00	12/31/02
40	C1758	Catheter, ureteral	10/1/00	12/31/02
41	C1760	Closure device, vascular (implantable/insertable)	8/1/00	2/31/02
42	L8614	Cochlear implant system	8/1/00	12/31/02
43	C1762	Connective tissue, human (includes fascia lata)	8/1/00	12/31/02
44	C1763	Connective tissue, non-human (includes synthetic)	10/1/00	12/31/02
45	C1881	Dialysis access system (implantable)	8/1/00	12/31/02
46	C1764	Event recorder, cardiac (implantable)	8/1/00	12/31/02
47	C1767	Generator, neurostimulator (implantable)	8/1/00	12/31/02
48	C1768	Graft, vascular	1/1/01	12/31/02

# OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

## July 2002 Update to the Hospital Outpatient PPS (continued)

#	HCPSC Codes	Category Descriptor	Date First Populated	Expiration Date
49	C1769	Guide wire	8/1/00	12/31/02
50	C1770	Imaging coil, magnetic resonance (insertable)	1/1/01	12/31/02
51	C1891	Infusion pump, non-programmable, permanent (implantable)	8/1/00	12/31/02
52	C2626	Infusion pump, non-programmable, temporary (implantable)	1/1/01	12/31/02
53	C1772	Infusion pump, programmable (implantable)	10/1/00	12/31/02
54	C1893	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away	10/1/00	12/31/02
55	C1766	Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away	1/1/01	12/31/02
56	C1892	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away	1/1/01	12/31/02
57	C1894*	Introducer/sheath, other than guiding, <b>other than</b> intracardiac electrophysiological, non-laser	8/1/00	12/31/02
58	C2629*	Introducer/sheath, other than guiding, <b>other than</b> intracardiac electrophysiological, laser	1/1/01	12/31/02
59	C1776	Joint device (implantable)	10/1/00	12/31/02
60	C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)	8/1/00	12/31/02
61	C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)	8/1/00	12/31/02
62	C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)	8/1/00	12/31/02
63	C1900	Lead, left ventricular coronary venous system	7/1/02	12/31/04
64	C1778	Lead, neurostimulator (implantable)	8/1/00	12/31/02
65	C1897	Lead, neurostimulator test kit (implantable)	8/1/00	12/31/02
66	C1898	Lead, pacemaker, other than transvenous VDD single pass	8/1/00	12/31/02
67	C1779	Lead, pacemaker, transvenous VDD single pass	8/1/00	12/31/02
68	C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)	1/1/01	12/31/02
69	C1780	Lens, intraocular (new technology)	8/1/00	12/31/02
70	C1878	Material for vocal cord medialization, synthetic (implantable)	10/1/00	12/31/02
71	C1781	Mesh (implantable)	8/1/00	12/31/02
72	C1782	Morcellator	8/1/00	12/31/02
73	C1784	Ocular device, intraoperative, detached retina	1/1/01	12/31/02
74	C1783	Ocular implant, aqueous drainage assist device	7/1/02	12/31/04
75	C2619	Pacemaker, dual chamber, non rate-responsive (implantable)	8/1/00	12/31/02
76	C1785	Pacemaker, dual chamber, rate-responsive (implantable)	8/1/00	12/31/02
77	C2621	Pacemaker, other than single or dual chamber (implantable)	1/1/01	12/31/02
78	C2620	Pacemaker, single chamber, non rate-responsive (implantable)	8/1/00	12/31/02
79	C1786	Pacemaker, single chamber, rate-responsive (implantable)	8/1/00	12/31/02
80	C1787	Patient programmer, neurostimulator	8/1/00	12/31/02
81	C1788	Port, indwelling (implantable)	8/1/00	12/31/02



July 2002 Update to the Hospital Outpatient PPS (continued)

#	HCPSC Codes	Category Descriptor	Date First Populated	Expiration Date
82	C2618	Probe, cryoablation	4/1/01	12/31/03
83	C1789	Prosthesis, breast (implantable)	10/1/00	12/31/02
84	C1813	Prosthesis, penile, inflatable	8/1/00	12/31/02
85	C2622	Prosthesis, penile, non-inflatable	10/1/01	12/31/02
86	C1815	Prosthesis, urinary sphincter (implantable)	10/1/00	12/31/02
87	C1816	Receiver and/or transmitter, neurostimulator (implantable)	8/1/00	12/31/02
88	C1771	Repair device, urinary, incontinence, with sling graft	10/1/00	12/31/02
89	C2631	Repair device, urinary, incontinence, without sling graft	8/1/00	12/31/02
90	C1773	Retrieval device, insertable	1/1/01	12/31/02
91	C2615	Sealant, pulmonary, liquid (Implantable)	1/1/01	12/31/02
92	C1817	Septal defect implant system, intracardiac	8/1/00	12/31/02
93	C1874	Stent, coated/covered, with delivery system	8/1/00	12/31/02
94	C1875	Stent, coated/covered, without delivery system	8/1/00	12/31/02
95	C2625	Stent, non-coronary, temporary, with delivery system	10/1/00	12/31/02
96	C2617	Stent, non-coronary, temporary, without delivery system	10/1/00	12/31/02
97	C1876	Stent, non-coated/non-covered, with delivery system	8/1/00	12/31/02
98	C1877	Stent, non-coated/non-covered, without delivery system	8/1/00	2/31/02
99	C1879	Tissue marker (implantable)	8/1/00	12/31/02
100	C1880	Vena cava filter	1/1/01	12/31/02

\* Long descriptor for this category code has been revised. The **bold** word(s) reflect an addition to the long descriptor.

\*\*The item-specific device code associated with this category code was initially approved as a pass-through but removed from pass-through status after it was determined that the procedure codes associated with the device were listed in the “inpatient only” list under OPSS. The category code was later added as a new category code when the procedure codes associated with the device were removed from the “inpatient only” list.

**Explanation of Terms/Definitions for Specific Category Codes**

**3D mapping catheter (C1732)** – Refers to a catheter used for mapping the electrophysiologic properties of the heart. Signals are identified by a specialized catheter and changed into a 3-dimensional map of a specific region of the heart.

**Adaptor for a pacing lead (C1883)** – Interposed between an existing pacemaker lead and a new generator. The end of the adaptor lead has the appropriate connector pin that will enable utilization of the existing pacemaker lead with a new generator that has a different receptacle. These are required when a generator is replaced or when two leads are connected to the same port in the connector block.

**Adhesion barrier (C1765)** – A bioresorbable substance placed on and around the neural structures, which inhibits cell migration (fibroblasts) and minimizes scar tissue formation. It is principally used in spine surgeries, such as laminectomies and diskectomies.

**Anchor for opposing bone-to-bone or soft tissue-to-bone (C1713)** – Implantable pins and/or screws that are used to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone. Screws oppose tissues via drilling as follows: soft tissue-to-bone, tendon-to-bone, or bone-to-bone fixation. Pins are inserted or drilled into bone, principally with the intent to facilitate stabilization or oppose bone-to-bone.

This may include orthopedic plates with accompanying washers and nuts. This category also applies to synthetic bone substitutes that may be used to fill bony void or gaps (i.e., bone substitute implanted into a bony defect created from trauma or surgery).

**Balloon dilatation catheter, nonvascular (C1726)** – Catheter used to dilate strictures or stenoses through the insertion of an uninflated balloon affixed to the end of a flexible catheter, followed by the inflation of the balloon at the specified site (e.g., common bile duct, ureter, small or large intestine).

For the reporting of vascular balloon dilatation catheters, see category “Transluminal angioplasty catheter” (C1725 and C1885).

July 2002 Update to the Hospital Outpatient PPS (continued)

**Balloon tissue dissector catheter (C1727)** – Balloon tipped catheter used to separate tissue planes, used in procedures such as hernia repairs.

**Catheter, ablation, noncardiac, endovascular (implantable) (C1888)** – Used to obliterate or necrose tissues in an effort to restore normal anatomic and physiologic function.

**Cardioverter-defibrillator, other than single or dual chamber (C1882)** – Includes cardiac resynchronization devices.

**Coated stent (C1874, C1875)** – Refers to a stent bonded with drugs (e.g., heparin) or layered with biocompatible substances (e.g., phosphorylcholine).

**Connective tissue, human (C1762)** – These tissues include a natural, cellular collagen or extracellular matrix obtained from autologous rectus fascia, decellularized cadaveric fascia lata, or decellularized dermal tissue. They are intended to repair or support damaged or inadequate soft tissue. They are used to treat urinary incontinence resulting from hypermobility or intrinsic sphincter deficiency (ISD), pelvic floor repair, or for implantation to reinforce soft tissues where weakness exists in the urological anatomy. Note this excludes those items that are used to replace skin. For reporting mesh when used to treat urinary incontinence, see the category “Mesh.” For reporting urinary incontinence repair device when used to treat urinary incontinence, see the category “Urinary incontinence repair device.”

**Connective tissue, nonhuman (includes synthetic) (C1763)** – These tissues include a natural, acellular collagen matrix typically obtained from porcine or bovine small intestinal submucosa, or pericardium. This bio-material is intended to repair or support damaged or inadequate soft tissue.

They are used to treat urinary incontinence resulting from hypermobility or ISD, pelvic floor repair, or for implantation to reinforce soft tissues where weakness exists in the urological or musculoskeletal anatomy. This excludes those items that are used to replace skin. For reporting mesh when used to treat urinary incontinence, see the category “Mesh.”

For reporting urinary incontinence repair device when used to treat urinary incontinence, see the category “Urinary incontinence repair device.”

**Cool-tip electrophysiology catheter (C2630)** – Ablation catheter that contains a cooling mechanism and has temperature-sensing capability.

**Covered stent (C1874, C1875)** – Refers to a stent layered with silicone or a silicone derivative (e.g., PTFE, polyurethane).

**Drainage catheter (C1729)** – Intended to be used for percutaneous drainage of fluids. (Note: This category does NOT include Foley catheters or suprapubic catheters. Refer to category C2627 to report suprapubic catheters.)

**Electrophysiology catheter (C1730, C1731, C1732, C1733, C2630)** – Assists in providing anatomic and physiologic information about the cardiac electrical conduction system.

Electrophysiology catheters are categorized into two main groups: (1) diagnostic catheters that are used for mapping, pacing, and/or recording only, and (2) ablation (therapeutic) catheters that also have diagnostic capability. The electrophysiology ablation catheters are distinct from noncardiac ablation catheters.

Electrophysiology catheters designated as “cool-tip” refer to catheters with tips cooled by infused and/or circulating saline. Catheters designated as “other than cool-tip” refer to the termister tip catheter with temperature probe that measures temperature at the tissue catheter interface.

**Extension for a pacing lead (C1883)** – Provides additional length to an existing pacing lead but does not have the capability of an adaptor.

**Extension for a neurostimulator lead (C1883)** – Conducts electrical pulses from the power source (generator or neurostimulator) to the lead. The terms neurostimulator and generator are used interchangeably.

**Guiding catheter (C1887)** – Intended for the introduction of interventional/diagnostic devices into the coronary or peripheral vascular systems. It can be used to inject contrast material, function as a conduit through which other devices pass, and/or provide a mechanism for measuring arterial pressure, and maintain a pathway created by the guide wire during the performance of a procedure.

**Infusion pump, nonprogrammable, temporary (implantable) (C2626)** – Short-term pain management system that is a component of a permanent implantable system used for chronic pain management.

**Intraocular lens (new technology) (C1780)** – Refers to the intraocular lenses approved by CMS as “new technology IOL.” A list of these lenses is published periodically in the *Federal Register*. The latest publication can be found on page 25740 of the *Federal Register* notice dated May 3, 2000.

**Intraoperative ocular device for detached retina (C1784)** – A perfluorocarbon substance instilled during a vitreoretinal procedure to treat detached retina.

**Joint device (C1776)** – An artificial joint such as a finger or toe that is implanted in a patient. Typically, a joint device functions as a substitute to its natural counterpart and is not used (as are anchors) to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone.

**Left ventricular coronary venous system lead (C1900)** – Designed for left heart placement in a cardiac vein via the coronary sinus and is intended to treat the symptoms associated with heart failure.

July 2002 Update to the Hospital Outpatient PPS (continued)

**Liquid pulmonary sealant (C2615)** – An absorbable, synthetic solution that forms a seal utilizing a photochemical polymerization process. It is used to seal visceral pleural air leaks incurred during pulmonary resection.

**Material for vocal cord medialization, synthetic (C1878)** – Synthetic material that is composed of a nonabsorbable substance such as silicone and can be injected or implanted to result in vocal cord medialization.

**Mesh (C1781)** – A mesh implant or synthetic patch composed of absorbable or nonabsorbable material that is used to repair hernias, support weakened or attenuated tissue, cover tissue defects, etc.  
 For reporting connective tissue (human or nonhuman) when used to treat urinary incontinence, see the category “Connective tissue, human” or “Connective tissue, nonhuman.”  
 For reporting urinary incontinence repair device when used to treat urinary incontinence, see the category “Urinary incontinence repair device.”

**Morcellator (C1782)** – Used for cutting, coring, and extracting tissue in laparoscopic procedures.  
 These are distinct from biopsy devices because morcellators are used for the laparoscopic removal of tissue.

**Pacemaker, other than single or dual chamber (C2621)** – Includes cardiac resynchronization devices as well as other pacemakers that are neither single or dual chamber.

**Patient programmer (C1787)** – Programmer that allows the patient to operate their neurostimulator, for example, programming the amplitude and rate of stimulation of a neurostimulator system. Only a nonconsole patient programmer is eligible for transitional pass-through payments.

**Peel-away introducer/sheath (C1892)** – A nonabsorbable sheath or introducer that separates into two pieces. This device is used primarily when removal of the sheath is required after a catheter or lead is in the desired position.

**Retrieval device, insertable (C1773)** – A device designed to retrieve other devices or portions thereof (e.g., fractured catheters, leads) lodged within the vascular system. This can also be used to retrieve fractured medical devices or to exchange introducers/sheaths.

**Septal defect implant system (C1817)** – An intracardiac metallic implant used for closure of various septal defects within the heart. The septal defect implant system includes a delivery catheter.  
 The category code for the septal defect implant system (C1817) includes the delivery catheter, therefore, the delivery catheter should not be reported separately.

**Stents with delivery system (C1874, C1876, C2625)** – Stents packaged with delivery systems generally include the following components: stent mounted or unmounted on a balloon angioplasty catheter, introducer, and sheath. These components should not be reported separately.

**Temporary noncoronary stent (C2617, C2625)** – Usually composed of a substance, such as plastic or other nonabsorbable material, designed to permit removal. Typically, this type of stent is placed for a period of less than one year.

**Tissue marker (C1879)** – A material that is placed in subcutaneous or parenchymal tissue (may also include bone) for radiopaque identification of an anatomic site. These markers are distinct from topical skin markers, which are positioned on the surface of the skin to serve as anatomical landmarks.

**Transluminal angioplasty catheter (C1725, C1885)** – Designed to dilate stenotic blood vessels (arteries and veins). For vascular use, the terms “balloon dilatation catheter” and “transluminal angioplasty catheter” are frequently used interchangeably.  
 For the reporting of nonvascular balloon dilatation catheters, see the category “Balloon dilatation catheter” (C1726).

**Transvenous VDD single pass pacemaker lead (C1779)** – A transvenous pacemaker lead that paces and senses in the ventricle and senses in the atrium.

**Urinary incontinence repair device (C1771, C2631)** – Used to attach or insert a sling graft for the purpose of strengthening the pelvic floor. It consists of the device components used to deliver (suprapubically or transvaginally) and/or fixate (via permanent sutures or bone anchors) the sling graft. The device may or may not be packaged with a sling graft. Report the appropriate category for a device with or without a sling graft.  
 For reporting connective tissue (human or nonhuman) when used to treat urinary incontinence, see the category “Connective tissue, human” (C1762) or “Connective tissue, nonhuman” (C1763). For reporting mesh when used to treat urinary incontinence, see the category “Mesh” (C1781).

**Vascular closure device (implantable/insertable) (C1760)** – Used to achieve hemostasis at arterial puncture sites following invasive or interventional procedures using biologic substances (e.g., collagen) or suture through the tissue tract.

**Vector mapping catheter (C1732)** – Refers to an electrophysiology catheter with an “in-plane” orthogonal array of electrodes. This catheter is used to locate the source of a focal arrhythmia.

**General Coding and Billing Instructions and Explanations For Pass-Through Devices**

**Devices Implanted, Removed, and Implanted Again, Not Associated With Failure (Applies to Transitional Pass-through Devices Only):** In instances where the physician is required to implant another device because the first device fractured, the hospitals may bill for both devices – the device that resulted in fracture and the one that was implanted into the patient. We realize that there may be instances where an implant is tried but later removed due

*July 2002 Update to the Hospital Outpatient PPS (continued)*

to the device's inability to achieve the necessary surgical result or due to inappropriate size selection of the device by the physician (i.e., physician implants an anchor to bone and the anchor breaks because the bone is too hard or must be replaced with a larger anchor to achieve desirable result). In such instances, Medicare will provide separate reimbursement for both devices. This situation does not extend to devices that result in failure or are found to be defective. For failed or defective devices, hospitals are advised to contact the vendor/manufacturer.

**Note:** This applies to transitional pass-through devices only and not to devices packaged into an APC.

**Kits:** Manufacturers frequently package a number of individual items used in a particular procedure in a kit. Generally, to avoid complicating the category list unnecessarily and to avoid the possibility of double coding, we have not established codes for such kits. However, hospitals are free to purchase and use such kits. If the kits contain individual items that separately qualify for transitional pass-through payments, these items may be separately billed using applicable codes. Hospitals may not bill for transitional pass-through payments for supplies that may be contained in kits.

**Multiple units:** Hospitals must bill for multiple units of items that qualify for transitional pass-through payments when such items are used with a single procedure by entering the number of units used on the bill.

**Reporting of multiple categories:** For items with multiple component devices that fall in more than one category (e.g., kits or systems other than those explicitly identified in the long descriptors), hospitals should code the appropriate category separately for each component. For example, the "Rotablator Rotational Angioplasty System (with catheter and advancer)" consists of both a catheter as well as an advancer/sheath. Hospitals should report category C1724 for the catheter and C1894 for the advancer/sheath.

Also, for items packaged as kits that contain a catheter and an introducer, hospitals should report both

appropriate categories. For example, the "Clinicath 16G Peripherally Inserted Central Catheter (PICC) Dual-Lumen PolyFlow Polyurethane" contains a catheter and an introducer. To appropriately bill for this item, hospitals should report category C1751 for the catheter and C1894 for the introducer.

**Reprocessed devices:** Hospitals may bill for transitional pass-through payments only for those devices that are "single use." Reprocessed devices may be considered "single use" if they are reprocessed in compliance with enforcement guidance of the Food and Drug Administration (FDA) relating to the reprocessing of devices applicable at the time the service is delivered. The FDA is phasing in new enforcement guidance relating to reprocessing during 2001 and 2002. For further information, see FDA's guidance document entitled "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals," published August 14, 2000, and subsequent FDA guidance or regulatory documents.

**April 2002 Outlier Logic Revision**

The outlier logic has been revised to add charges for packaged services with a status indicator "P" retroactive to April 1, 2002. Community mental health centers that believe the outlier amount was computed incorrectly for this period may resubmit claims.

**Clarification On HCPCS J9266 (Pegaspargase/ single dose vial)**

An article published in the Third Quarter 2002 *Medicare A Bulletin* (pages 43-48) indicated that HCPCS code J9266 (Pegaspargase/singl dose vial; APC 843) would no longer be eligible for pass-through status since this drug is no longer manufactured. However, due to additional information received which indicated that this drug is still manufactured, Medicare has decided not to remove this drug from the pass-through list for the April 2002 update but continue to recognize it as a pass-through under the hospital OPSS. ❖

Source: CMS Transmittal A-02-050, CR 2207

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# ELECTRONIC DATA INTERCHANGE

## HIPAA Model Compliance Extension Plan and Instructions Now Available

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) became law. It requires, among other things, that the Department of Health and Human Services establish national standards for electronic health care transactions and code sets. October 16, 2002 is the deadline for covered entities such as health plans, clearinghouses and providers (such as physicians, dentists, hospitals, nursing homes and others) to comply with these new standards. However, in December 2001, the Administrative Simplification Compliance Act (ASCA, Public Law 107-105) gave covered entities not compliant by October 16, 2002 the opportunity to extend their compliance deadline by 1 year – to October 16, 2003. This extension opportunity is applicable to all HIPAA-covered entities other than small health plans (those with less than \$5 million in annual receipts whose compliance date is already set for October 16, 2003). In order to qualify for this extension, covered entities must submit a compliance plan by October 15, 2002.

A model compliance plan and instructions on how to complete and submit it are available on the Centers for Medicare & Medicaid Services (CMS) Web site, [www.cms.hhs.gov/hipaa](http://www.cms.hhs.gov/hipaa). You can submit this online model plan electronically through the Web site or print and mail it. You can submit your own paper version of the plan as long as it provides equivalent information (covered entity and contact information; reasons for filing for the extension; HIPAA implementation budget information; and where you are in implementing and testing including whether or not you plan to use a vendor). CMS strongly encourages electronic filing but

if you must file on paper, you should send your form to Attention: Model Compliance Plans, Centers for Medicare & Medicaid Services (CMS), P.O. Box 8040, Baltimore, MD. 21244-8040. The deadline for both electronic and paper submissions is October 15, 2002.

If you file electronically through the Web site, you will receive an electronic confirmation number acknowledging and granting your extension. If you file a paper version, you won't receive a confirmation, but if your paper plan consists of the required equivalent information, you may consider your extension granted.

The instructions give more details on how to complete the form; explanation of who should file for an extension; data you need to include; and where to get more information on definitions, frequently asked questions, etc.

For more information, submit questions to [askhipaa@cms.hhs.gov](mailto:askhipaa@cms.hhs.gov).

### Providers Using Medicare Supplied Billing Software

Medicare contractors will continue to provide electronic billing software for providers to use to submit their Medicare claims. The HIPAA-compliant version of this software is available now from on or near July 15, 2002, from PC-ACE Pro32®. Any providers who will continue to use the non-HIPAA version Medicare billing software at any time between October 16, 2002, and October 16, 2003, must submit a Compliance Extension Plan as described above. ❖

Source: CMS Transmittal A/B-02-071, CR 2168

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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## New Remittance Advice Remark Codes and Claim Adjustment

### Reason Codes

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that Medicare, and all other health insurance payers in the United States, comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services.

The X12N 835 version 4010-implementation guide has been established as the standard for compliance for remittance advice transactions. The implementation guide for that format is available electronically at [www.wpc-edi.com/hipaa](http://www.wpc-edi.com/hipaa).

### New and Revised Health Care Remittance Advice Remark Codes

The Centers for Medicare & Medicaid Services (CMS) is the national maintainer of remittance advice remark codes used by both Medicare and non-Medicare entities. The list of remark codes is updated continuously as needed, and both Medicare and non-Medicare entities can request new codes or modifications in the existing codes to address their business needs.

The list of remark codes is available at [www.wpc-edi.com/hipaa/](http://www.wpc-edi.com/hipaa/). The list is updated each March, July, and November. The list may be downloaded from this Web site during those three months to obtain the most current set of approved remark codes.

The following list summarizes additions and modifications made to the remark codes through February 28, 2002.

#### MA01 Modified to:

If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late. An institutional provider, e.g., hospital, SNF, HHA or hospice may appeal only if the claim involves a medical necessity denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.

#### MA02 Modified to:

If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 60 days of receipt of this notification. Decisions made by a Peer Review Organization (PRO) must be appealed to that PRO. (An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent

skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.)

#### MA03 Modified to:

If you do not agree with the approved amounts and \$100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the \$100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision. An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.

#### MA126 New Code

Pancreas transplant not covered unless kidney transplant performed

#### N23 Modified to:

Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.

#### N70 Modified to:

Home health consolidated billing and payment applies.

#### N71 Modified to:

Your unassigned claim for a drug or biological or clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims.

#### N73 Modified to:

A SNF is responsible for payment of outside providers who furnish these services/supplies to residents. Only the professional component of physician services can be paid separately.

#### N95 New Code

This provider type may not bill this service.

#### N96 New Code

Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.

*New Remittance Advice Remark Codes and Claim Adjustment Reason Codes (continued)*

- N97 New Code**  
Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.
- N98 New Code**  
Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50 percent or greater improvement through test stimulation. Improvement is measured through voiding diaries.
- N99 New Code**  
Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.
- N100 New Code**  
PPS code corrected during adjudication.
- N101 New Code**  
Additional information is needed in order to process this claim. Please resubmit the claim with the identification number of the Provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters "HSP" and entered into item 32 on the claim form. You may bill only one site of service provider number per claim.
- N102 New Code**  
This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.
- N103 New Code**  
Social Security records indicate that this beneficiary was a prisoner when this claim was submitted. Medicare does not cover items and services furnished to beneficiaries while they are incarcerated, unless under State or local law, the beneficiary is personally liable for the cost of his or her health care while incarcerated.
- N104 New Code**  
This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at [www.cms.gov](http://www.cms.gov).
- N105 New Code**  
This is a misdirected claim/service for an RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.
- N106 New Code**  
Payment for services furnished to skilled nursing facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.

- N107 New Code**  
Services furnished to skilled nursing facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.
- N108 New Code**  
This item/service was denied because the upgrade information was invalid.
- N109 New Code**  
This claim was chosen for complex review and was denied after reviewing the medical records.
- N110 New Code**  
This facility is not certified for film mammography.
- N111 New Code**  
No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
- N112 New Code**  
This claim is excluded from your electronic remittance advice.

**New Health Care Claim Adjustment Reason Codes**

The committee that maintains the health care claim adjustment reason codes, a non-CMS body, meets at the beginning of each X12 trimester meeting (February, June and October) and makes decisions about additions, modifications and retirement of existing reason codes. The updated list is posted three times a year after each X12 trimester meeting at <http://www.wpc-edi.com/hipaa/>.

A reason code may be retired if determined to be duplicative or no longer applicable. These changes are always effective with a specified 835 future version, and never retroactively. Remark and reason code changes, other than retirements, are not version specific. The reason code committee has indicated that future updates will identify which code should be used in lieu of the retired code.

The committee did not approve any reason code changes in October 2001.

In February 2002, the committee determined that reason codes 16, 17 and 125 will have an additional sentence added to their current descriptions that reads: Additional information is supplied using the "Remittance Advice Remark Codes" whenever appropriate.

**New PLB Composite Adjustment Code Changes**

Effective with version 4010, the following adjustment codes will be used as appropriate in the PLB segment:

- XF for outlier
- IM for Indirect Medical Education

**Additional Information Regarding Generating a Remittance Advice**

Every X12 835 version 4010 transaction issued by an intermediary must comply with the implementation guide (IG) requirements, i.e., these must balance at the service, claim and transaction levels, each required segment must

*New Remittance Advice Remark Codes and Claim Adjustment Reason Codes (continued)*

be reported, each required or applicable situational data element in a required or situational segment must be reported, and the data in a data element must meet the minimum length and data attribute (AN, ID, R, etc.) specifications in the implementation guide.

To assist with meeting the IG requirements to balance at the service, claim, and transaction levels, intermediary standard systems will make forced balancing as applicable and necessary. The following adjustment reason codes will be used to report instances when force balancing has occurred:

- Adjustment reason code **A7** – presumptive payment adjustment – will be used to report the amount by which a line or claim is out of balance at the line or claim level.
- Adjustment reason code **CA** – manual claim payment adjustment – will be used to report the amount by which a transaction is out-of-balance as a PLB adjustment. PLB Medicare composite reason code CS/CA will be reported in this situation. ❖

Source: CMS Transmittal AB-02-067, CR 1959

*Third-party Web sites.* This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

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## Avoiding Duplicate EMC Transmissions

A duplicate transmission occurs when an EMC (electronic media claims) sender location submits a batch of claims that were previously submitted and accepted by Blue Cross Blue Shield of Florida. These batches are rejected as duplicates before being routed to Medicare A of Florida for processing.

Several steps are listed below that will help you and your staff avoid transmitting duplicate claim batches:

- Keep a log of the date, time, number of claims and total charges for each transmission, which should be referenced prior to each transmission.
- If you do not receive a confirmation/acknowledgment or if your batch seems to have aborted during transmission within the same connection as your claim transmission, contact the Help Desk at (904) 905-8880 for a verbal confirmation prior to resubmitting it. You should do this only **after** attempting to retrieve/obtain your confirmation/acknowledgment during a subsequent connection and are unable to receive it.

- When you are experiencing delays in claim payments, research the status of the claims by contacting Medicare A Customer Service toll-free at (877) 602-8816 prior to resubmitting a batch. Check a random sample of claims in the batch to see if the claims were received.
- If the claims are found, then the batch was received and the claims are being processed. If the claims are not found then the batch may not have been received.

### Software Problems

If you determine that for some unknown reason your computer system is inadvertently resubmitting claim batches without your knowledge, contact your software support vendor immediately.

If you observe the above tips your location should be able to avoid duplicate batch transmission problems. ❖



## PATIENT FRIENDLY ADVISORY

### Helping Medicare Patients Pay for Prescriptions

Paying for prescription drugs may be a key concern for Medicare patients. The original Medicare plan does not cover prescription drugs except in a few cases, like certain cancer drugs. Many Medicare + Choice plans and some Medigap policies cover prescription drugs, but often cap coverage at certain dollar limits.

As a health care provider, you want your patients to not only take the medication prescribe by their physicians for their health condition, but also to comply with directions for correctly using it. The high cost of prescriptions can deter patients from purchasing and using their medications as directed. Too often we hear stories where a senior has chosen not to purchase an important medication due to cost, or purchased the prescription, but cut the dosage in half to make it last longer.

Help is available to assist people with Medicare to pay for their prescriptions. To help Medicare patients, providers may access the **Prescription Drug Assistance Programs Database** at [www.medicare.gov](http://www.medicare.gov). This Web site provides information on programs that offer discounts or free medication including state prescription drug assistance programs, programs sponsored by pharmaceutical companies, and disease-specific programs. The Prescription Drug Assistance Program also provides information on drug benefits offered through Medicare managed care plans and Medigap policies.

In Florida, the **Medicare Prescription Discount Program** enables beneficiaries to obtain prescription drugs at lower costs. This program requires Florida pharmacies (more than 3,300) who accept Medicaid to guarantee a discount no greater than the average wholesale price of the medication minus nine percent. A dispensing fee of \$4.50 is added to the total. This discount is available to all Florida residents presenting a Medicare card, regardless of income.

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In some instances, Medicare patient's current pharmacy may already charge a price below this amount. Discounts may vary from pharmacy to pharmacy when there is more than one manufacturer for the prescribed drug. Different pharmacies may not stock the drug from the same manufacturer. It is important that patients shop for the best prices for the medications they take.

The **Pharmaceutical Expense Assistance Program** is limited to those individuals who qualify for both Medicare and Medicaid (QMB – qualified Medicare beneficiary, SLMB – specified low-income Medicare beneficiary plans) and who are not currently receiving a pharmacy benefit. This monthly benefit is limited to \$80 per program participant. Applicants must be age 65 or over, have an annual income between 90-120 percent of the federal poverty level, and be eligible for both Medicare and Medicaid. The participant will pay a required co-pay of ten percent per prescription.

The delay of adding prescription coverage to the federal Medicare program has sparked an interest by the pharmaceutical companies to create their own discounts. Several companies offer substantial discounts on the medications they produce. A couple of programs offer one discount card that covers several pharmaceutical companies all at once. **These programs require that recipients be enrolled in Medicare and meet certain income levels.**

For more information about prescription drug assistance programs in Florida and for a list of companies that have a discount program, go to <http://elderaffairs.state.fl.us/>. Click on the SHINE (Serving the Health Insurance Needs of Elders) link, and open the prescription drug assistance fact sheet. You or your patients can also call the Elder Helpline at 1-800-963-5337 and ask for a SHINE insurance counselor. For general Medicare information, call 1-800-MEDICARE (1-800-633-4227). ❖

**Please continue to look for  
“The Patient Friendly Advisory”  
in future issues of the Medicare A Bulletin**

**Editor Note:** The Patient Friendly Advisory section provides assistance to Medicare Part A facility medical staff in answering patients' questions and concerns related to the Medicare program. The Medicare Beneficiary Education staff provides the information in this section.

# EDUCATIONAL RESOURCES

## *The Ultimate Medicare Expo*

First Coast Service Options, Inc. is proud to present this year's most spectacular Medicare event, the Ultimate Medicare Expo (UME). This two-day symposium is structured to offer a variety of educational sessions and you can enroll in courses of your choice. The UME is open to Florida providers, People with Medicare (PWM), caregivers, pre-retirees, and billing staff. The UME will also offer an "interactive" session. This session will include PWM, caregivers, pre-retirees, providers, and billing staff working together to understand the important issue of the Advance Beneficiary Notice.

This Expo is packed with everything needed to help optimize Medicare providers' performance and offers PWM information needed to make informed healthcare decisions. In commemoration of September 11, we will feature a "Celebration of Life" presentation. Come and join us for this exciting event.

When:	September 10 & 11, 2002
Where:	Radisson Mart Plaza Hotel 711 NW 72nd Avenue Miami, FL 33126 (305) 261-3800
Registration:	Complete the registration form and the class schedules and fax to: (904) 791-6035

You can't afford to miss this Expo. Some of the many benefits to the provider are:

- You'll gain strategies for implementing processes to improve reimbursement efficiency.
- You'll discover proven ways to resolve your Medicare denials.
- Medicare experts will answer your questions.

*The Ultimate Medicare Expo is a one-of-a-kind event guaranteed to increase your Medicare Knowledge.*

### Registration Information

For your convenience, we have designated specific times for registration and check in. *Take advantage of early registration on September 9, 2002.*

Date	Registration Time
September 9, 2002	3:00 pm – 7:00 pm
September 10, 2002	7:30 am – 8:45 am
September 11, 2002	7:30 am – 8:45 am

### Commemoration Ceremony

Join us as we celebrate the courage and heroism exhibited one year ago by our fellow Americans.

#### September 11, 2002 (Day 2)

9:00 am – 9:30 am  
Celebration of Life





**ULTIMATE MEDICARE EXPO  
CLASS SCHEDULE  
September 10 -11, 2002  
(Days 1 & 2)**



REGISTRANT'S NAME: \_\_\_\_\_

PROVIDER #: \_\_\_\_\_



**IMPORTANT CLASS  
SCHEDULE INSTRUCTIONS**

1. Submit one registration form per person
2. Select **only one class** per time slot
3. Your registration form must accompany your class schedule(s)

REGISTRATION DEADLINE 08/26/02

**September 10 - DAY 1**

**September 11 - DAY 2**

**7:30 – 8:45**

**Registration Check-in/Vendor visitation**

**7:30 – 8:45**

**Registration Check-in/Vendor visitation**

**9:00 – 9:15**

**General Session (All UME attendees)**

**9:45 – 11:15**

- HOPPS (A)
- Inquiries, Appeals, & Overpayments (B)
- Medicare Secondary Payer Workshop (B)
- Primary Care (B)
- Rehabilitation Services (A)

**9:30 – 12:00**

- CMS-1500/EMC Workshop (B)
- Data Analysis/Progressive Corrective Action Process (PCA) (B)
- Global Surgery/Advanced Modifiers (B)
- HIPAA Privacy (A/B)
- UB-92/Direct Data Entry (DDE) Workshop (A)

**11:15 – 12:30**

**Interactive Session (All UME Attendees)  
Topic: Advanced Beneficiary Notices**

**1:30 – 3:00**

- Advanced Modifiers (A)
- Anesthesia/Pain Management (B)
- Fraud and Abuse (A/B)
- Reimbursement Efficiency (B)
- Vision (B)

**1:30 – 3:00**

- E & M Documentation (B)
- HIPAA Administrative Simplification Compliance Act (ASCA) (A/B)
- Orthopedics (B)
- Partial Hospitalization Program (A)
- Reimbursement Efficiency (A)

**3:30 – 5:00**

- Dermatology (B)
- E & M Coding (/B)
- Medical Review (A/B)
- Medicare Secondary Payer (A)
- Skilled Nursing Facility (A)

- (A) – Part A Course or Workshop
- (B) – Part B Course or Workshop
- (A/B) – Part A & B Course



**ULTIMATE MEDICARE EXPO  
REGISTRATION FORM  
September 10 & 11, 2002**



**FOUR EASY STEPS TO REGISTER**

**NOTE: ALL REGISTRATIONS MUST BE RECEIVED BY 8/26/02**

1. Fax both registration form and class schedule(s) to **(904) 791-6035**
2. Make checks payable to: **FCSO Account #700390**
3. Mail the forms (after you have faxed them) and payment to:  
**UME Seminar Registration  
PO Box 45157  
Jacksonville, Florida 32232-5157**
4. Bring your UME Confirmation notice to the event

Registrant's Name \_\_\_\_\_

Provider's Name \_\_\_\_\_

Medicare Billing Provider # \_\_\_\_\_ Sender Number: \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, ZIP Code \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

**Payment is being issued for:**

Seminar/Material <i>*UME Course Materials will be distributed at the event (upon arrival)</i>	Quantity	Price (each)	Total
<b>Ultimate Medicare Expo (UME)</b> <i>Note: UME Course Materials are not included.</i>	N/A	<b>\$299.00</b>	
<b>UME Part A Handbook on CD*</b> (see course descriptions for a list of the courses included) <i>After event, deadline to order is October 1, 2002.</i>		\$75.00	
<b>UME Part B Handbook on CD*</b> (see course descriptions for a list of the courses included) <i>After event, deadline to order is October 1, 2002.</i>		\$75.00	
<b>UME Individual Course Material*</b> (All individual course material are included in the Part A or Part B handbook. <u>Therefore, you do not have to order in addition to the Part A &amp; Part B handbook:</u> _____		\$30.00	

**Method of payment: The only acceptable forms of payment are checks and money orders.**  
Cash and credit cards are **NOT ACCEPTABLE** forms of payment.

If your organization is tax exempt, a copy of the tax-exempt statement should be included with your registration. Materials purchased are taxable.

**To secure your registration all payments must be received prior to the registration deadline of 8/26/02.**

Check (# \_\_\_\_\_) Money Order

<b>Subtotal:</b>
<b>Add 7% tax for materials only:</b>
<b>Total:</b>

**Important Registration Information:**

Cancellations and Refunds	Substitutions	Confirmation Notice	Hotel Information
<i>Cancellation requests must be received in writing 14 days prior to the event.</i> No refunds will be issued after that time.  All refunds are subject to a \$35.00 cancellation fee per person. (Rain checks will not be issued for cancellations. Additionally, rain checks issued for previous seminars may not be applied towards this event)	If you are unable to attend, your company may send <b>one substitute</b> to take your place for the <b>entire seminar</b> . Once you have signed in at the registration desk, substitutions will not be permitted during the remainder of the event. <b>Remember:</b> Registration must be informed of all changes in advance.	A confirmation notice will be faxed to you within 14 days of receiving your registration form.  If you do not receive a confirmation notice (not the confirmation form generated from your fax machine, but the confirmation notice provided by Medicare Education and Outreach), please contact us at (904) 791- 8600.	<b>Radisson Mart Plaza Hotel</b> 711 NW 72nd Ave. Miami, FL 33126 (305) 261-3800

*For additional information, please visit our Web site at [www.floridamedicare.com](http://www.floridamedicare.com), or call our registration hotline at (904) 791-8103.*



**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.

<b>1. TELL US ABOUT YOURSELF. PLEASE PRINT</b>			
<b>Name</b>			
<b>Title/Position</b>			
<b>Company/Organization</b>			
<b>Address</b>			
<b>City, State, Zip Code</b>			
<b>Phone Number</b>	(     )     -	<b>Extension:</b>	
<b>Fax Number</b>	(     )     -		
<b>E-Mail Address</b>			
<b>2. PLEASE INDICATE HOW MANY MODULES YOU WOULD LIKE TO PURCHASE.</b>			
<b>QUANTITY</b>	<b>TITLE</b>	<b>PRICE (EA.)</b>	<b>TOTAL</b>
	<b>Medicare Part A Resource Manual</b> <b>Includes our most popular subjects:</b> Direct Data Entry (DDE); Fraud and Abuse; HIPAA; How to Help Patients Understand Medicare; ICD-9-CM Coding; Introduction to Cost Report Auditing; Introduction to Cost Reports; Medical Review; Medicare Part C; Medicare Secondary Payer; PC-ACE™PRO 32; Provider Enrollment; Provider-Based Regulations; Reconsiderations, Reviews, and Inquiries; Reimbursement Efficiency; and UB-92 Claims Filing	\$80.00	\$
		<b>Sub-Total</b>	\$
		<b>Add 7% Tax</b>	\$
		<b>Total</b>	\$
<b>3. PAYMENT INFORMATION</b>			
<input type="checkbox"/> <b>SEND YOUR PAYMENT</b>	Submit the completed form with your check or money order: § Payable to <b>First Coast Service Options, Inc. #700241</b> § Mail to <b>Medicare Education and Outreach, Attn: Phyllis Brooks, 11Tower, P.O. Box 45157, Jacksonville, FL 32232-5157</b>  Your order will be shipped within four to six weeks.		





**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 700284).

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
_____	<b>Medicare A Bulletin Subscriptions</b> - One subscription of the <i>Medicare A Bulletin</i> 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: <input type="checkbox"/> Subscription Renewal or <input type="checkbox"/> New Subscription	700284	\$75.00

Subtotal \$ \_\_\_\_\_

Tax (7%) \$ \_\_\_\_\_

Total \$ \_\_\_\_\_

**Mail this form with payment to:**  
**First Coast Service Options, Inc.**  
**Medicare Publications - ROC 11T**  
**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 #700284**  
**(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](http://www.floridamedicare.com).*

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\* This special issue is available only on the provider Web site  
[www.floridamedicare.com](http://www.floridamedicare.com).

## 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](http://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.



## Addresses

### **CLAIMS STATUS**

Coverage Guidelines

**Billing Issues Regarding**

**Outpatient Services, CORE, ORF, PHP**

Medicare Part A Customer Service

P. O. Box 2711

Jacksonville, FL 32231-0021

(904) 355-8899

### **APPEAL RECONSIDERATIONS**

**Claim Denials (outpatient services only)**

Medicare Fair Hearings (Part A)

P. O. Box 45203

Jacksonville, FL 32232-5203

### **MEDICARE SECONDARY PAYER (MSP)**

**Information on Hospital Protocols**

**Admission Questionnaires**

**Audits**

Medicare Secondary Payer

Hospital Review

P. O. Box 45267

Jacksonville, FL 32232-5267

### **General MSP Information**

**Completion of UB-92 (MSP Related)**

**Conditional Payment**

Medicare Secondary Payer

P. O. Box 2711

Jacksonville, FL 32231-0021

(904) 355-8899

### **Automobile Accident Cases**

**Settlements/Lawsuits**

**Other Liabilities**

Medicare Secondary Payer Subrogation

P. O. Box 44179

Jacksonville, FL 32231-4179

### **PROVIDER EDUCATION**

Medicare Education and Outreach

P. O. Box 45157

Jacksonville, FL 32232-5157

### **Seminar Registration Hotline**

(904) 791-8103

### **ELECTRONIC CLAIM FILING**

**"DDE Startup"**

Direct Data Entry (DDE)

P. O. Box 44071

Jacksonville, FL 32231-4071

(904) 791-8131

### **FRAUD AND ABUSE**

Medicare Anti-fraud Branch

P. O. Box 45087

Jacksonville, FL 32232-5087

(904) 355-8899

### **REVIEW REQUEST**

**Denied claims that may have been payable under the Medicare Part A program**

Medicare Part A Reconsiderations

P. O. Box 45053

Jacksonville, FL 32232-5053

### **OVERPAYMENT COLLECTIONS**

**Repayment Plans for Part A Participating Providers**

**Cost Reports (original and amended)**

**Receipts and Acceptances**

**Tentative Settlement Determinations**

**Provider Statistical and Reimbursement (PS&R) Reports**

**Cost Report Settlement (payments due to provider or Program)**

**Interim Rate Determinations**

**TEFRA Target Limit and Skilled Nursing Facility Routine Cost Limit Exceptions**

**Freedom of Information Act Requests (relative to cost reports and audits)**

Provider Audit and Reimbursement

Department (PARD)

P.O. Box 45268

Jacksonville, FL 32232-5268

(904) 791-8430

## Phone Numbers

### **PROVIDERS**

**Customer Service Representatives:**

877-602-8816

### **BENEFICIARY**

800-333-7586

### **ELECTRONIC MEDIA CLAIMS**

**EMC Start-Up:**

904-791-8767, option 4

**Electronic Eligibility**

904-791-8131

**Electronic Remittance Advice**

904-791-6865

**Direct Data Entry (DDE) Support:**

904-791-8131

**PC-ACE Support**

904-355-0313

**Testing:**

904-791-6865

**Help Desk**

**(Confirmation/Transmission)**

904-905-8880

## Medicare Web Sites

### **PROVIDERS**

Florida Medicare Contractor

[www.floridamedicare.com](http://www.floridamedicare.com)

Centers for Medicare & Medicaid Services

[www.hcfa.gov](http://www.hcfa.gov) and [www.cms.hhs.gov](http://www.cms.hhs.gov)

### **BENEFICIARIES**

Florida Medicare Contractor

[www.medicarefla.com](http://www.medicarefla.com)

Centers for Medicare & Medicaid Services

[www.medicare.gov](http://www.medicare.gov)



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***MEDICARE A BULLETIN***

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

