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.*

Routing Suggestions:

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

CMS Centers for Medicare & Medicaid Services

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

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

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A PHYSICIAN'S FOCUS

"Off-label" Use of Marketed, FDA-Approved Medical Devices

Title XVIII of the Social Security Act, Health Insurance for the Aged and Disabled, establishes the Medicare program. The law outlines broad coverage of many medical and health care services. Given the complexity of the United States health care system and evolving technologies, the law attempts to categorize covered services (benefit categories) in lieu of an inclusive list (specific covered items). The law specifically excludes those items or services that are "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." The Centers for Medicare & Medicaid Services (CMS), as administrator of the Medicare program, exercises the authority to identify which items are included in a benefit category. More specific coverage and policy decisions are addressed by CMS with formal communications and national coverage determinations (NCDs) or by the CMS contractors with local medical review policies (LMRPs).

So how does the Medicare program address coverage of devices? Generally, devices are covered by the Medicare program based on the benefit category as determined by CMS. Decisions are coordinated with policy as determined by national coverage determinations, manual coverage provisions in interpretive manuals, or local medical review policies. Devices used in clinical research are considered experimental or investigational and are not covered, except as outlined in the Category B Investigational Device Exemption policy (effective date November 1995). The Medicare program uses the categorization of devices as defined by the Food and Drug Administration (FDA) as a *factor* in the determination of coverage. Approximately 1,700 different generic types of devices have been classified and assigned to one of three regulatory classes based on the level of control necessary to assure the safety and effectiveness of the device (see Web site *www.fda.gov/cdrh/devadvice/313.html*). Devices approved for marketing by the FDA have labeling requirements that may include intended uses, adequate directions for use, contraindications, and safety and effectiveness considerations. Labeling cannot be misleading or false.

The Medicare program covers devices approved for marketing by the FDA if:

- A benefit category exists and the device is not statutorily excluded.
- An NCD of noncoverage (or coverage limitation) does not exist.
- In the absence of an NCD, the local contractor does not have a noncoverage (or LMRP coverage limitation) policy.
- The device is used in an episode of care that is reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member.

If there is an NCD or a LMRP coverage limitation, criteria have to be met for coverage.

So how does the Medicare program address coverage of *"off-label" use of marketed, FDA-approved medical devices*? The same criteria for coverage of the labeled indications apply with the caveat that providers (physicians and hospitals) have an obligation to the patient in terms of identifying investigational/experimental indications or not medically necessary indications that are noncovered (possible financial liability for patient) and informed consent (possible additional risk to patient for the off-label use). Again, the device must be used in an episode of care that is reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member. Given the use of prospective payment systems, products and devices ancillary to a primary procedure may qualify for reimbursement without direct identification. Since billing of a service does not guarantee that the service meets Medicare coverage requirements, providers are encouraged to have mechanisms for determining, on a current and updated basis, whether devices furnished to Medicare beneficiaries are eligible for coverage and, more importantly, safe and effective.

Currently, there is *no prior approval program* in traditional Medicare and contractors review claims post billing. As a Medicare contractor, First Coast Service Options, Inc. recognizes the complex billing issues given the many devices with their primary and ancillary uses and encourages providers to share issues with the contractor for research and clarification by sending an email to: *medical.policy@fcso.com*.

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

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About *The Medicare A Bulletin*

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

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

Publication Name	Publication Date	Effective Date of Changes
First Quarter 2003	Mid-November 2002	January 1, 2003
Second Quarter 2003	Mid-February 2003	April 1, 2003
Third Quarter 2003	Mid-May 2003	July 1, 2003
Fourth Quarter 2003	Mid August 2003	October 1, 2003

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 $65.00. A subscription order form may be found in the Educational Resources section in each issue. Issues published since January 1997 may be downloaded from the provider education 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 notification of revisions to finalized medical policies and additions, revisions, and corrections to previously published LMRPs. In addition, effective with the First Quarter 2003, this section may contain information on wide spread probe review conducted by the fiscal intermediary. 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 publication.

The Educational Resources section includes educational material, such as seminar schedules, Medicare provider education Web site information, and reproducible forms. An index and important addresses and phone numbers are in the back of every issue.

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.

Do You Have Comments?

The publications staff welcomes your feedback on the *Bulletin* and appreciates your continued support. Please mail comments to:

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Medicare Communication & Education
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Jacksonville, FL 32232-5270

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare intermediary. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education Web site *www.floridamedicare.com*. 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.

GENERAL INFORMATION

Reporting of Noncovered Charges on Other than Part A Inpatient Claims

The Centers for Medicare & Medicare Services (CMS) has issued instructions for reporting outpatient claims containing noncovered charges and the proper use of occurrence code 32, and condition codes 20 and 21.

Beneficiaries are assumed to be liable on claims using condition code 21, since these claims, sometimes called "no-pay bills" and having all noncovered charges, are submitted to Medicare to obtain a denial that can be passed to subsequent payers. An advance beneficiary notice (ABN) is not required in these cases. If an ABN is given, condition code 21 cannot be used.

Claims with condition code 20 may be submitted with both covered and noncovered charges. An ABN, specifically Form R-131, should not be employed when condition code 20 is used. Note that condition code 20 may be used when:

1. A home health (HH) ABN, Form R-296, is used because payment will be made under the HH prospective payment system (PPS), or
2. A hospital or skilled nursing facility (SNF) inpatient notice of noncoverage is provided, since a Form R-131 will not be given in these cases.

Claims are billed with condition code 20 at a beneficiary's request, where the provider has already advised the beneficiary that Medicare is not likely to cover the service(s) in question. Providers may directly collect payment from beneficiaries in such cases for noncovered charges, but if, upon review, Medicare decides a service in question is actually covered and pays, providers must return any payment collected from beneficiaries for these services. Medicare reviews all HH and SNF services in question on these bills using condition code 20 to make a payment determination.

Occurrence code 32 on a claim signifies that an ABN, Form R-131, was given to a beneficiary on a specific date. This code must be employed if this specific ABN form is given, and condition code 20 will not be used on the subsequent claim (i.e., no charges will be submitted as noncovered). All services on such claims with occurrence code 32 must be covered charges, even if the result of full adjudication of these claims is expected to be that services will be found to be noncovered. If such services are noncovered after full adjudication, the beneficiary remains liable for the services. If instead, as a result of medical review, Medicare finds services are covered, the Medicare program becomes liable since the provider will receive payment direct from Medicare.

The use of a provider ABN, Form R-131 and occurrence code 32 can apply to all outpatient or institutional Part B services, with three exceptions:

1. A HH ABN, Form R-296 and condition code 20, can apply to HH PPS services.
2. The provider ABN, Form R-131, and occurrence code 32 are to be used when needed for hospice services paid under either Trust Fund A or B.
3. A totally separate process will be used for ambulance claims containing noncovered miles.

Only services for which the ABN was given should be shown on the claim with occurrence code 32, since the code pertains to every service on the claim. Providers must give separate ABNs for different procedures if performed on different dates, and show the services and the dates the ABNs were given on separate bills for each date involved. The one exception is that only one ABN is required for a series of services given under standing orders.

If a service not pertaining to the ABN was rendered in the same period as service(s) requiring an ABN, such services must be submitted on separate claims, and the statement dates of these claims **cannot** overlap.

Note: If the time periods cannot be separated (i.e., a service requiring an ABN is given on the same day a service not requiring an ABN), a single claim must be submitted, just for the overlapping period, using occurrence code 32, showing all services as covered, and placing modifier GA on the CPT/HCPCS code to identify the service (revenue code) line for which the ABN (CMS R-131) was given.

Since this is an exception process, providers are reminded to use this mechanism only when it is impossible to separate the billing periods.

The final instance in which beneficiaries are liable for noncovered changes is for services they request to be billed to Medicare, but Medicare does not cover by statute. Examples of services not covered by statute include personal comfort items, hearing aides and hearing examinations, routine eye and dental care. Medicare claim processing edits are being refined to effectuate the processing of such claims. Providers should advise beneficiaries each time they are aware services not covered by statute are being requested before Medicare is billed, but ABNs are not to be used in these cases.

If, in a situation in which giving an ABN, Form R-131 is not appropriate, a beneficiary demands a Medicare determination for any line(s) for other than HH PPS services, provider must submit those lines on a separate bill showing the charges as noncovered and put condition code 20 on the bill. If a beneficiary wants an MSN for denial reasons on any line(s), providers must submitted those lines on a separate bill and show condition code 21 on that bill. If the provider gives the beneficiary an ABN under any other circumstances, the provider must show the charges as covered and also put occurrence code 32 on the claims to fix beneficiary liability. There are no provider billing requirements for billing services excluded by statute other than billing such items as noncovered. Denial reasons will be generated for the lines containing noncovered charges. ❖

Source: CMS Transmittal A-02-117, CR 2336

Overpayment Interest Rate

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

Effective February 11, 2003, the interest rate applied to Medicare overpayments is **10.75 percent**, based on the revised PCR. The following table lists previous interest rates.

Period	Interest Rate
November 19, 2002 – February 10, 2003	11.25%
August 8, 2002 – November 18, 2002	12.625%
May 8, 2002 – August 7, 2002	11.75%
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% ❖

Source: CMS Transmittal AB-03-019; CR 2430

Deported Medicare Beneficiaries

The Centers for Medicare & Medicaid Services (CMS) has restated the payment policy, as mandated by the Social Security Act, in which a deported beneficiary is not entitled to receive Medicare-covered services.

A recent audit of Medicare payments by the Office of Inspector General identified vulnerability for the Medicare trust fund with respect to this issue. The study identified improper payments for beneficiaries who, on the date of service on the claim, had been deported. To address this vulnerability, CMS is establishing claim level editing using data from the Social Security Administration.

Medicare Payment Policy

No payments may be made for Medicare benefits furnished to an individual who has been deported from the United States.

Appeal Rights

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis of deportation status.

Implementation of Payment Policy

Effective for claims with dates of service **on or after April 1, 2003,** Medicare contractors will deny claims for items and services furnished to deported beneficiaries using reason code 96 (noncovered charges) and remark code N126 – "Social Security records indicate that this individual has been deported. The payer does not cover items and services furnished to individuals who have been deported." ❖

Source: CMS Transmittal AB-02-162, CR 2377

Home Health Consolidated Billing—HCPCS Quarterly Update

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). Services appearing on this list submitted on claims to both Medicare fiscal intermediaries (FIs) and carriers, including durable medical equipment regional carriers (DMERCs), will not be paid on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Items incidental to physician services, as well as supplies used in institutional settings, are not subject to HH consolidated billing.

Updates of the HH consolidated billing code list may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes). These temporary codes may describe services subject to CB billing in addition to the permanent list of HCPCS codes that is updated annually.

This quarterly update adds a single nonroutine supply code to the list of codes subject to CB, effective for services processed **on or after April 1, 2003.** The new code to be added is:

A6440 Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per roll (at least 10 yards, unstretched)

This code was identified through additional review of the annual HCPCS update that was reflected in the first quarterly update. However, it was identified too late for inclusion in Medicare system changes for the January quarter.

Other updates for the remaining quarters of the calendar year will occur as needed due to the creation of new temporary codes representing services subject to HH consolidated billing prior to the next annual update.

Providers and suppliers interested in an updated complete list of codes subject to HH CB may refer to the HH consolidated billing master code list available at *www.cms.hhs.gov/medlearn/refhha.asp*. ❖

Source: CMS Transmittal AB-03-002, CR 2515

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Reactivation of *CPT* Codes for Hepatitis B Vaccine

The Centers for Medicare & Medicaid Services (CMS) has reconsidered the instructions concerning new codes to be used in billing for hepatitis B vaccine issued November 1, 2002, in the Intermediary Manual (transmittal number 1866), and in the Hospital Manual (transmittal number 792) provided information in carrier and fiscal intermediary (FI) billing for hepatitis B vaccine effective January 1, 2003. HCPCS Q codes Q3021, Q3022 and Q3023 will not be established as new codes for Medicare purposes at this time. Therefore, Medicare is reactivating *CPT* codes *90740, 90743, 90744, 90746* and *90747* **effective January 1, 2003.**

The information concerning codes *90723* and *90748* is still correct.

Interim Claim Processing Guidelines

Although the effective date for these changes is January 1, 2003, the necessary changes will not be made until the April 2003 release to the outpatient prospective payment system (OPPS) outpatient code editor (OCE) software is implemented.

In the interim the following actions are needed:

- Providers should not bill Medicare for claims for hepatitis B vaccine containing *CPT* codes *90740, 90743, 90744, 90746* or *90747*, with dates of service January 1, 2003 through March 31, 2003, **until on or after April 1, 2003.** If a claim with a date of service January 1, 2003 through March 31, 2003, is received containing the above *CPT* codes, it will be returned to the provider.
- In situations where the provider furnishes additional services that would be reported on the same claim as the hepatitis B vaccine *CPT* codes, the provider may wish to remove the charge for the vaccine in order to receive payment for the remaining services and then submit an adjustment bill in April to receive payment for the vaccine *CPT* codes.
- Claims received for HCPCS codes Q3021, Q3022 or Q3023 will be returned to the provider. ❖

Source: CMS Transmittal AB-02-185, CR 2356

Timely Claim Filing Guidelines for Medicare Providers

All Medicare claims must be submitted to the contractor within the established timeliness parameters. For timeliness purposes, services furnished in the last quarter of the calendar year are considered furnished in the following calendar year. The time parameters are:

Dates of Service	*Last Filing Date*
October 1, 2000 – September 30, 2001	by December 31, 2002
October 1, 2001 – September 30, 2002	by December 31, 2003
October 1, 2002 – September 30, 2003	by December 31, 2004
October 1, 2003 – September 30, 2004	by December 31, 2005*****

*****If December 31 falls on a federal nonworking day, the last filing date is extended to the next succeeding workday. A federal nonworking day is considered a Saturday, Sunday, legal holiday, or a day declared by statute or executive order as a nonworking day for federal employees.

Periodic interim payment (PIP) providers must submit claims by the last day of the year following the year of the discharge date.

Claims must be submitted complete and free of errors. Any claim filed with invalid or incomplete information, and returned to provider (RTP) for correction, is not protected from the timely filing guidelines. ❖

AMBULANCE SERVICES

Second Clarification Regarding Ambulance Fee Schedule Implementation

During the implementation of the ambulance fee schedule, issues concerning the interpretation of Medicare policy have arisen that require clarification. This article provides additional guidance on these issues, and supplements previously issued instructions regarding the implementation of the ambulance fee schedule.

Change in Medicare Policy Concerning Bed-Confinement

The final rule published in the *Federal Register* on February 27, 2002 (67 FR 9100) supersedes earlier Medicare policy on the issue of bed-confinement. The preamble of the final rule states that the beneficiary is bed-confined if he/she is: unable to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair. As defined in the preamble, the term "bed confined" is not synonymous with "bed rest" or "nonambulatory." Medicare's current policy is that bed-confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits. It is simply one element of the beneficiary's condition that may be taken into account in the intermediary's/carrier's determination. Therefore, the current regulations (42 CFR section 410.40(d)) provide that a Medicare ambulance transport may only be payable if other forms of transportation are contraindicated by the beneficiary's condition. This policy is effective with the implementation of the Medicare fee schedule **on April 1, 2002.**

Second Clarification Regarding Ambulance Fee Schedule Implementation (continued)

Mandatory Assignment Rules

Mandatory Assignment and Claim Submittal Requirements

When an ambulance provider/supplier, or a third party under contract with the provider/supplier, furnishes a Medicare-covered ambulance service to a Medicare beneficiary and the service is not statutorily excluded under the particular circumstances, the provider/supplier must submit a claim to Medicare and accept assignment of the beneficiary's right to payment from Medicare.

Mandatory Assignment for Managed Care Providers/ Suppliers

Mandatory assignment for ambulance services, in effect with the implementation of the ambulance fee schedule on April 1, 2002, applies to ambulance providers/ suppliers under managed care as well as under fee-for-service. (The ambulance fee schedule is effective for claims with a date of service on or after April 1, 2002.) During the fee schedule transition period, Medicare payment for ambulance services is a blend of the reasonable cost/charge and fee schedule amount (80/60 percent reasonable cost/charge amount, and 20/40 percent fee schedule amount for services furnished in 2002/2003).

Per 42 CFR section 422.214, any provider or supplier without a contract establishing payment amounts for services provided to a beneficiary enrolled in a Medicare + Choice (M+C) coordinated care plan or M+C private fee-for-service plan must accept, as payment in full, the amounts that they could collect if the beneficiary were enrolled in original Medicare. The provider or supplier can collect from the M+C plan enrollee the cost-sharing amount required under the M+C plan, and collect the remainder from the M+C organization.

Mandatory Assignment and Beneficiary Signature Requirements

Medicare requires the signature of the beneficiary, or that of his/her representative, for both the purpose of accepting assignment and submitting a claim to Medicare. If the beneficiary is unable to sign because of a mental or physical condition, a representative payee, relative, friend, representative of the institution providing care, or a government agency providing assistance may sign on his/ her behalf. A provider/supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.

Medicare does not require that the signature to authorize claim submission be obtained at the time of transport for the purpose of accepting assignment of Medicare payment for ambulance benefits. When a provider/supplier is unable to obtain the signature of the beneficiary, or that of his/her representative, at the time of transport, it may obtain this signature any time prior to submitting the claim to Medicare for payment. (Per 42 CFR section 424.44, there is a 15 to 27 month period for filing a Medicare claim.)

If the beneficiary/representative refuses to authorize the submission of a claim, including a refusal to furnish an authorizing signature, then the ambulance provider/supplier may not bill Medicare, but may bill the beneficiary (or his/ her estate) for the full charge of the ambulance items and services furnished. If, after seeing this bill, the beneficiary/representative decides to have Medicare pay for these items and services, then a beneficiary/representative signature is required and the ambulance provider/supplier must afford the beneficiary/representative this option within the claims filing period.

Claims Jurisdiction for Air Ambulance Suppliers During the Transition Period

During the transition period, air ambulance suppliers must continue to submit claims to the carrier that has jurisdiction for the locality in which its air ambulance is based (i.e., garaged or hangared), per MCM sections 3102.C.1 and 2. Payment of a claim during the transition period is determined in part by the reasonable charge amount established in the carrier jurisdiction where the ambulance is based (i.e., garaged or hangared) and in part by the fee schedule amount in the jurisdiction of the point-of-pickup, as represented by its ZIP code.

For suppliers that provide services in multiple states, no additional enrollment is necessary for claims submission until the end of the transition period unless the supplier has established a base in another state. (Only if the supplier has established a base/hangar in another state, must it then also enroll with the carrier for the other state.) The carrier with jurisdiction for the claim has the supplier's reasonable charge amount and also the fee schedule amounts for all states in which the ambulance supplier provides services to determine the blended payment.

Payment for Services Performed Under Standing Orders

Under the Medicare ambulance fee schedule, payment for the transport includes payment for all medically necessary services and supplies. However, during the transition period, a supplier that had previously billed separately for medically necessary services may continue to do so. In situations where a supplier provides a service under a standing order (e.g., a standing order for performing a rhythm strip, placing oxygen, and starting an intravenous line when an advanced life support [ALS] ambulance is called), Medicare payment for such a service depends on whether it is medically necessary.

Under Medicare rules, whether a particular separately billable service is medically necessary is dependent on the particular circumstances of the beneficiary's condition at the time of transport. For the purpose of Medicare payment, services furnished pursuant to a standing order requiring that something be done regardless of the patient's needs are not recognized as being medically necessary on the basis of such an order. Services furnished by licensed personnel based on recognition of patient need and authorized by standing order, such as in an algorithm, or that are consistent with EMT protocols established in that state, can be paid for, provided the services are reasonable and necessary based on the patient's condition at the time they are furnished.

Second Clarification Regarding Ambulance Fee Schedule Implementation (continued)

Transport of Persons Other than the Beneficiary

Medicare payment policy remains unchanged with respect to the transport of persons other than the beneficiary. That is, no payment may be made for the transport of ambulance staff or other personnel when the beneficiary is not onboard the ambulance (e.g., an ambulance transport to pick up a specialty care unit from one hospital to provide services to a beneficiary at another hospital). This policy applies to both ground and air ambulance transports.

Effect of Beneficiary Death on Medicare Payment for Ground and Air Ambulance Transports

Because the Medicare ambulance benefit is a transport benefit, if no transport of a Medicare beneficiary occurs, then there is no Medicare-covered service. In general, if the beneficiary dies before being transported, then no Medicare payment may be made. Thus, in a situation where the beneficiary dies, whether any payment under the Medicare ambulance benefit may be made depends on the time at which the beneficiary is pronounced dead by an individual authorized by the state to make such pronouncements.

The chart below shows the Medicare payment determination for various ground ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary.

Ground Ambulance Scenarios: Beneficiary Death	
Time of Death Pronouncement	**Medicare Payment Determination**
Before dispatch	None
After dispatch, before beneficiary is loaded onboard ambulance (before or after arrival at the point-of-pickup).	The provider's/supplier's BLS base rate, no mileage or rural adjustment; use the QL modifier when submitting the claim.
After pickup, prior to or upon arrival at the receiving facility.	Medically necessary level of service furnished.

The next chart shows the Medicare payment determination for various air ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary. If the flight is aborted for other reasons, such as bad weather, the Medicare payment determination is based on whether the beneficiary was onboard the air ambulance. (See "Payment for Air Ambulance Transports Cancelled Due to Weather…"section.)

Air Ambulance Scenarios: Beneficiary Death	
Time of Death Pronouncement	**Medicare Payment Determination**
Prior to takeoff to point-of-pickup with notice to dispatcher and time to abort the flight.	None. **Note:** This scenario includes situations in which the air ambulance has taxied to the runway, and/or has been cleared for takeoff, but has not actually taken off.)
After takeoff to point-of-pickup, but before the beneficiary is loaded.	Appropriate air base rate with no mileage or rural adjustment; use the QL modifier when submitting the claim.
After the beneficiary is loaded onboard, but prior to or upon arrival at the receiving facility.	As if the beneficiary had not died.

Payment for Air Ambulance Transports Canceled Due to Weather or Other Circumstance Beyond the Pilot's Control

The chart below shows the Medicare payment determination for various air ambulance scenarios in which the flight is aborted due to bad weather, or other circumstance beyond the pilot's control.

Air Ambulance Scenarios: Aborted Flights	
Aborted Flight Scenario	**Medicare Payment Determination**
Any time before the beneficiary is loaded onboard (i.e., prior to or after take-off to point-of-pickup.)	None.
Transport after the beneficiary is loaded onboard.	Appropriate air base rate, mileage, and rural adjustment.

Payment When More than One Ambulance Arrives at the Scene

The general Medicare program rule is that the Medicare ambulance benefit is a transportation benefit and without a transport there is no payable service. When multiple ground and/or air ambulance providers/suppliers respond, payment may be made only to the ambulance provider/supplier that actually furnishes the transport. Ambulance providers/suppliers that arrive on the scene but do not furnish a transport are not due payment from Medicare.

Second Clarification Regarding Ambulance Fee Schedule Implementation (continued)

Billing for Ground-to-Air Ambulance Transports

For situations in which a beneficiary is transported by ground ambulance to or from an air ambulance, the ground and air ambulance providers/suppliers providing the transports must bill Medicare independently. Under these circumstances, Medicare pays each provider/supplier individually for its respective services and mileage. Each provider/supplier must submit a claim for its respective services/mileage to the intermediary/carrier that has jurisdiction for the locality in which its ambulance is based. (See "Claims Jurisdiction for Air Ambulance…" above.)

Resident and Nonresident Billing

The ambulance fee schedule has no effect on Medicare's longstanding policy concerning resident versus nonresident billing. In areas that distinguish between residents and nonresidents, Medicare beneficiaries must be charged the same rate as all others in the same category. That is, all residents of a particular jurisdiction must be charged the same "resident" rate and all nonresidents of that city and state must be charged the same "nonresident" rate.

Reasonable Charge Amount for ALS Mileage During the Transition Period

During the transition period, the HCPCS ground mileage code A0425 reasonable charge amount for the blended payment is calculated using a simple average (not a weighted average) of the 2001 reasonable charge allowances for HCPCS codes A0380 and A0390, updated by the ambulance inflation factor. (HCPCS codes A0380 and A0390 are invalid for dates of service on or after April 1, 2002).

If a supplier has established a customary charge for only ALS mileage or only BLS mileage, then that customary charge, subject to the inflation indexed charge (IIC) rules, is used to establish the supplier-specific customary charge amount for the reasonable charge portion of the blended payment for A0425 during the transition period. However, the program's payment allowance for the reasonable charge portion of the blended transition rate for A0425 is based on the lower of the supplier's customary charge (subject to the IIC rules), the prevailing charge, or the prevailing IIC. Therefore, the payment allowance under the reasonable charge portion of the blended payment for A0425 during the transition period will not exceed the prevailing charge or prevailing IIC that includes both BLS mileage and ALS mileage charge data for the locality in which the charge data was accumulated. The program's payment allowance for A0425 is then based on the lower of the blended rate and the actual charge on the claim.

Physician Certification Statement Requirements

The current regulations governing physician certification statement (PCS) requirements are specified at 42 CFR section 410.40(d). A PCS is required for the following ambulance services:

- Nonemergency, scheduled, repetitive ambulance services
- Unscheduled, nonemergency ambulance services or nonemergency ambulance services scheduled on a nonrepetitive basis for a resident of a facility who is under the care of a physician.

  Note: For nonemergency, scheduled, repetitive ambulance services, the physician's order must be dated no earlier than 60 days before the date that the service is furnished.

A PCS is not required for the following ambulance services:

- Emergency
- Nonemergency, unscheduled ambulance services for a beneficiary who, at the time of the transport, was residing either at home or in a facility and who was not under the direct care of a physician.

If unable to obtain the physician's signature, it is acceptable to obtain a signed certification statement from the physician assistant, nurse practitioner, registered nurse, clinical nurse specialist (where all applicable state licensure or certification requirements are met), or discharge planner, who has personal knowledge of the beneficiary's condition at the time that the ambulance transport is ordered or the service is furnished. This individual must be employed by the beneficiary's attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported.

For nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis, providers/suppiers must obtain a written order from the beneficiary's attending physician, within 48 hours after the transport, per 42 CFR section 410.40(d)(3). If unable to obtain a written order from the attending physician within 48 hours, providers/suppliers may submit a claim for the service if a PCS or certification from an acceptable alternative person as described in 42 CFR section 410.40(d)(3)(iii) has been obtained, or after 21 days if acceptable documentation of attempts to obtain the certification has been obtained. This policy also applies in a situation where a provider/supplier responds to a nonemergency call and, upon arrival at the point-of-pickup, the condition of the beneficiary requires emergency care.

Note: Although the beneficiary's condition in this scenario would require the provider/supplier to concentrate on the emergent treatment of the patient upon arrival at the scene, the claim for this service would not qualify as an "emergency transport," as defined in program memorandum AB-02-130.

When a PCS cannot be obtained in accordance with section 410.40(d)(3)(iv), a provider/supplier may send a letter via U.S. Postal Service (USPS) certified mail with a return receipt proof of mailing or other similar commercial service demonstrating delivery of the letter as evidence of the attempt to obtain the PCS. ❖

Source: CMS Transmittal AB-03-007, CR 2470

Multiple Patient Ambulance Transport

The Centers for Medicare & Medicaid Services (CMS) has provided reimbursement policy and claim processing instructions for ambulance services when multiple patients are transported simultaneously in the same ambulance to the same destination.

The final regulation to establish an ambulance fee schedule contains a provision that clarifies the reimbursement policy for pricing a single ambulance vehicle transport of a Medicare beneficiary where more than one patient is onboard the ambulance.

Reimbursement Policy

Effective for claims with dates of service **on or after April 1, 2002,** if **two patients** are transported to the same destination simultaneously, for each Medicare beneficiary, Medicare allows 75 percent of the payment allowance for the base rate applicable to the level of care furnished to that beneficiary plus 50 percent of the total mileage payment allowance for the entire trip.

If three or more patients are transported to the same destination simultaneously, the payment allowance for the Medicare beneficiary (or each of them) is equal to 60 percent of the base rate applicable to the level of care furnished to the beneficiary. However, a single payment allowance for mileage is prorated by the number of patients onboard. The applicable percentage is based on the total number of patients transported, including both Medicare beneficiaries and non-Medicare patients.

This policy applies to both ground and air transports.

Claim Processing Instructions

For claims with dates of service on or after April 1, 2002, providers must report value code 32 (multiple patient ambulance transport) when an ambulance transports more than one patient at a time to the same destination. Providers must report value code 32 and the number of patients transported in the amount field as a whole number to the left of the delimiter.

Providers may not report additional ambulance services on a claim that contains a multiple patient ambulance transport, even if the point-of-pickup ZIP code is the same. A separate claim must be submitted for additional ambulance services.

Interim Billing Instructions

Due to systems changes to the intermediary standard systems, providers are requested not to submit ambulance transport claims for multiple patients **until on or after April 1, 2003.** Value code 32 will not be recognized by intermediary standard systems until April 1, 2003.

For relevant claims submitted before April 1, 2003, without value code 32, providers may resubmit these claims for reprocessing on or after April 1, 2003. ❖

Source: CMS Transmittal A-02-108, CR 2186

Noncovered Miles for Ambulance Services

Medicare has a longstanding policy that mileage for an ambulance trip is covered only to the nearest, appropriate facility. Medicare recognizes that there are instances when a beneficiary may request to be transported to a facility that is not the closest appropriate facility. In these situations, there would be additional mileage that is not covered by Medicare. This policy applies to both ground and air ambulance services.

Coding Guidelines

For claims with dates of services **on or after April 1, 2003,** providers must report noncovered ambulance mileage under the following HCPCS code, using existing billing instructions for ambulance services:

A0888 Non-covered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)

Providers must continue to report the ambulance base rate line and the covered ambulance mileage line. In addition to the base rate and mileage ambulance lines, providers must report a third line for noncovered ambulance miles on the same bill.

Ambulance services provided under arrangement between a provider and an ambulance company would be reported in the same manner except providers would report a QM modifier instead of a QN modifier.

Other Instances Where Mileage Is Not Covered

There are cases where the provider does not incur any cost for mileage (e.g., a subsidy is received from a local municipality or the transport vehicle is owned and operated by a governmental or volunteer entity), or where no mileage is payable by Medicare (e.g., if the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene). In these situations, providers report the ambulance trip and the noncovered ambulance miles on two separate lines of the same claim.

Effective for claims with dates of service **on or after April 1, 2003,** providers must discontinue reporting $1.00 in form locator 48 "Noncovered Charges" and begin following the instructions outlined in this notification for reporting noncovered ambulance mileage.

Additional billing requirement information will be posted to the provider education Web site at *www.floridamedicare.com* as it becomes available. ❖

Source: CMS Transmittal A-02-113, CR 2331

GENERAL COVERAGE

Clarification Regarding Nonphysician Practitioners Billing on Behalf of Diabetes Self-Management Training

The Centers for Medicare & Medicaid Services (CMS) has confirms that Medicare nonphysician practitioners, such as nurse practitioners or registered dietitians who are eligible to render other Medicare services, may bill on behalf of a diabetes self-management training (DSMT) program furnished in an outpatient setting. Payment to nonphysician practitioners billing on behalf of the DSMT program should be made as if rendered by a physician. In addition, some outstanding issues regarding DSMT and medical nutrition therapy have been clarified.

Policy Clarification

All suppliers/providers who may bill for other Medicare services or items and who represent a DSMT program that is accredited as meeting quality standards can bill and receive payment for the entire DSMT program.

Registered dietitians are part of a multi-disciplinary team that provides DSMT services for the DSMT program. A dietitian may not be the sole provider of the DSMT service unless he or she is performing the service in a rural area as defined in 42 CFR 410.144. The accreditation organizations, the American Diabetes Association (ADA) or the Indian Health Service (IHS), will determine if the program can qualify to have a single-member team. The program may also include a program coordinator, physician advisor, and other trainers. However, only one person or entity from the program bills Medicare for the whole program. The benefit provided by the program may not be subdivided for the purposes of billing Medicare.

A hospital that has a DSMT program (accredited by the ADA or IHS) can be the biller without any reassignment. If a dietitian or certified diabetic educator has a DSMT program accredited under his or her name and he or she works for a hospital, then the dietician needs to reassign his or her benefits to the hospital. If a physician is part of the DSMT program, (i.e., a physician advisor), he or she can be the certified provider and bill Medicare using the physician's Medicare provider number. A registered dietitian, who has a Medicare provider number and is part of the DSMT program, can bill on behalf of the DSMT program.

The MNT benefit is a completely separate benefit from the DSMT benefit. CMS had originally planned to limit how much of both benefits a beneficiary might receive in the same time period. However, the national coverage decision, published May 1, 2002, allows a beneficiary to receive the full amount of both benefits in the same time period. Therefore, a beneficiary can receive the full 10 hours of initial DSMT and the full three hours of MNT. However, Medicare does not allowed to bill for both DSMT and MNT on the same date of service. In subsequent years, the beneficiary can receive two hours of DSMT (with a referral) and two hours of MNT (with a referral).

Medicare covers three hours of MNT in the beneficiary's initial calendar year. There will be no carrying over of initial hours to the next calendar year. For example, if a physician gives a referral to a beneficiary for three hours of MNT but a beneficiary only uses two hours in November, the calendar year ends in December and if the third hour is not used, it cannot be carried over into the following year. The following year a beneficiary is eligible for two follow-up hours (with a physician referral). Every calendar year a beneficiary must have a new referral for follow-up hours.

Payment to nonphysician practitioners billing on behalf of a DSMT program (G0108 or G0109) should be made at the full Medicare physician fee schedule rate and will not be paid at 85 percent of the fee schedule like other nonphysician practitioner services. This is because the payment is for the DSMT program and is not being made for the services of a single practitioner.

Nonphysician practitioners that bill on behalf of a DSMT program are subject to mandatory assignment.

HCPCS Codes for Medical Nutrition Therapy

Two new G codes have been created for MNT when there is a change in the beneficiary's condition:

G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
G0271	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes

The above new G codes for additional hours of coverage must be used after the completion of the three hours of basic coverage under 97802-97804 when a second referral is received during the same calendar year. No specific limit is set for the additional hours.

These new codes are part of the annual 2003 HCPCS update and payable under the Medicare physician fee schedule methodology. Therefore, the codes are effective for dates of service **on or after March 1, 2003.**

Advance Beneficiary Notice

The beneficiary is liable for services denied over the limited number of hours with referrals for DSMT or MNT. An advance beneficiary notice (ABN) should be issued in these situations. In absence of evidence of a valid ABN, the provider will be held liable. An ABN should not be issued for Medicare-covered services such as those provided by hospital dietitians or nutrition professionals who are qualified to render the service in their state but who have not obtained Medicare provider numbers. ❖

Source: CMS Transmittal AB-02-151, CR 2373

Electrical Stimulation for the Treatment of Wounds

For services furnished **on or after April 1, 2003,** Medicare will cover electrical stimulation for the treatment of wounds only for chronic stage III or stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers. Medicare does not cover all other uses of electrical stimulation for the treatment of wounds. Electrical stimulation will not be covered as an initial treatment modality.

The use of electrical stimulation will only be covered after appropriate standard wound care has been tried for at least 30 days and there are no measurable signs of healing. If electrical stimulation is being used, wounds must be evaluated periodically by the treating physician, but no less than every 30 days by a physician. Continued treatment with electrical stimulation is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment. Additionally, electrical stimulation must be discontinued when the wound demonstrates a 100 percent epithelialzed wound bed.

Billing Instructions

This service is billing on Form UB-92 CMS-1450 or electronic equivalent.

The following types of bill (TOB) for this service are:

12x – Hospital inpatient Part B
13x – Hospital outpatient
22x – Skilled nursing facility (SNF) (hospital-based inpatient Part B)
Note: TOB 22x is used for free standing SNFs as well as hospital-based. There is no differentiation in TOB for this aspect.
23x – Skilled nursing facility (outpatient)
71x – Rural health clinic (RHC)
73x – Federally qualified health clinic (FQHC)
74x – Outpatient rehabilitation facility (ORF)
75x – Comprehensive outpatient rehabilitation facility (CORF)

Applicable CPT/HCPCS Codes:

97014 *electrical stimulation unattended (not covered by Medicare)*

97032 *Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes*

Note: *CPT* code *97032* cannot be reported for wound care of any sort because wound care does not require constant attendance.

G0281 Electrical stimulation, (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care

Note: HCPCS code G0281descriptor indicates one or more areas, therefore reporting for G0281 is limited to one service per day.

G0282 Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281

G0295 Electromagnetic stimulation, to one or more areas (not covered by Medicare)

Applicable Revenue Codes

The following revenue codes must be used in conjunction with the HCPCS codes identified:

420 – Physical therapy
430 – Occupational therapy
520, 521 – (RHC)
977, 978 – (CAH)

Payment Guidelines

Medicare will not cover the device (HCPCS code E0761) used for the electrical stimulation for the treatment of wounds. However, Medicare will cover the service. Payment for these services is made under the Medicare physician fee schedule for hospitals, CORFs, ORFs, OPT, and SNF.

Payment methodology for both independent and provider-based RHCs, and free-standing and provider based FQHCs is made under the inclusive rate for the visit furnished to the RHC/FQHC patient. Only one payment will be made for the visit furnished to the RHC/FQHC patient to obtain the therapy service.

Payment methodology for critical access hospitals (CAHs) will be made on a reasonable cost basis unless the CAH has elected the optional method of payment for outpatient services, in which case, procedures outlined in section 3610.00 of the Part A Intermediary Manual will be used.

Part B deductible and coinsurance apply to these services. ❖

Source: CMS Transmittal AB-02-161, CR 2313

Noncoverage of Multiple Electroconvulsive Therapy

The Medicare Coverage Issues Manual indicates that the clinical effectiveness of multiple-seizure electroconvulsive therapy (MECT) has not been verified by scientifically controlled studies. In addition, studies have demonstrated an increased risk of adverse effect with multiple seizures. Accordingly, MECT **cannot** be considered reasonable and necessary and is noncovered.

Claim Processing Instructions

Effective for dates of service **on or after April 1, 2003**, Medicare does **not** covered multiple-seizure electroconvulsive therapy in any setting or under any code. The following HCPCS code will be noncovered effective April 1, 2003.

90871 *Electroconvulsive therapy (includes necessary monitoring); multiple seizures, per day*

The changes to the outpatient code editor software will be made via the quarterly update process. ❖

Source: CMS Transmittal AB-03-003, CR 2499

Hyperbaric Oxygen Therapy for the Treatment of Diabetic Wounds of the Lower Extremities

Hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. Effective for services furnished **on or after April 1, 2003,** a national coverage decision expanded the use of HBO therapy to include coverage for the treatment of diabetic wounds of the lower extremities in patients who meet all of the following three criteria:

- Patient has type I or type II diabetes and has a lower extremity wound that is due to diabetes (ICD-9-CM diagnosis 250.7, 250.8, 707, 707.1, 707.10, 707.12, 707.13, 707.14, and 707.19).
- Patient has a wound classified as Wagner grade III or higher.
- Patient has failed an adequate course of standard wound therapy.

The use of HBO therapy will be covered as adjunctive therapy only after there are no measurable signs of healing for at least 30 days of treatment with standard wound therapy and must be used in addition to standard wound care. Standard wound care in patients with diabetic wounds includes:

- Assessment of a patient's vascular status and correction of any vascular problems in the affected limb if possible
- Optimization of nutritional status
- Optimization of glucose control
- Debridement by any means to remove devitalized tissue
- Maintenance of clean, moist bed of granulation tissue with appropriate moist dressings
- Appropriate off-loading, and necessary treatment to resolve any infection that might be present.

Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBO therapy. Continued treatment with HBO treatment is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

The Center for Medicare & Medicaid Services (CMS) has concluded that special supervision and credentialing requirements should not be imposed on physicians who perform HBO therapy. The higher level of supervision will be direct supervision as is required for all "incident to" therapies. CMS encourages physicians who perform HBO therapy to obtain adequate training in the use of HBO therapy and in advanced cardiac life support.

Note: Topical application of oxygen does not meet the definition of HBO therapy as stated above. Also, its clinical efficacy had not been established. Therefore, no Medicare reimbursement may be made for the topical application of oxygen.

Billing Requirements

Claims for HBO therapy must be submitted on Form UB-92 CMS-1450 or its electronic equivalent following the general bill review instructions in section 3604 of the Medicare Intermediary Manual, Part 3.

Applicable Bill Types

The applicable bill types are 11x, 13x and 85x.

CPT/HCPCS Coding

99183 *Physician attendance and supervision of hyperbaric oxygen therapy, per session*

C1300 Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval

Note: Code C1300 is not available for use other than in a hospital outpatient department. In skilled nursing facilities (SNFs), HBO therapy is part of the SNF PPS payment for beneficiaries in covered Part A stays.

For hospital inpatients and critical access hospitals (CAHs) not electing method I, HBO therapy is reported under revenue code 940 without any HCPCS code. For inpatient services, show ICD-9-CM procedure code 93.59 in form locator 80 and 81.

For CAHs electing method I, HBO therapy is reported under revenue code 940 along with HCPCS code 99183.

Payment Methodology

For services furnished **on or after April 1, 2003**, payment is allowed for HBO therapy for diabetic wounds of the lower extremities when performed as a physician service in a hospital outpatient setting and for inpatients. Payment is allowed for claims with valid ICD-9-CM diagnosis codes as shown above. Claims with invalid diagnosis codes will be denied as not medically necessary.

For hospitals, payment will be based upon the ambulatory payment classification or the inpatient diagnosis related group.

Deductible and coinsurance apply. ❖

Source: CMS Transmittal AB-02-183, CR 2388

Neuromuscular Electrical Stimulation

Neuromuscular Electrical Stimulation (NMES) involves the use of a device that transmits an electrical impulse to activate muscle groups by way of electrodes. Coverage of NMES to treat muscle atrophy is limited to the treatment of patients with disuse atrophy where the nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves and other nonneurological reasons for disuse atrophy. The type of NMES that is used to enhance walking in spinal cord injury (SCI) patients is commonly referred to as functional electrical stimulation (FES). These devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence.

Coverage Guidelines

For services furnished **on or after April 1, 2003**, Medicare will cover NMES/FES to enhance walking for SCI patients who have completed a training program, which consists of at least 32 physical therapy sessions with the device over a period of three months.

Coverage for NMES/FES for walking will be limited to SCI patients with **all** of the following characteristics:

- Persons with intact lower motor units (L1 and below) (both muscle and peripheral nerve).
- Persons with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently.
- Persons that demonstrate brisk muscle contraction to NMES and have sensory perception of electrical stimulation sufficient for muscle contraction.
- Persons that possess high motivation, commitment and cognitive ability to use such devices for walking.
- Persons that can transfer independently and can demonstrate standing independently for at least three minutes.
- Persons that can demonstrate hand and finger function to manipulate controls.
- Persons with at least six-month post recovery spinal cord injury and restorative surgery.
- Persons without hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis.
- Persons who have demonstrated a willingness to use the device long-term.

NMES/FES to enhance walking for SCI patients will **not** be covered for SCI patients with **any** of the following:

- Presence of cardiac pacemakers or cardiac defibrillators
- Severe scoliosis or severe osteoporosis
- Irreversible contracture
- Autonomic dysreflexia
- Skin disease or cancer at area of stimulation.

ICD-9-CM Requirements

The NMES/FES to enhance walking in SCI patients is covered by Medicare if provided in a hospital setting, either inpatient or outpatient and in a comprehensive outpatient rehabilitation facility (CORF) or outpatient rehabilitation facility (ORF). The beneficiary must meet all of the conditions listed above to be eligible for this benefit.

Diagnosis code 344.1 must be present for payment to be made. However, while paraplegia of both lower limbs is a necessary condition for coverage, the nine coverage criteria listed above are also required. Intermediaries must deny payment for patients with any of the following diagnosis codes:

- Presence of cardiac pacemakers (V45.89 & V53.31) or cardiac defibrillators (V45.00, V45.01, V45.02 & V45.09)
- Severe scoliosis or severe osteoporosis (733.00-733.09, 736.89, 736.9, 737.30 – 737.39, 737.40, 737.43, 738.4, 738.5 & 754.2)
- Irreversible contracture (736.00 – 736.09, 736.30 – 736.39, 736.6, 736.70 - 736.79, 736.81 & 736.89)
- Autonomic dysreflexia (337.3); or the following diagnosis: Skin diseases or cancer at area of stimulation.

Billing Instructions

The applicable types of bill (TOB) are:

11x, 12x – Inpatient acute care hospitals that are not critical access hospitals (CAHs), including inpatient rehabilitation facilities
13x – Outpatient hospital services (OPPS)
74x – Outpatient rehabilitation facilities (ORFs)
75x – Comprehensive outpatient rehabilitation facilities (CORFs)

Applicable Revenue Codes

420 – Revenue code

Applicable *CPT* Code

Applicable *CPT* code for TOB 12x, 13x, 74x and 75x

97116 *Therapeutic procedure, one or more areas, each 15 minutes; gait training (include stair climbing)*

Note: This is the only code to be billed. It must be used for one-on-one face-to-face service provided by the physician or therapist.

Payment Methodology

Payment for inpatient hospital is included in the diagnosis related group.

Part B deductible and coinsurance apply to this service. ❖

Source: CMS Transmittal AB-02-156, CR 2314

Update to the Mammography Quality Standard Act File for Certified Digital Mammography Centers

Section 104 of the Benefits Improvement and Protection Act (BIPA) of 2000, entitled "Modernization of Screening Mammography Benefit," provided new payment methodologies for both diagnostic and screening mammograms that utilize digital technology. The new digital mammography codes have a higher payment rate. In order for Medicare to know whether the mammography facility is certified to perform digital mammography and, therefore, due a higher payment rate, the Food and Drug Administration (FDA) will send an updated file via the Centers for Medicare & Medicaid Services (CMS) mainframe telecommunication system, on a weekly basis.

Effective April 1, 2003, Medicare will use an additional indicator on the Mammography Quality Standard Act (MQSA) file to identify the FDA-approved mammography facilities for digital mammography. This additional indicator will provide Medicare with the necessary information for the new digital mammography codes that have a higher payment rate.

The FDA must certify facilities to perform film mammography and digital mammography. In this case, the facility's name and FDA certification number will show up on this file twice. One line will indicate film certification with effective date/expiration date while the other line will indicate digital certification with effective date/expiration date. The facilities may not have the same effective date and expiration date for both film and digital certification.

Medicare pays for film mammography and digital mammography at different rates and pays for a service only if the provider or supplier is certified by the FDA to perform those types of mammogram for which payment is sought. ❖

Source: CMS Transmittal AB-02-149, CR 1729

Restating Guidelines for Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes.

Coverage and billing guidelines for the diagnosis and treatment of peripheral neuropathy with loss of protective sensation (LOPS) in people with diabetes were published in the Third Quarter 2002 *Medicare A Bulletin* (pages 8-9). Since then, the Centers for Medicare & Medicaid Services (CMS) has requested fiscal intermediaries to restate the coverage and billing requirements for these services.

Coverage and Billing Requirements

Peripheral neuropathy with LOPS in people with diabetes benefit is covered by Medicare when submitted with one of the ICD-9-CM diagnosis codes 250.60, 250.61, 250.62, 250.63, or 357.2 reported with HCPCS codes G0245, G0246 and G0247. Effective for claims with dates of service **on or after January 1, 2003,** these services will be denied when submitted without one of the appropriate diagnoses supporting the medical necessity.

HCPCS code G0247 must be billed on the same claim with the same date of service as either HCPCS G0245 or G0246 to be considered for payment. Effective for claims with dates of service **on or after January 1, 2003,** HCPCS code G0247 will be denied if it is not submitted on the same claim as G0245 or G0246.

For additional information on this Medicare benefit see the local medical review policy published in the Fourth Quarter 2002 *Medicare A Bulletin* (pages 86-87). ❖

Source: CMS Transmittal AB-02-158, CR 2444

New CLIA Waived Tests

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), effective September 27, 2002. The *Current Procedural Terminology* (*CPT*) codes for these new tests must have the modifier QW to be recognized as a waived test.

- Roche Diagnostics CoaguChek PST, effective: May 7, 1999, CPT code: 85610QW
- Quidel QuickVue Advance pH and Amines Test, effective: June 13, 2002, CPT codes: 82120QW and 83986QW
- Cholestech GDX A1C Test (prescription home use), effective: July 1, 2002, CPT code: 83036QW
- Quidel QuickVue® In-Line Strep A, effective: July 8, 2002, CPT code: 87880QW QW
- HemoCue® Glucose 201 Microcuvettes and Glucose 201 Analyzer, effective: July 12, 2002,CPT codes: 82947QW, 82950QW, 82951QW, and 82952QW
- Genzyme OSOM® Strep A Ultra Test – 25 Test Kit Size, effective July 19, 2002, CPT code: 87880QW
- O2 Unlimited Donna Ovulation Tester, effective: August 26, 2002, CPT code: 87210QW
- Stesans Maybe?Mom Mini Ovulation Microscope, effective: August 26, 2002, CPT code: 87210QW
- Diagnostic Chemicals ImmunoDip™ Urinary Albumin Test, effective: August 29, 2002, CPT code: 83518QW.

New waived codes have been assigned for the following tests:

- 82274QW for the Enterix InSure™ Fecal Occult Blood Test that was listed as a new waived test in transmittal AB-02-091, change request 2263; and
- 87210QW for the O2 Unlimited Donna Ovulation Tester and Stesans Maybe?Mom Mini Ovulation Microscope.

TEST NAME	MANUFACTURER	CPT CODES	USE
Roche Diagnostics Coaguchek PST	Roche Diagnostics	85610QW	Aid in screening for congenital deficiencies of factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumadin or warfarin effect; screen for vitamin K deficiency
Quidel QuickVue Advance pH and Amines Test	Quidel Corporation	82120QW 83986QW	Qualitative test of a vaginal fluid sample for elevated pH (pH greater than or equal to 4.7) and the presence of volatile amines
Cholestech GDX A1C Test (Prescription Home Use)	Cholestech Corporation	83036QW	Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes
Quidel QuickVue® In-Line Strep A	Quidel Corporation	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection, which typically causes strep throat, tonsillitis, and scarlet fever
HemoCue® Glucose 201 Microcuvettes and Glucose 201 Analyzer	HemoCue, Inc.	82947QW 82950QW 82951QW 82952QW	Measures glucose levels in whole blood
Genzyme OSOM® Strep A Ultra Test –25 Test Kit Size	Genzyme Corporation	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection, which typically causes strep throat, tonsillitis, and scarlet fever
O2 Unlimited Donna Ovulation Tester	O2 Unlimited Corp.	87210QW	Detects ferning pattern in saliva which is used in the determination of ovulation (optimal for conception)
Stesans Maybe?Mom Mini Ovulation Microscope	LEC Associates	87210QW	Detects ferning pattern in saliva which is used in the determination of ovulation (optimal for conception)
Diagnostic Chemicals ImmunoDip™ Urinary Albumin Test	Diagnostic Chemicals Limited	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

Information on CLIA services may be found in the following Medicare manuals:

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-02-154, CR 2413

Medicare Telehealth Update

Section 1834(m) of the Social Security Act (the Act) established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20.00. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare economic index (MEI) as defined in section 1842(i)(3) of the Act.

The MEI increase for 2003 is 3.0 percent.

Additionally, the psychiatric diagnostic interview examination was added to the list of Medicare telehealth services as specified at 42 CFR Subpart B, section 410.78.

Originating Site Facility Fee Payment Amount Update

For calendar year 2003, the payment amount for HCPCS code Q3014 (telehealth originating site facility fee) is 80 percent of the lesser of the actual charge or $20.60.

Addition to the List of Medicare Telehealth Services

Effective January 1, 2003, the psychiatric diagnostic interview examination *(CPT* code 90801) is a Medicare telehealth service for providers eligible for telehealth originating site facility fee payments (hospital, rural health clinics, federally qualified health centers, critical access hospitals). ❖

Source: CMS Transmittal AB-02-160, CR 2403

CRITICAL ACCESS HOSPITAL SERVICES

January 2003 Update to the Medicare Outpatient Code Editor

The Medicare outpatient code editor (OCE) specifications (version 18.1) have been updated with new additions, changes, and deletions to the *Current Procedural Terminology*/Healthcare Common Procedure Coding System (*CPT*/HCPCS) codes and the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes.

This OCE update is used to process bills from hospitals that are not paid under the outpatient prospective payment system such as Indian health service hospitals, critical access hospitals, Maryland hospitals, and hospitals located in American Samoa, Guam, and Saipan. Claims from Virgin Islands hospitals with dates of service on or after January 1, 2002, are also processed through this OCE. Below are the specifications to the January 2003 update to the Medicare OCE (version 18.1).

Nonreportable *CPT* Codes

The following *CPT* codes has been removed from the list of nonreportable services, r**etroactive to August 1, 2002:**

99183

Deleted HCPCS Codes

The following HCPCS codes have been removed from the list of valid codes, **effective October 1, 2002:**

C8915 C8916 C8917. ❖

Source: CMS Transmittal A-03-001, CR 2522

HOSPITAL SERVICES

Cost-Based Payment for Certified Registered Nurse Anesthetists

Currently, outpatient services of certified registered nurse anesthetists (CRNAs) furnished by hospitals subject to outpatient prospective payment system (OPPS) that qualify for cost-based payment under 42 CFR 412.113(c) are made through biweekly interim payments subject to retrospective adjustments based on a settled cost report.

The Centers for Medicare & Medicaid Services (CMS) has provided instructions that will allow these small rural hospitals that qualify for cost-based CRNA services to bill and be properly paid for these services. These instructions replace the interim instructions published in the First Quarter 2003 *Medicare A Bulletin* (page 27).

Billing Instructions

In order for interim payments to be made to these hospitals based on submitted claims, a number of changes are required in the reporting and acceptance of revenue code 964 "Anesthetists (CRNA)." Effective for claims with dates of service **on or after April 1, 2003,** the follows guidelines apply:

- Hospitals that qualify for cost-based CRNA services must report these services under revenue code 964
- Hospitals must **not** bill HCPCS (Healthcare Common Procedure Coding System) codes when billing for CRNA services.
- Reporting and acceptance of revenue code 964 for other OPPS hospitals (without a CRNA pass-through exemption) may not be allowed.

Note: Value code 05 "Professional component included in charges and also billed separately to carrier" should not be reported with revenue code 964.

Hospital should bill the beneficiaries for coinsurance for cost-based CRNA services billed under revenue code 964. Coinsurance is based on 20 percent of charges. The Part B deductible is applicable. ❖

Source: CMS Transmittal A-02-109, CR 2325

Medical Nutrition Therapy Services for Beneficiaries with Diabetes or Renal Disease—Policy Change

An article published in the Fourth Quarter 2002 of the Medicare A Bulletin (pages 14-15) stated that medical nutrition therapy (MNT) cannot be billed to fiscal intermediaries (FIs). After reviewing this policy, the Centers for Medicare & Medicaid services (CMS) has determined that MNT services can be billed to FIs when performed in an outpatient hospital setting. In addition, two new additional codes have been developed for MNT services when there is a change in the beneficiary's condition. For additional information on MNT see "Clarification Regarding Nonphysician Practitioners Billing on Behalf of Diabetes Self-Management Training," (page 12) of this publication.

Change in Policy

Hospital outpatient departments can bill for the MNT services through the local FI if the nutritionists or registered dietitians reassign their benefits to the hospital. If the hospitals do not get the reassignments, the nutritionists and registered dietitians will have to bill the local Medicare carrier under their own provider number or the hospital will have to bill the local Medicare carrier.

Nutritionists and registered dietitians must obtain a Medicare provider number before they can reassign their benefits.

There is no facility fee for this benefit.

Medicare has covered MNT services beginning with dates of service **on or after January 1, 2002.**

Billing Requirements

This service is billed on Form UB-92 CMS-1450, or its electronic equivalent, but will not change the enrollment requirement for dieticians/nutritionists.

The cost of the service is billed under revenue code 942 in floor locator (FL) 42. The provider will report *CPT* codes in FL 44, and the definition of the code in FL 43.

Types of Bill

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

CPT/HCPCS Codes

MNT services are reported under the following *CPT*/HCPCS 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.

This code is to 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*.

97803 *re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes*

Medical Nutrition Therapy Services for Beneficiaries with Diabetes or Renal Disease—Policy Change (continued)

This code is to be billed for all individual reassessments and all interventions after the initial visit (see *CPT* code *97802*). This code should also be used when there is a change in the patient's medical condition that affects the nutritional status of the patient (see the heading, Additional Covered Hours for Reassessments and Interventions).

97804 *group (2 or more individual(s)), each 30 minutes*

This code is to be billed for all group visits, initial and subsequent. This code can also be used when there is a change in a patient's condition that affects the nutritional status of the patient and the patient is attending in a group.

In addition to the above codes, two new G codes have recently been created for MNT services.

These new G codes are to be used when there is a change in the beneficiary's condition. These two new G codes are part of the 2003 HCPCS update payable under the Medicare physician fee schedule methodology. Therefore, the new G codes are effective for dates of service **on or after March 1, 2003.**

G0270 Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes

G0271 Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes

These new G codes must be used when additional hours of MNT services are performed beyond the number of hours typically covered, (three hours in the initial calendar year, and two follow-up hours in subsequent years with a physician referral) when the treating physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary.

Payment Methodology for MNT

Payment for MNT services is made under the Medicare physician fee schedule. Payment will be the lesser of the actual charge, or 85 percent of the fee schedule amount. Coinsurance is based on 20 percent of the lesser of these two amounts. ❖

Source: CMS Transmittal A-03-009, CR 2550

Clarification to Single Drug Pricer Initiative—2003 Fees for Blood Clotting Factors

An article was published in the January 2003 *Medicare A Bulletin* Special Issue (page 21) addressing the implementation of the single drug pricer (SDP) initiative. Since then, the Centers for Medicare & Medicaid Services has issued the following statement to clarify the coverage of drugs and biologics affected by this initiative.

"The presence or absence of a particular drug on the SDP file does not represent a determination that the Medicare program either covers or does not cover that drug. The amounts shown on the SDP file indicate the maximum Medicare payment allowance, if the Medicare contractor determines that the drug meets the program's requirements for coverage. Similarly, the absence of a particular drug from the SDP file means that if the Medicare contractor determines that the drug is covered by Medicare, the local contractor must then determine the program's payment allowance by applying the program's standard drug payment policy rules. Medicare contractors separately determine whether a particular drug meets the program's general requirements for coverage and, if so, whether payment may be made for the drug in the particular circumstance under which it was furnished. Examples of this latter determination include, but are not limited to, determinations as to whether a particular drug and route of administration are reasonable and necessary to treat the beneficiary's condition, whether a drug may be excluded from payment because it is usually self-administered, and whether a least costly alternative to the drug exists."

SDP instructions apply to blood clotting factors furnished to hospital inpatients. All hospital outpatient drugs are excluded because the payment allowance for such drugs is determined by different payment methodologies. The national SDP fees established for blood clotting factor services are:

Code	Fees
J7190	$0.87
J7191	$2.04
J7192	$1.26
J7193	$1.12
J7194	$0.37
J7195	$1.12
J7198	$1.43

The January 2003 *Medicare A Bulletin* Special Issue is available on the provider education Web site at: *www.floridamedicare.com.* ❖

Source: CMS Transmittal AB-03-014, CR 2544

MEDICAL POLICIES

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), Medicare contractors no longer distribute full-text local medical review policies (LMRPs) to providers in hardcopy format. Providers may obtain full-text LMRPs on the provider education Web site, *www.floridamedicare.com*. Final LMRPs, draft LMRPs available for comment, LMRP statuses, and LMRP comment/response summaries may be printed from the Part A section under Medical Policy (A).

This section of the *Medicare A Bulletin* features summaries of new and revised medical policies developed as a result of either local medical review or focused medical review initiatives. Both initiatives are designed to ensure the appropriateness of medical care and that the intermediary's medical policies and review guidelines are consistent with accepted standards of medical practice.

Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date claims are *processed*, not the date of service (unless otherwise noted in the policy). Medicare contractors are required to offer a 45-day notice period for LMRPs; the date the LMRP is posted to the Web site is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new and revised LMRPs are posted to the Web site, subscribe to the FCSO *eNews* mailing list. It's very easy to do; simply sign on to the provider education Web site, *www.floridamedicare.com;* click on the yellow "Join our electronic mailing list" bar and follow the prompts.

More Information

For more information, or to obtain a hardcopy of a specific LMRP if you do not have Internet access, contact Medical Policy at:

Medical Policy – 19T
First Coast Service Options, Inc.
P.O. Box 2078
Jacksonville, FL 32231-0048
Or call (904) 791-8465

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This Bulletin Should Be Shared with All Health Care Practitioners and Managerial Members of the Provider Staff. Bulletins Are Available at no Cost from Our Provider Education Web Site at *www.floridamedicare.com*.

29540: Strapping—Revision to Policy

The local medical review policy (LMRP) for Strapping – 29540 was published in the First Quarter 2002 *Medicare A Bulletin* (pages 31-32). Since that time, diagnosis code 734 (flat foot) has been removed from the "ICD-9-CM Codes that Support Medical Necessity" section of this policy. The Medicare Intermediary Manual, section 3158, specifically excludes coverage for the treatment of flat foot. This revision is effective for claims processed **on or after January 23, 2002**.

Additionally, diagnosis code range 707.10-707.19 (ulcers of lower limbs, except decubitus) has been added to the same section.

Furthermore, revenue code 42x has been changed to 420, revenue code 43x has been changed to 430, and it was clarified that revenue code 510 is only appropriate with types of bill 13x and 85x.

Effective Date

These revisions are effective for claims processed **on or after December 19, 2003**. ❖

61885: Vagus Nerve Stimulation—Revision to Policy

The local medical review policy for Vagus Nerve Stimulation – 61885 was published in the December 1999 Special Issue *Medicare A Bulletin* (pages 22-24). Since that time, type of bill 85x has been added and type of bill 71x has been removed from the "Type of Bill Code" section of the policy.

Additionally, revenue code 361 has been changed to 36x in the "Revenue Codes" section of the policy.

Effective Date

These revisions are effective for services processed **on or after January 30, 2003**. ❖

70450: Computerized Tomography Scans—Correction to Policy

The local medical review policy for Computerized Tomography Scans – 70450 was published in the Third Quarter 2001 *Medicare A Bulletin* (pages 38-41). Diagnosis range 237.5-237.9 for neoplasm of uncertain behavior of endocrine glands and nervous system was inadvertently omitted from publication of the policy. Florida Medicare apologizes for any inconvenience this may have caused.

Effective Date

This revision is effective for claims processed **on or after August 1, 2000**. ❖

53850: Prostate Treatments—Revision to Policy

The local medical review policy (LMRP) for Prostate Treatments – 53850 was published in the Second Quarter 2002 *Medicare A Bulletin* (pages 23-24). Since that time, information has been submitted that supports the deletion of the contraindication of "prostate gland with an obstructive median lobe" for patients undergoing transurethral needle ablation (TUNA).

Based on the above information, a minor revision has been made to the LMRP.

Effective Date

This revision is effective for claims processed **on or after December 19, 2002**. ❖

64550: Application of Surface (Transcutaneous) Neurostimulator—Implementation of New Policy

Transcutaneous electrical nerve stimulator (TENS) is a type of electrical nerve stimulator that is employed to treat chronic intractable pain and for the relief of acute post-operative pain. TENS is the application of electrical stimulation to skin electrodes, which may be placed over a painful area. Placement in paravertebral locations as well as over nerves proximal, distal, and even contralateral to a site of pain may also be used. The electrical signals from the TENS interfere with the transmission of painful stimuli sent to the brain producing analgesia. TENS can produce analgesia for a wide range of medical conditions.

The complete LMRP is available on the provider education Web site at *www.floridamedicare.com*.

Effective Date

This revision is effective for claims processed **on or after March 24, 2003**. ❖

72192: Computerized Tomography of the Pelvis—Revision to Policy

The local medical review policy (LMRP) for Computerized Tomography of the Pelvis – 72192 was published in the First Quarter 2002 *Medicare A Bulletin* (pages 26-27). Since that time, revenue code 350 has been changed to 35x, type of bill 85x has been added, and type of bill 71x has been removed from the policy.

Effective Date

These revisions are effective for claims processed **on or after February 4, 2003**. ❖

74150: Computerized Axial Tomography of the Abdomen—Addition to the Policy

The local medical review policy for Computerized Axial Tomography of the Abdomen – 74150 was published in the Fourth Quarter 2001 *Medicare A Bulletin.* Since that time, diagnosis codes 162.2-169.9 (malignant neoplasm of lung) and 202.83 (other lymphoma, intra-abdominal lymph nodes) were added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy.

Effective Date

This revision is effective for claims processed **on or after January 23, 2003**. ❖

Full-text for these local medical review policies are available on the provider education Web site at *www.floridamedicare.com*.

77280: Therapeutic Radiology Simulation-Aided Field Setting—Revision to Policy

The local medical review policy for Therapeutic Radiology Simulation-Aided Field Setting – 77280, has been revised to clarify that service for therapeutic radiology simulation-aided field settings will be considered medically reasonable for patients, including those with certain benign conditions, for whom a radiation therapy course of treatment needs to be established. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy has been revised with this information.

Effective Date

This revision is effective for claims processed **on or after February 1, 2003**. ❖

80100: Qualitative Drug Screen—Revision to Policy

The local medical review policy for Qualitative Drug Screen – 80100 was published in the October/November 2000 *Medicare A Bulletin.* Since that time, the policy has been revised to allow coverage for patients receiving active treatment for substance abuse when the results of the drug screen are utilized in the management of the patient's care. Language changes were made to the "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections of the policy. In addition, ICD-9-CM codes V70.4 (Examination for medico legal purposes) and V70.5 (Health examination of defined subpopulation (occupational or pre-employment) were added to the "ICD-9-CM Codes that DO NOT Support Medical Necessity" section of the policy.

Note: These screening diagnoses have always been noncovered.

Additionally, type of bill 85x has been added and 71x has been removed from the "Type of Bill Code" section of the policy.

Effective Date

These revisions are effective for claims processed **on or after February 6, 2003**. ❖

77300: Basic Radiation Dosimetry Calculation—Revision to Policy

The local medical review policy for Basic Radiation Dosimetry Calculation – 77300, has been revised to provide clarification of those persons qualified to perform basic radiation dosimetry calculations. These calculations may be performed by a radiation oncologist, or a qualified medical physicist, or qualified medical dosimetrist under the technical supervision of the radiation oncologist. Documentation should indicate that the calculations were reviewed, signed and dated by both the qualified medical physicist or dosimetrist and the physician.

Effective Date

This revision is effective for claims processed **on or after February 1, 2003**. ❖

93965: Non-Invasive Evaluation of Extremity Veins—Revision to Policy

The local medical review policy for Non-Invasive Evaluation of Extremity Veins– 93965 has been revised to include venous mapping for the selection of a vein suitable for creation of a dialysis fistula or prior to surgical revascularization as a covered indication.

In addition, type of bill 85x has been added and type of bill 71x has been deleted from the policy.

Effective Date

These revisions are effective for services processed **on or after January 31, 2003**. ❖

C1305: Apligraf® (Graftskin)—Replacement of Policy

The local medical review policy for Apligraf® (Graftskin) – C1305 is discontinued effective for services on or after March 24, 2003. Indication and Limitations for this service may be found in policy MAHD/ER - Metabolically Active Human Dermal/Epidermal Replacement.

Policy Ending Date

Ending of this policy is effective for services furnished on or after March 24, 2003. ❖

G0108: Diabetes Outpatient Self-Management Training—Revision to Policy

The local medical review policy (LMRP) for Diabetes Outpatient Self-Management Training – G0108 was published in the Fourth Quarter 2001 *Medicare A Bulletin* (pages 68-70). Since that time, transmittal 1762, dated August 21, 2002 was issued to add verbiage "in the 12 months" to the Medical Eligibility for Coverage in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Effective Date

Revision to this policy is not affected by an effective date. ❖

Full-text for these local medical review policies are available on the provider education Web site at *www.floridamedicare.com*.

G0245: Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes—Revision to Policy

The local medical review policy for Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes – G0245 has been revised. In order for claims to be processed correctly and be considered for payment, HCPCS code G0247 must be billed on the same claim with the same date of service as either G0245 or G0246. The "Coding Guidelines" section of the policy has been revised with this information.

Effective Date

This revision is effective for services furnished **on or after January 1, 2003**. ❖

G0262: Wireless Capsule Endoscopy—Implementation of New Policy

The wireless capsule endoscopic imaging is intended as an adjunctive tool in the detection of abnormalities of the small bowel. This procedure requires that a patient ingest a small capsule containing a disposable light source, miniature color video camera, battery, antenna and a data transmitter. Following ingestion of the capsule, natural contraction and relaxation of the gastrointestinal tract propels the capsule forward. The camera contained in the capsule records images of the intestinal mucosa as it travels the length of the digestive system. During the entire procedure, which normally takes approximately eight hours, the patient wears a data recorder around the waist to capture and store the images transmitted by the capsule's camera. After completion of the procedure, the patient data recorder is connected to a computer workstation where the images are downloaded and the physician makes a diagnosis. The capsule is excreted naturally from the body. HCPCS code G0262 is new for 2003 and is intended to represent this new technology in the field of gastrointestinal (GI) endoscopy. Local medical review policy (LMRP) *G0262 – Wireless Capsule Endoscopy* has been developed to provide indications and limitations of coverage for this new technology.

The complete LMRP is available on the provider education Web site at *www.floridamedicare.com*.

Effective Date

Implementation of this policy is effective for services processed **on or after March 24, 2003**. ❖

J2430: Pamidronate (Aredia®, APD)—Revision to Policy

The local medical review policy (LMRP) for Pamidronate – J2430 was published in the June/July 2000 *Medicare A Bulletin* (pages 49-50). Since that time, diagnosis code V10.3 (personal history of malignant neoplasm; breast) has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of this policy.

Pamidronate is FDA approved as an adjunct treatment of osteolytic lesions of breast cancer and myeloma. Billing of Pamidronate for metastatic breast cancer requires a dual diagnosis. To ensure reimbursement for this indication, dual diagnoses must be submitted. The primary site or personal history (V10.3) and secondary site of the malignancy must both be billed to indicate that the breast malignancy is metastatic (i.e., both ICD-9-CM codes 198.5 or 174.0-175.9 and V10.3 must be billed).

In addition, critical access hospital – 85x has been added and rural health clinic – 71x has been removed from the "Type of Bill Code" section of the policy.

Effective Date

This revision is effective for claims processed **on or after January 23, 2003**. ❖

J9999: Antineoplastic Drugs—Correction to Policy

The local medical review policy for Antineoplastic Drugs – J9999 was published in the First Quarter 2002 *Medicare A Bulletin* (pages 70-77). Diagnosis code 198.89 for secondary malignant neoplasm of other specified sites for HCPCS code J9355 (Trastuzumab [Herceptin®]) was inadvertently omitted from publication of the policy. Florida Medicare apologizes for any inconvenience this may have caused.

Effective Date

This revision is effective for claims processed **on or after November 5, 2002**. ❖

MAHD/ER: Metabolically Active Human Dermal/Epidermal Replacements—Implementation of New Policy

Bioengineered human dermal replacements (Dermagraft), and human skin equivalents (Apligraf® and OrCel) contain the characteristics of dermal, or both dermal and epidermis and have been shown to be effective in the treatment of open wounds. These products function not only as biological dressings, but also act as a delivery system for growth factors and extracellular matrix components through the activity of live human fibroblast contained in their dermal element. HCPCS code J7340 is used to describe the products Apligraf and OrCel, and HCPCS code J7342, which is new for 2003, is used to describe Dermagraft.

Full-text for these local medical review policies are available on the provider education Web site at *www.floridamedicare.com*.

Local medical review policy LMRP) *MAHD/ER – Metabolically Active Human Dermal/Epidermal Replacements* has been developed to provide indications and limitations of coverage for these products.

The complete LMRP is available on the provider education Web site at *www.floridamedicare.com*.

Effective Date

This revision is effective for claims furnished **on or after March 24, 2003**. ❖

Fulvestrant (Faslodex®)

Fulvestrant (Faslodex®) is an estrogen receptor antagonist without known agonist effects. On April 25, 2002, the Food and Drug Administration (FDA) approved Faslodex for the treatment of hormone receptor positive metastatic breast cancer in postmenopausal women with disease progression following anti-estrogen therapy.

Currently, Florida Medicare covers the FDA-approved indication only. Faslodex is currently billed using C9120 to the fiscal intermediary as a pass-through drug under the hospital outpatient prospective payment system effective **January 1, 2003.** (See January 2003 *Medicare A Bulletin* Special Issue, page 41.) ❖

Oxaliplatin (Eloxatin™)

Oxaliplatin (Eloxatin™) is a chemotherapeutic agent. On August 25, 2002, the Food and Drug Administration (FDA) approved oxaliplatin for injection in combination with infusional 5-fluorouracil/Leucovorin™ (5FU/LV) for the treatment of patients with metastatic carcinoma of the colon or rectum whose disease has recurred or progressed during or within six months of completion of first line therapy with the combination of bolus 5-FU/LV and Irinotecan.

Currently, Florida Medicare covers the FDA-approved indication only. Oxaliplatin is currently billed under the unclassified drug code, J9999. Currently, a pass through code or C-code has not been established for this drug. ❖

2003 HCPCS Local Medical Review Policy Changes

Florida Medicare has revised local medical review policies (LMRPs) impacted by the 2002 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and removed accordingly.

LMRP Title	2003 Changes
11600 – Excision of Malignant Skin Lesions	• Descriptor changes for codes *11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, 11646* • Added type of bill code 85x • Language in Indications and Limitations of Coverage and/or Medical Necessity and Coding Guidelines sections changed to reflect descriptor changes.
17304 – Mohs Micrographic Surgery (MMS)	• Descriptor changes for codes *17304* and *17310* • Added type of bill code 85x • Policy converted to new format
29540 – Strapping	• Descriptor change for code *29540* • Language in LMRP Description and Indications and Limitations of Coverage and/or Medical Necessity sections changed to reflect descriptor change
33216 – Implantation of Automatic Defibrillators	• Descriptor change for code *33216* • Added code *33215* • Changed policy identification number to *33215* • Added type of bill code 85x • Policy converted to new format
33282 – Insertable Loop Recorder	• Removed code C1764 • Removed revenue code 278 • Added type of bill code 85x
36521 – Protein A Column Apheresis (Prosorba®)	• Removed code *36521* • Added codes *36515* and *36516* • Changed policy identification number to *36515*
43235 – Diagnostic and Therapeutic Esophagogastroduodenoscopy	• Added code *43236*
44388 – Colonoscopy	• Added code 45381 and 45386
62263 – Percutaneous Lysis of Epidural Adhesions	• Descriptor change for code *62263* • Added code *62264* • Language in Coding Guidelines section changed to reflect descriptor change • Added type of bill code 85x • Policy converted to new format

Full-text for these local medical review policies are available on the provider education Web site at *www.floridamedicare.com*.

2003 HCPCS Local Medical Review Policy Changes (continued)

LMRP Title	2003 Changes
70450 – Computerized Tomography Scans	• Descriptor changes for codes 70450, 70480, 70486, 70490, 72125, 72128, *72131*, *73200*, and *73700* • Language in Indications and Limitations of Coverage and/or Medical Necessity section changed to reflect descriptor changes • Changed policy title to Computed Tomography Scans
71250 – Computerized Axial Tomography of the Thorax	• Descriptor change for code *71250* • Changed policy title to Computed Tomography of the Thorax
72192 – Computed Tomography of the Pelvis	• Descriptor change for code *72192*
74150 – Computerized Axial Tomography of the Abdomen	• Descriptor change for code *74150* • Changed policy title to Computed Tomography of the Abdomen
76075 – Bone Mineral Density Studies	• Removed codes G0131 and G0132 • Added code *76070* and *76071* • Changed policy identification number to *76070*
76090 – Diagnostic Mammography	• Descriptor change for code G0236 • Language in Coding Guidelines section changed to reflect code G0236
76092 – Screening Mammograms	• Descriptor change for code *76085* • Language in Coding Guidelines section changed to reflect code *76085* and G0236
77280 – Therapeutic Radiology Simulation– Aided Field Setting	• Descriptor change for code *76370* in Coding Guidelines section
77326 – Brachytherapy Isodose Calculation	• Descriptor change for code *77326* • Language in Indications and Limitations of Coverage and/or Medical Necessity section changed to reflect descriptor change • Added type of bill code 85x • Policy converted to new format
85044 – Reticulocyte Count	• Descriptor changes for codes *85044* and *85045* • Added type of bill code 85x • Policy converted to new format
88142 – Pap Smears	• Descriptor changes for codes G0144 and G0145 • Removed codes 88144 and 88145 • Added codes 88174 and 88175 • Added type of bill code 85x to Coding Guidelines section
88230 – Cytogenetic Studies	• Added codes G0265 and G0266 • Added type of bill code 85x • Policy converted to new format
93268 – Patient Demand Single or Multiple Event Recorder	• Descriptor changes for codes *93012* and *93268* • Removed codes G0004, G0005, G0006, G0007, and G0015 • Removed type of bill codes 71x and 75x • Added type of bill code 85x • Policy converted to new format
94664 – Diagnostic Aerosol or Vapor Inhalation	• Removed codes *94664* and *94665* • Added code *94640* • Language in Coding Guidelines section Removed • Changed policy identification number to *94640*
95004 – Allergy Skin Tests	• Descriptor change for code *95027* • Added type of bill code 85x • Policy converted to new format
95805 – Sleep Testing	• Descriptor change for code *95822* • Language in Coding Guidelines section changed to reflect descriptor change • Added type of bill code 85x • Policy converted to new format

Full-text for these local medical review policies are available on the provider education Web site at *www.floridamedicare.com*.

2003 HCPCS Local Medical Review Policy Changes (continued)

LMRP Title	2003 Changes
97010 – Physical Medicine and Rehabilitation	• Removed code *97014* • Added code G0283
DYSPHRT – Dysphagia/Swallowing Diagnosis and Therapy	• Removed codes G0195 and G0196 • Added codes *92610* and *92611* • Language in Coding Guidelines section changed to reflect deletion of procedure code *92525*
G0030 – Positron Emission Tomography (PET) Scan	• Descriptor changes for codes G0125, G0210– G0218, G0220-G0230 • Descriptor change in Reasons for Denials section for code G0219 • Descriptor changes for codes G0232 and G0233 **(Not related to 2003 HCPCS changes)**
G0104 – Colorectal Cancer Screening	• Code range *45330-45339* was changed to *45330-45345* and procedure code range *45378-45385* was changed to *45378-45386* in the Indications and Limitations of Coverage and/or Medical Necessity section • Added type of bill code 85x
J0585 – Botulinum Toxin type A (Botox)	• Descriptor change for code *95869*
J0587 – Botulinum Toxin type B (Myobloc™)	• Descriptor changes for codes *95867* and *95869* in the Coding Guidelines section
J0635 – Vitamin D Analogs in Chronic Renal Disease	• Removed codes J0635, J2500, and W0237 • Added codes J0636 and J2501 • Changed policy identification number to J0636
J1561 – Intravenous Immune Globulin	• Removed code J1561 • Added code J1564 • Language in Coding Guidelines section related to number of units was Removed • Changed policy identification number to J1563
J2915 – Ferrlecit®	• Removed code J2915 • Added code J2916 • Language in Coding Guidelines section changed • Changed policy identification number to J2916
J3240 – Thyrotropin Alfa (Thyrogen®)	• Descriptor change for code J3240 • Removed code C9108 • Language in Coding Guidelines section changed to reflect descriptor change
J3490 – Zoledronic Acid (Zometa®)	• Removed code C9115 • Added code J3487 • Language in Coding Guidelines section changed • Changed policy identification number to J3487
J9212 – Interferon	• Added code Q3025
J9999– Antineoplastic Drugs	• Removed code J9999/C9110 (Alemtuzumab) • Added code J9010 • Language in Coding Guidelines section changed
VISCO – Viscosupplementation Therapy For Knee	• Removed code Q3030 • Added code J7317

Full-text for these local medical review policies are available on the provider education Web site at *www.floridamedicare.com*.

SKILLED NURSING FACILITY SERVICES

Diagnostic Services Furnished to Beneficiaries Receiving Treatment for End-Stage Renal Disease

The skilled nursing facility consolidated billing (SNF CB) provision requires a SNF to include on its Part A bill almost all of the services that its residents receive during the course of a Part A covered stay. However, there are several categories of services that the law (section 1888(e)(2)(A)(ii) of the Social Security Act) specifically excludes from this provision, and these excluded services remain separately billable under Part B by the outside supplier that furnishes them. One of the excluded categories encompasses those items and services that fall within the scope of the Part B benefit that covers chronic dialysis for beneficiaries with end-stage renal disease (ESRD) (section 1861(s)(2)(F) of the Act). In addition to covering the ESRD-related dialysis services themselves, the Part B benefit also covers any associated diagnostic tests. See regulations at 42 CFR 410.50(b) – (c) and 410.52(a)(3).

The SNF CB applies to diagnostic tests that are not ESRD-related. As such, SNF CB applies to diagnostic tests for beneficiaries that do not have ESRD. This would include tests related to "acute dialysis" (that is, dialysis for a beneficiary who is not an ESRD beneficiary), because non-ESRD dialysis services and associated diagnostic tests do not fall within the scope of the Part B dialysis benefit. In addition, SNF CB applies to a diagnostic test for an ESRD beneficiary if the test is unrelated to the beneficiary's ESRD.

The SNF CB does **not** apply to diagnostic tests that are ESRD dialysis-related. "ESRD-related" means the following statements:

- The beneficiary must be an ESRD patient.
- The test must have been ordered by an ESRD facility.
- The test must relate directly to the dialysis treatment of the beneficiary's ESRD.

A supplier or provider may bill the carrier or intermediary, respectively, for an ESRD dialysis-related diagnostic test, provided the test is outside the ESRD-facility composite rate, notwithstanding that the beneficiary is a SNF Part A resident.

A supplier or provider may not bill Medicare separately for a diagnostic test for a SNF Part A resident if the test is either within the ESRD facility composite rate or not an ESRD dialysis-related diagnostic test.

Implementation of Modifier CB

Effective April 1, 2003, for dates of service **on or after April 1, 2001,** Medicare will not apply the SNF CB edits to line items for diagnostic services where **modifier CB** (services ordered by a dialysis facility physician as part of the ESRD beneficiary's dialysis benefit, is not part of the composite rate, and is separately reimbursable) is placed on the line item to indicate that this service was rendered to an ESRD beneficiary in a SNF Part A stay who is receiving chronic dialysis related services at an independent or provider-based dialysis facility.

CMS is not requiring that a provider or supplier report the modifier for every service rendered to an ESRD beneficiary; however, the provider or supplier must be aware that SNF CB editing will be applied if the line item does not contain **modifier CB.** Indeed, the provider or supplier may use **modifier CB** only for those line items for which **all** following factors are present:

- The beneficiary has ESRD entitlement.
- The test is related to the dialysis treatment for the beneficiary's ESRD.
- The test is ordered by a dialysis facility.
- The test is not included in the dialysis facility's composite rate payment.
- The beneficiary is a resident in a SNF Part A stay.

The use of **modifier CB** is inappropriate unless the provider has exercised due diligence to confirm that the test is appropriately excluded from SNF CB. This means that the provider must confirm the above information from the dialysis facility.

Provider Responsibility

SNF should notify the dialysis facility of the Part A status of its resident who undergoes dialysis at a dialysis facility.

It is improper for the dialysis facility to inform a provider that a test is related to the dialysis treatment of ESRD if, in fact, the beneficiary is undergoing acute dialysis rather than chronic ESRD dialysis.

Denied Claims Due to SNF CB

Providers that have had claims denied due to SNF CB and provided a diagnostic service to a beneficiary who has ESRD in an independent or provider-based dialysis facility for dates of service **April 1, 2001 and later** can resubmit these claims with **modifier CB** for each line item. For claims with dates of service beyond the timely filing deadline, the claim(s) may be appealed for payment.

The carrier or intermediary may also reopen these claims for payment. ❖

Source: CMS Transmittal AB-02-175, CR 2475

ESRD SERVICES

End-Stage Renal Disease Drug Pricing Update

Editor's Note: An update to the end-stage renal disease (ESRD) drug list was published in the January 2003 Medicare A Bulletin Special Issue (pages 23-26). The ESRD drug pricing update listed below supersedes the previous pricing update.

The following revised 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 or after January 1, 2003,** and represent the Medicare maximum reimbursement for separately billable ESRD drugs and/or pharmaceuticals.

On January 1, 2003, the Centers for Medicare & Medicaid Services (CMS) implemented a single drug pricer (SDP) for drugs and biological to standardize prices for some of Medicare covered drug. The ESRD drug pricing list has been updated based on the Medicare fees established with the implemetation of the SDP initiative. See article on this issue on page 20 of this publication.

- 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).

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	$ 2.08
J0210*	Aldomet, methyldopate HCL, up to 250 mg	$11.88
J2997	Alteplase, recombinant, activase, 1 mg	$35.63
00047	Amikin, Amikacin, 100 mg/2 cc	$30.88
J0280	Aminophylline, aminophyllin, 250 mg	$ 1.05
J0285	Amphotericin B, Fungizone, 50 mg	$11.06
J0290	Ampicillin sodium, 500 mg	$ 1.65
J0690	Ancef, cefazolin sodium, Kefzol, 500 mg	$ 1.74
J3430	Aquamephyton, phytonaidione (vitamin K), 1 mg	$ 2.45
J0380*	Aramine, metaraminol bitartrate, 10 mg	$ 1.27
J7504	Atgam, lymphocyte immune globine, 250 mg	$290.31
J2060	Ativan, lorazepam, 2 mg	$ 3.14
J0460	Atropine sulfate, 0.3 mg	$ 0.83
X0004	Azactam, aztreonam, 1 gm	$17.94
00151	Bactrim, 80 mg/ml-16 mg/ml, 5 cc	$ 3.07
J0530	Bicillin C-R, penicillin-G, 600,000 units	$10.64
J0540	Bicillin C-R, penicillin-G, 1,200,000 units	$20.89
J0550	Bicillin C-R, penicillin-G, 2,400,000 units	$44.75
J0560	Bicillin L-A,penicillin-G, 600,000 units	$ 5.65
J0570	Bicillin L-A, penicillin-G, 1,200,000 units	$ 5.65
J0580	Bicillin L-A, penicillin-G, 2,400,000 units	$11.31
J0592	Buprenix, buprenorphine hydrochloride, 0.1 mg	$ 0.97
J0636	Calcijex, calcitriol, 0.1 mcg	$ 1.38
J0630	Calcitonin-salmon, up to 400 units	$38.41
X0014	Calcium chloride 10%, 10 cc	$2.05
J0610	Calcium gluconate, 10 ml	$ 1.12
J1955	Carnitine, levocarnitine, 1 gm	$34.20
J0710	Cefadyl, cephapirin sodium), 1 gm	$ 2.67
J0715	Ceftizoxime sodium, Cefizox, 500 mg	$ 4.96
00248	Cefobid, Cefoperazone sodium, 1 gm	$16.38
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 Drug Pricing Update (continued)

CPT/HCPCS CODE	NAME	PRICE
J0697	Cefuroxime sodium, 750 mg	$ 6.42
J0702	Celestone Soluspan, 3 mg-3mg/ml	$ 3.89
J0743	Cilastatin sodium imipenem, Primaxin I.V., 250 mg	$15.87
87000	Cipro, 200 mg	$13.69
X0017	Cleocin Phosphate, clindamycin phosphate, 300 mg	$3.56
J0745	Codeine phosphate, 30 mg	$ 0.48
J0800	Corticotropin Acthar Gel 40 Units	$92.93
J0835	Cortrosyn, cosyntropin, 0.25 mg	$16.76
J9070	Cyclophosphamide, Cytoxan, 100 mg	$ 5.98
J9080	Cyclophosphamide, Cytoxan, 200 mg	$11.34
J9090	Cyclophosphamide, Cytoxan, 500 mg	$23.81
J9091	Cyclophosphamide, Cytoxan, 1 gm	$47.64
J9092	Cyclophosphamide, Cytoxan, 2 gm	$95.27
J2597	DDAVP, desmopressin acetate), 1mcg	$ 4.12
J1100	Decadron, dexamethasone sodium phosphate, 1 mg	$ 0.10
J2175	Demerol, meperidine HCL, 100 mg	$ .56
J1070	Depo-Testosterone, up to 100 mg	$ 5.15
J1080	Depo-Testosterone, 1 cc, 200 mg	$ 8.94
J0895	Desferal, deferoxamine mesylate), 500 mg/5 cc	$14.81
J1100	Dexamethasone sodium phosphate, 1 mg/ml	$ 0.10
J7060	Dextrose 5%, 500 cc	$ 7.51
J1730*	Diazoxide, Hyperstat, 300 mg/20 ml	122.95
J1450	Diflucan, Fluconazole, 200 mg	$92.68
J1160*	Digoxin, Lanoxin, up to 0.5 mg	$ 1.79
J1165	Dilantin, phenytoin sodium, 50 mg	$ 0.86
J1170	Dilaudid, hydromophone, 4 mg	$ 1.55
J1200*	Diphenhydramine HCL (Benadryl), up to 50 mg	$ 1.61
X0023*	Dopamine HCL, Intropin, 40 mg/1 cc	$ 0.62
J1240	Dramamine, dimenhydrinate, 50 mg	$ 0.39
J1364	Erythromycin lactobionate, 500 mg	$ 3.51
J0970	Estradiol valerate, Delestrogen, up to 40 mg	$ 1.62
J2916	Ferrlecit, sodium ferric gluconate complex in sucrose injection 12.5 mg	$ 8.17

CPT/HCPCS CODE	NAME	PRICE
00623	Flagyl, Metronidazole, 500 mg	$13.35
J9190	Fluorouracil, 500 mg	$ 2.82
X0100	Folic Acid, 5 mg/cc	$1.28
J0713	Fortaz, ceftazidime, 500 mg	$ 6.75
J1470	Gamma globulin, 2 cc	$22.80
J1550	Gamma globulin, 10 cc	$114.00
J1570	Ganciclovir sodium, Cytovene, 500 mg	$35.25
J1580	Garamycin, gentamicin, 80 mg	$ 1.95
J1630	Haldol, haloperidol, 5 mg	$ 7.32
J1644*	Heparin sodium 1000 units	$ 0.35
00739	Hepatitis B immune globulin, 1 ml	$135.43
90371	Hepatitis B immune globulin, 5 ml	$649.80
90740	Hepatitis B vaccine, dialysis or immunosupressed patient dosage (3 dose schedule), for intramuscular use	$110.92
90747	Hepatitis B vaccine, dialysis or immunosupressed patient dosage (4 dose schedule), for intramuscular use	$110.92
J0360*	Hydralazine HCL, Apresoline, 20 mg	$17.81
J1720	Hydrocortisone sodium succinate (Solu-Cortef), 100 mg	$ 1.73
J3410	Hydroxyzine HCL, 25 mg	$ 0.83
J1561	Immune globulin, Gammimune N, 5%, 500 mg)	$42.75
J1563	Immune globulin, intravenous, 1 gm	$55.20
J7501	Imuran, Azathioprine, 100 mg	$59.84
J1790	Inapsine, droperidol), 5 mg	$ 1.58
J1800*	Inderal, propranolol HCL, 1 mg/1 cc	$11.63
J1750	Infed, iron dextran), 50 mg	$17.91
90657	Influenza virus vaccine, split virus, 6-35 months dosage	$ 4.01
90658	Influenza virus vaccine, split virus, 3 years and above dosage	$ 4.01
90659	Influenza virus vaccine, whole virus	$ 8.02
J1815*	Insulin, per 5 units	$ 0.10
J1840	Kantrex, kanamycin sulfate, 500 mg	$3.30
J1890	Keflin, cephalothin sodium, 1 gm	$10.26
J3301	Kenalog, triamcinolone acetonide), 10 mg	$ 1.52

***This drug is included in the composite rate.

End-Stage Renal Disease Drug Pricing Update (continued)

CPT/HCPCS CODE	NAME	PRICE
J1940	Lasix, furosemide, 20 mg	$1.01
X0056	Levophed bitartrate, Norepinephrine bitartrate 4 cc	$10.43
X0043	Levothyroxine, 0.2 mg	$24.85
J1990	Librium, chlordiazepoxide hydrochloride, 100 mg	$24.99
J2000*	Lidocaine HCL, 50 cc	$ 4.12
00971	Mandol, Cefamandole, 1 gm	$8.61
J2150*	Mannitol 25%, in 50 cc	$5.23
J1051	Medroxyprogesterone acetate, Depo-Provera, 50 mg	$ 4.98
J0694	Mefoxin, cefoxitin sodium, 1 gm	$10.69
00987	Mezlin, Mezlocillin, 1 gm	$ 4.24
J2270	Morphine sulfate, 10 mg	$0.72
J7505	Muromonab-CD3, parenteral, 5 mg	$777.31
X0027	Nafcil, nafcillin sodium, 500 mg	$ 1.34
J2320	Nandrolone decanoate, Deca-Durabolin, 50 mg	$ 5.21
J2321	Nandrolone decanoate, Deca-Durabolin, 100 mg	$10.40
J2322	Nandrolone decanoate, Deca-Durabolin, 200 mg	$12.64
J2310	Narcan, naloxone HCL, 1 mg	$ 2.26
J3260	Nebcin, tobramycin sulfate, 80 mg	$ 6.38
J2300	Nubain, nalbuphine HCL, 10 mg/1 cc	$ 1.44
J2700	Oxacillin sodium, 250 mg	$ 0.80
J2501	Paracalcitol, 1 mcg	$ 5.02
J2510	Penicillin G procaine, aqueous, 600,000 units	$ 9.05
X0101	Pentam, 300 mg	$93.81
J2550	Phenergan, promethazine HCL, 50 mg	$ 2.24
J2560	Phenobarbital sodium, 120 mg	$ 1.62
01231	Pipracil, Piperacillin sodium, 1 gm	$ 7.01
90732	Pneumovax, Pneumococcal vaccine 0.5 cc	$13.10
J3480*	Potassium chloride, per 2 mEq/ml	$ 0.08
J1410	Premarin, estrogen congugated, 25 mg	$56.75
J0743	Primaxin-I.M., 500 mg	$29.86
J0743	Primaxin-I.V., 250 mg	$15.87
J0780	Prochlorperazine, Compazine, up to 10 mg	$ 2.45
X0076	Prolastin, 500 mg	$104.50
J2680	Prolixin Decanoate, fluphenazine, 25 mg	$13.89
J2690*	Pronestyl, procainamide HCL, 1 gm	$11.03
J2720*	Protamine sulfate, 10 mg	$0.76
J2765	Reglan, metoclorpramide HCL, 10 mg	$ 1.90
J0696	Rocephin, ceftriaxone sodium, 250 mg	$14.92
89991	Sandoglobulin, 1gm	$86.81
X0102	Septra, 80 mg/ml-16 mg/ml, 5 ml	$3.07
X0038	Sodium bicarbonate 8.4%, 50 cc	$ 2.74
00515	Sodium chloride 9%, 30 cc	$1.39
00510	Sodium chloride 9%, 50 cc	$9.19
00511	Sodium chloride 9%, 100 cc	$6.03
00512	Sodium chloride 9%, 150 cc	$8.65
00513	Sodium chloride 9%, 250 cc	$9.19
00514	Sodium chloride 9%, 500 cc	$5.94
J1720	Solu Cortef, hydrocortisone sodium succinate 100 mg	$1.73
X0040	Solu Cortef 500 mg	$6.64
J2920	Solu-Medrol, methylprednisolone sodium succinate, up to 40 mg	$ 1.58
J2930	Solu-Medrol, methylprednisolone sodium succinate, up to 125 mg	$ 1.92
01478	Stadol, 1 mg	$ 7.66
01479	Stadol, 2 mg	$ 7.81
J3010	Sublimaze, fentanyl citrate, 2 cc	$ 1.97
J3070	Talwin Lactate, pentazocine HCL, 30 mg	$ 5.23
01601	Talwin Lactate, 60 mg	$ 8.01
J3120	Testosterone enanthate, Delatestryl enanthate, up to 100 mg	$ 0.57
J3130	Testosterone enanthate, Delatestryl enanthate, up to 200 mg	$16.25
J3150	Testosterone propionate, up to 100 mg	$ 0.94
90703	Tetanus toxoid, 1.ml	$ 8.32
J3230	Thorazine, chlorpromazine HCL, up to 50 mg	$ 3.97
01671	Ticar, Ticarcillin, 1 gm	$ 4.25
J3250	Tigan trimethobenzamide HCL, up to 200 mg	$ 1.55

*****This drug is included in the composite rate.

End-Stage Renal Disease Drug Pricing Update (continued)

CPT/HCPCS CODE	NAME	PRICE
X0042	Timentin, 100 mg-3 gm	$14.32
J3280	Torecan, thiethylprrazine maleate, up to 10 mg	$ 4.34
J3320	Trobicin, spectinomycin dihydrochloride, up to 2 g	$26.80
X0099	Unasyn, 3 gm	$21.01
J3360	Valium, diazepam, 5 mg	$ 3.77
J3370	Vancocin, vancomycin HCL, 500 mg	$ 7.41
W0233	Venofer, 100 5 mg	$65.36
X0057*	Verapamil, 5 mg	$ 2.14
J2250	Versed, midazolam HCL, 1 mg	$ 1.41

CPT/HCPCS CODE	NAME	PRICE
X0044	Vibramycin, Doxycycline, 100 mg	$14.01
J3420	Vitamin B-12 cyanocobalamin, up to 1,000 mcg	$1.26
00522	Water for injection, 30 cc	$ 1.90
00521	Water for injection, 500 cc	$ 7.13
J2501	Zemplar, 1 mcg	$ 5.02
J0697	Zinacef, cefuroxime sodium, 750 mg	$6.42
X0062	Zofran, 2 mg/1 cc	$12.18
01958	Zovirax, 500 mg	$46.55

* This drug is included in the composite rate.

ELECTRONIC DATA INTERCHANGE

HIPAA

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.

The Health Insurance Portability and Accountability Act—Administrative Simplification (HIPAA–AS)

HIPAA-AS Overview

The Health Insurance Portability and Accountability Act of 1996 – Administrative Simplification was enacted to promote standardization and efficiency in the health care industry. It is important for providers to know how this law will impact them, and what the key requirements and dates are. Providers can gain an overview of HIPAA–AS requirements by reviewing key resources published by the Centers for Medicare & Medicaid Services (CMS). These publications are reprinted in this edition of the *Medicare A Bulletin* and are available on First Coast Service Options, Inc.'s (FCSO) provider education Web site, *www.floridamedicare.com.*

- **CMS HIPAA Electronic Transactions & Code Sets Information Series – *HIPAA 101***
  This resource provides direction about the who, what, why, and how of HIPAA–AS. *HIPAA 101* is the first in a series of ten informational publications to be issued by CMS about Electronic Transactions. This initial document is reprinted on page 37. The topics covered in the series are summarized in *HIPAA 101*. As further installments are published by CMS, we will post them to the provider education Web site.

- **Provider HIPAA Readiness Checklist – Getting Started**
  This resource uses a checklist approach to help a health care provider tackle the HIPAA Transactions requirement. First, it helps determine if a provider is covered by the requirement, then recommends the appointment of a 'HIPAA point person' to work the requirement on the provider's behalf. The tool goes on to familiarize the provider with key HIPAA deadlines, how it affects provider operations and guides providers on what kind of questions to ask their payers and health plans. This document is available on the provider education Web site, and is reprinted on page 35.

- **HIPAA Resources** is a comprehensive list of Internet links and phone numbers that can be used to get more information needed to accomplish compliance with HIPAA–AS. Please note that there is contact information to learn more about the HIPAA privacy requirement, which is effective April 14, 2003. This document is available on the provider education Web site, and is reprinted on page 36.

  Technical information about the Electronic Transactions requirements can be found in the ANSI X12N Implementation Guides which are available on the provider education Web site on the "HIPAA" page in the section titled: "Links to Other Related Web Sites".

- **Medicare companion documents** to these guides are also available on the provider education Web sites on the "Electronic Data Interchange" page in the section titled "News". These statements contain supplemental contractor expectations regarding data submission, processing and adjudication. Refer to the document dated December 30, 2001.

Medicare Contractor Status

Electronic Transactions and Code Sets: FCSO Medicare is implementing requirements per CMS guidelines. We are conducting trading partner testing on the X12N 4010 version of the 837 Claim, 835 Remittance, and 837 Coordination of Benefits (COB). FCSO expect to be implementing the addenda updates to the standards (version 4010A1) when they are final. Current estimates from CMS indicate trading partner testing may begin in April. Dates are subject to change depending on the release of the final rule.

CMS filed for a one-year extension for all Medicare contractors before the Administrative Simplification Compliance Act (ASCA) deadline of October 15, 2002.

The following table indicates FCSO's testing status and expected dates. The 276/277 Claim Status Inquiry/Response and 270/271 Eligibility Benefit Inquiry/Response transactions will not be tested with trading partners until the addenda updates are implemented.

Look for further information on the new 4010A1 updates to all affected transactions, as well as specifics on the 270/271 Eligibility Inquiry/Response, in the upcoming Medicare EDI Bulletin on the provider education Web site.

Medicare's Trading Partner Testing

Transaction	4010	4010A1 Addenda (Estimate)
X12N 837 Inbound Claims	Ongoing	4/2003
X12N 835 Remittance	Ongoing	4/2003
X12N 837 Outbound COB	Ongoing	4/2003
X12N 276/277 Claim Status/Response	N/A	4/2003
X12N 270/271 Eligibility Request/Response	N/A	4/2003

Privacy: HIPAA restricts the release of a patient's protected health information (PHI) without the consent of that patient where the release goes beyond the need to provide for patient care. PHI must be more carefully handled in all respects. The deadline for compliance with the Privacy provisions of HIPAA-AS is April 14, 2003.

Contracts are required to be drawn up and executed between covered entities and those business associates with whom PHI is sent for the performance of a service. When drawing up such contracts, covered entities should clearly identify the organization with which they share PHI.

A provider that submits a claim to a health plan (such as Medicare) and a health plan that assesses and pays the claim are both acting on their own behalf as a covered entity, and not as the "business associate" of the other. If a health plan were to perform a service on behalf of a provider using protected health information (e.g., billing service for provider or quality improvement initiative on behalf of provider), then a business associate agreement would be needed. For example, FCSO performs services for Medicare (CMS). FCSO is expected to be "classified" as a "business associate" of CMS (the covered entity), for the purposes of the HIPAA Privacy Rule. For more information, please refer to *http://www.hhs.gov/ocr/hipaa/*.

Responsibility for the enforcement of the Privacy requirements belongs to the U.S. Department of Health & Human Services' Office of Civil Rights. Privacy-related questions should be directed to *OCRPrivacy@hhs.gov* or call 1-866-627-7748. Another resource for information is *http://www.hhs.gov/ocr/hipaa/whatsnew.html*.

Security: HIPAA security requirements will outline measures to prevent unauthorized access to PHI. FCSO intends to comply with the Security requirements, which had not been finalized as of the end of 2002.

National Identifier: HIPAA calls for providers, plans and employers to have standard national numbers that identify them on standard transactions. The standard for plans and providers is expected in 2003. Employers will use the employer identification number (EIN).

Key Requirement of HIPAA-AS Electronic Transactions

A key requirement of the law is for covered entities to begin testing the new format for the electronic claim transaction (837) by **April 16, 2003**. FCSO expects to begin trading partner testing of the 837 **version 4010A1** (addenda) in April, depending on when the rule is released. Those submitters who have successfully completed testing on version 4010 are not required to re-test for version 4010A1; FCSO will, however, schedule re-testing upon request.

FCSO's strategy for 837 testing involves testing billing software used by providers and submitters. In the very near future FCSO will be contacting providers, billing services, clearinghouses, and software vendors to discuss HIPAA readiness and schedule 837 claim testing. Due to the large volume of senders required to test, Medicare encourages senders to begin their implementation and testing now. Providers who utilize a clearinghouse, billing service, or vendor software, should contact them to determine their plans for HIPAA and their status. Encourage them to test.

It is very important that those submitting electronic claims test with Medicare as soon as possible. Testing will occur on a first-come, first-served basis. Senders who wait until the last months before the due date may not have enough time to prepare and test. HIPAA-AS requires exclusive use of the ANSI X12N version 4010A1 as of October 2003. To schedule testing call:

For Florida Medicare Part A: Audrey Lipinski @ 904-791-6805.

Other Important Things to Know about HIPAA Transactions Requirements

PC-ACE Pro32® is a low cost electronic claim submission software package offered by Medicare. Version 4010 has been tested and is being rolled out to current customers. When the 4010A1 version is final and implemented, the update will be distributed.

FCSO Medicare provider education Web site
This Web site provides up-to-date information about HIPAA and Medicare at: *www.floridamedicare.com.* Refer to the "HIPAA – Hot Topics" at the top of the "What's New" page for a set of basic, "getting started" instructions from CMS. The HIPAA page also provides a comprehensive list of resources helpful for providers to become compliant with HIPAA Transactions.

Electronic Billing Vendor List
Billing vendors have begun to test their software for compliance with the HIPAA Transactions requirement. A directory of those who have successfully tested with FCSO can be found on the *www.floridamedicare.com* Web site. Refer to the "ANSI 4010 Approved Vendor List" in the "Electronic Data Interchange (EDI)" section under "Other." This list is updated every two weeks. ❖

***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.*

Provider HIPAA Readiness Checklist—Getting Started

Moving toward Compliance with the Electronic Transactions and Code Sets Requirements

- The Administrative Simplification Requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will have a major impact on health care providers who do business electronically as well as many of their health care business partners. Many changes involve complex computer system modifications. Providers need to know how to make their practices compliant with HIPAA. The Administrative Simplification Requirements of HIPAA consist of **four** parts:

  1) Electronic transactions and code sets
  2) Security
  3) Unique identifiers
  4) Privacy.

- HIPAA does not require a health care provider to conduct all transactions listed under #1 electronically. Rather, if you are going to conduct any one of these business transactions electronically they will need to be done in the standard format outlined under HIPAA. Whether or not you contract a third party biller or clearinghouse to conduct any of these transactions for you, it is up to you as the health care provider to see to it that your transactions are being conducted in compliance with HIPAA. The checklist provided below is designed to help you start thinking about what you need to do to prepare for meeting the **electronic transactions and code set requirements.**

1. Determine, as a health care provider if you are covered by HIPAA

❑ If you conduct, or a third party biller or clearinghouse conducts on your behalf, any one of the following business transactions electronically you are most likely covered by HIPAA:

- Claims or equivalent encounter information
- Payment and Remittance Advice
- Claim Status Inquiry/Response
- Eligibility Inquiry/Response
- Referral Authorization Inquiry/Response

If you do not conduct any one of the above transactions electronically, you are most likely not covered by HIPAA and you do not need to continue with the checklist.

2. Assign a HIPAA point person to handle the remaining checklist items

❑ Assign a staff person to be your ***HIPAA point person*** (HPP), such as your office manager, to keep abreast of HIPAA and what is required of your office.
❑ Give this individual the authority, resources, and time to prepare for HIPAA changes.
❑ Use this staff person to educate others in your office on the impact of HIPAA on your practice.

3. Familiarize yourself with the key HIPAA deadlines

❑ April 16, 2003 – You (or your software vendors) need to start testing your software and computer systems internally ***no later*** than this date. By testing this means ensuring your software is capable of sending and receiving the transactions you do electronically in the standard HIPAA format.
❑ October 16, 2003 – This is the date you must be ready to conduct transactions electronically in the standard HIPAA format with your health plans/payers.

4. How HIPAA affects what you do

- ❑ Determine if your software is ready for HIPAA (each health care provider is responsible for making sure the software they use will be compliant with HIPAA according to the key deadlines above).
- ❑ Speak with your practice management software vendors (or billing agent or clearing house if you use one) to assess which items under #1 you conduct on paper and which you conduct electronically. Determine what you will need to do differently. For instance, under HIPAA additional data may be required and data fields you use now may no longer be required.
- ❑ Ask your vendor how and when they will be making HIPAA changes and document this in your files.
- ❑ Remind your vendors you must start testing your systems *no later* than April 16, 2003. Similarly, if you use a third party billers or clearinghouses, remind them of this testing deadline.

5. Talk to the health plans and payers you bill (especially the ones you bill most frequently)

- ❑ Ask them what they are doing to get ready for HIPAA and what they expect you to do.
- ❑ Ask them if they will have a HIPAA companion guide that specifies their coding and transaction requirements that are not specifically determined by HIPAA (while HIPAA mandates standard transactions, some health plans may not require data elements for every field). For instance, ask your payers for billing instructions on how to code for services that were previously billed using local codes (under HIPAA local codes are eliminated).
- ❑ Ask them whether they will have "Trading Partner Agreements" that specify transmission methods, volumes, and timelines as well as coding and transaction requirements that are not specifically determined by HIPAA. These may also specify how HIPAA compliance testing and certification are to be done.
- ❑ Ask them about testing your software to make sure, for instance, that they will be able to receive a claim you submit with your updated software.
- ❑ If you use software or systems provided by the health plan/payer (such as on-line direct data entry) to conduct transactions, ask whether they intend on continuing to support these systems.

For more information on HIPAA please visit CMS' Web site at* http://www.cms.hhs.gov/hipaa*, send an email to* askhipaa@cms.hhs.gov*, or call 1 (866) 282-0659.

This is an informational checklist and does not constitute legal advice.

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HIPAA Resources

1) CMS Website – ***http://www.cms.hhs.gov/hipaa*** - Answers to Frequently Asked Questions, links to other HIPAA sites, and information on the law, regulations, and enforcement are located here.

2) Covered Entity Decision Tool – ***http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp***. Use this tool to help determine if you are a "covered entity" under HIPAA.

3) FREE HIPAA Roundtable Conference Call – This is a good source of information and a forum to get answers to your questions on HIPAA Administrative Simplification. At this time we have not scheduled our next call, but stay tuned!

4) FREE Video – CMS' Meeting the HIPAA Challenge: Implementing the Administrative Simplifications of HIPAA. For free video, e-mail your request to ***askhipaa@cms.hhs.gov*** or call **1 (866)-282-0659**. Stay tuned for information on our new video, which is in the works.

5) FREE Listserve – ***http://aspe.hhs.gov/admnsimp/lsnotify.htm*** - Sign up to receive notification when proposed or final rules on HIPAA have been published in the *Federal Register* (The *Federal Register* is the place where the government, upon passing a law, tells the public how the law will be implemented).

6) CMS E-Mail box – ***askhipaa@cms.hhs.gov***. Send your questions on HIPAA administrative simplification here.

7) CMS HIPAA Hotline – 1 (866) 282-0659 – This hotline has been established to help answer your HIPAA administrative simplification questions.

8) CMS Medicaid HIPAA Web address – ***www.cms.hhs.gov/medicaid/hipaa/adminsim/***

9) Privacy-related information – ***http://www.hhs.gov/ocr/hipaa/whatsnew.html*** - The U.S. Department of Health & Human Services' Office for Civil Rights oversees the privacy requirements. Visit their Web site for more information. Privacy-related questions should be directed to ***OCRPrivacy@hhs.gov*** or call **1 (866)-627-7748.**

10) Other information on "administrative simplification" requirements of HIPAA – ***http://aspe.hhs.gov/admnsimp/*.**

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CMS HIPAA Electronic Transactions & Code Sets Information Series

HIPAA 101 For Health Care Providers' Offices

Complying with HIPAA's Electronic Transactions and Code Sets Standards Requirements

==========

THE 10-PART INFORMATION SERIES:

1 HIPAA 101

2 Are You a Covered Entity?

3 Enforcement

4 Key HIPAA Dates and Tips for Getting Ready

5 What Electronic Transactions and Code Sets are Standardized Under HIPAA?

6 Is Your Software Vendor or Billing Service Ready for HIPAA?

7 What to Expect from your Payers

8 What do you Need to Know about Testing

9 Trading Partner Agreements

10 Final Steps for Compliance with Electronic Transactions and Code Sets

The law known as "HIPAA" stands for the Health Insurance Portability and Accountability Act of 1996. This law was passed to promote more standardization and efficiency in the health care industry.

There are four parts to HIPAA's Administrative Simplification:

1. Electronic Transaction and Code Sets Standards requirements
2. Privacy requirements
3. Security requirements
4. National Identifier requirements

This is the first informational paper in a series of ten. Collectively, the papers provide information, suggestions, tips, guidance and checklists to assist health care providers in understanding what they need to focus on to become HIPAA compliant. Each paper deals with one significant topic related to the HIPAA electronic transaction and code set rule.

HIPAA will directly impact health care providers who transmit any health care information in electronic form in connection with a covered transaction, as well as indirectly impacting their business partners. But these impacts will eventually result in overall improvements in many areas of the health care industry.

WHAT is HIPAA Administrative Simplification?

The requirements for each area of HIPAA Administrative Simplification are:

1) Electronic Transaction and Code Sets Standards Requirements

National standards (for formats and data content) are the foundation of this requirement. HIPAA requires every provider who does business electronically to use the same health care transactions, code sets, and identifiers. Many of the electronic changes required under HIPAA are highly technical. But, it is important for you to know about the HIPAA Administrative Simplification requirements and how they will impact your office.

Transaction and code set standards requirements were created to give the health care industry a common language to make it easier to transmit information electronically (for instance, when a physician's office inquires about a patient's insurance eligibility, or a dentist submits a bill to a health plan for payment).

Standard Transactions

==========

1 Claims or equivalent Encounter Information

2 Payment and Remittance Advice

3 Claim Status Inquiry and Response

4 Eligibility Inquiry and Response

5 Referral Certification and Authorization Inquiry and Response

6 Enrollment and Disenrollment in a Health Plan

7 Health Plan Premium Payments

8 Coordination of Benefits

9 Claims Attachments

10 First Report of Injury

Standard Code Sets

==========

1 Physician Services and other Health Care Services - **Combination of HCPCS and CPT-4**
2 Medical Supplies, Orthotics, and DME - **HCPCS**
3 Conditions, & other health problems & their manifestations – **ICD-9-CM, Vols 1&2**
4 Dental Services – **Code on Dental Procedures and Nomenclature**
5 Drugs/Biologics – **NDC**

2) Privacy Requirements

The privacy requirements limit the release of patient protected health information without the patient's knowledge and consent beyond that required for patient care. Patient's personal information must be more securely guarded and more carefully handled when conducting the business of health care.

3) Security Requirements

The security regulation will outline the minimum administrative, technical, and physical safeguards required to prevent unauthorized access to protected health care information. The Department of Health & Human Services will be publishing the final instructions on security requirements.

4) National Identifier Requirements

HIPAA will require that health care providers, health plans, and employers have standard national numbers that identify them on standard transactions. The employer identification number (EIN), issued by the Internal Revenue Service (IRS), was selected as the identifier for employers and was adopted effective July 30, 2002. The remaining identifiers are expected to be determined in the coming year.

WHO is Impacted by HIPAA?

The law applies directly to three specific groups commonly referred to as "covered entities." These three groups include:

1) Health Care Providers who transmit any health information in electronic form in connection with a transaction for which standards requirements have been adopted.

2) Health Plans

3) Health Care Clearinghouses

~ TIPS ~
For Your Information

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TIP 1

The U.S. Department of Health and Human Services has proposed changes to the transactions standards requirements to facilitate their implementation. This includes for instance, repealing the National Drug Code (NDC) standard except for retail pharmacy transactions, although this has not been adopted.

TIP 2

Something to keep in mind is that with HIPAA, local codes are replaced by standard codes.

TIP 3

It is important to know that as a health care provider, it is your responsibility to make sure that the software you use or the third party biller or clearinghouse you use to help process your claims, is compliant with HIPAA. If you are unsure as to whether or not they are able to produce HIPAA compliant transactions, call them and ask!

HIPAA, however, indirectly impacts many others in the health care field. For instance, software billing vendors and third party billing services that are not clearinghouses are not required to comply with the law; however, they may need to make changes in order to be able to continue do business with someone who is "covered" by HIPAA.

WHY HIPAA?

HIPAA requirements should help providers take advantage of new technologies to make doing business with health plans less costly and more efficient. Right now, there are over 400 different ways to submit a claim! With HIPAA there will be one way to submit a claim. This should make getting paid quicker and easier. With these standards requirements in place, your office staff may spend less time on the phone getting information they need for patients' paperwork.

If you have access to the Internet and would like to receive a free e-mail notification of when new HIPAA rules are published, simply sign up for the "free" listserv (e-mail communication list). This will let you know, for instance, when the security rule is published. For instructions about how to join, visit:

http://aspe.os.dhhs.gov/admnsimp/lsnotify.htm.

For more information on HIPAA……

E-mail your questions to *askhippa@cms.hhs.gov*

Join the HIPAA Listserv to find out when new HIPAA rules are published: *http://aspe.hhs.gov/admnsimp/lsnotify.htm*

Call the CMS HIPAA HOTLINE 1-866-627-7748

Log onto the CMS HIPAA Web site *http://www.cms.hhs.gov/hipaa/*

For Privacy inquiries only: *http://www.hhs.gov/ocr/hipaa/whatsnew.html*

Compliance Deadlines for Covered Providers

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April 14, 2003

The deadline for compliance with the privacy requirements.

April 16, 2003

For those who submitted a "compliance plan" and received a one-year extension to get ready to meet the standards requirements for electronic transactions and code sets, you should start testing your software **no later than** (or make sure your third party billers/ clearinghouses do so) this date to ensure you will be able to move the health care data in the new standardized format.

October 16, 2003

The deadline for complying with the electronic transaction and code set standards requirements for those who requested an extension.

NEXT STEPS?

To help you get started preparing for compliance with electronic transaction and code sets, follow these next steps:

- ❑ Find out if HIPAA applies to you.
- ❑ Determine the gaps between how you do business now and what HIPAA requires. In the column on the left are the HIPAA compliance dates you should be aware of.
- ❑ Find out what your health plans and payers' HIPAA implementation and testing plans are.
- ❑ Find out what your billing service is doing for HIPAA.
- ❑ Talk with your provider associations about HIPAA.
- ❑ Find out from your regional "Strategic National Implementation Process" (SNIP) representatives about regional HIPAA efforts. They are local groups with extensive knowledge of HIPAA.
- ❑ To find your local SNIP, go to: h*ttp://snip.wedi.org/public/articles/index.cfm?cat=5*
- ❑ Use the CMS HIPAA Checklist for Small Providers: *http://www.cms.hhs.gov/hipaa/hipaa2/ReadinessChkLst.pdf*

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ELECTRONIC CLAIM SUBMISSION

Changes to Medicare Part A Electronic Claim Submission Guidelines for ANSI Version 4010

Two important changes affecting claims processing have been communicated from the Centers for Medicare & Medicaid Services (CMS):

001 Revenue Line Amount

After April 1, 2003, Medicare Part A will no longer require the 0001 revenue line amount to be submitted in ANSI 837 version 4010 claim files. Instead, the amount in the 2300 loop CLM02 (total claim charge amount) will be used. Until April 1, 2003, all test and production 4010 claims will still require the 0001 line. After April 1 2003, if a 0001 revenue line is received, it will be ignored during processing.

This change does not affect National Standard Format (NSF) version 6.0 or ANSI 837 version 3051. Those formats continue to require the 0001 revenue line.

449 Revenue lines

After April 1, 2003, Medicare Part A will map only the first 449 revenue lines to the FISS processing system in files received in the ANSI 837 4010 format. If a claim containing more than 449 lines is received, all line items after line 449 will be dropped. **This is a change from previous instructions given that allowed 450 service lines per claim.**

If, after April 1, 2003, a claim is received with over 449 revenue lines, only the first 449 will map, causing the CLM02 total claim charge amount not to balance with the total claim charge amount calculated by the processing system. The claim will return to provider (RTP) with the appropriate reason code.

For additional information

Medicare A submitters who would like additional information about these changes or testing information for ANSI 837 4010 should contact Audrey Lipinski at 904/791-6865 or via email at audrey.lipinski@fcso.com. ❖

Source: CMS Transmittal A-02-119, CR 2387

EDUCATIONAL RESOURCES

Medicare Education and Outreach—Upcoming Events

A calendar for upcoming Medicare Education and Outreach events is posted to our provider education Web site, *www.floridamedicare.com*. Events scheduled through June 2003 are listed below.

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

Date	Event	Location
March		
5	PCOMM (Provider Communications - formerly PET Advisory Group)	Orange Park, FL
April	No events	
May		
20-22	**Medifest**	**Orlando, FL**
June		
4	PCOMM	St Augustine, FL
18	Basics Skills Workshop	St Petersburg, FL
19	Beyond the Basics Workshop	St Petersburg, FL

MEDIFEST 2003

You asked for it and it's back!

Medicare Education and Outreach is proud to announce the return of this popular event. This 2½ day symposium is designed with the provider in mind.

- You will have the opportunity to select 10 classs from 31 different topics.
- You will gain an understanding of Medicare guidelines and local medical review policies.
- You will be able to take classes to understand ICD-9-CM and *CPT* coding, fraud and abuse, Medicare secondary payer, claim Form UB-92 CMS-1450, hospital outpatient prospective payment system (OPPS), reason code resolution and much more!

FREE Exhibit Area

Everyone is invited to visit our free exhibit area to learn about office automation options available from vendor representatives and to speak with Medicare staff.

Continuing Education Units

Continuing education units (CEUs) are available for some Medifest classes. Details will be available at the event.

Tips for Registrants

- Pre-registration and pre-payment are required!
- Be sure to register for only one class per time slot.
- Register as early as possible, and no later than the deadline, to secure your space in the classes you want.
- Some classes require the use of current *CPT* or ICD-9-CM books. Check the class descriptions for more details; if in doubt, bring both books.

Classes, Schedules, and Registration

Complete class descriptions and schedules are available on our provider education Web site, *www.floridamedicare.com*; participants may register online via the Web site as well. Schedules and a registration form may be also found on the following pages.

MEDIFEST Class Schedule

The price for the MEDIFEST Event is $299 per person. Please keep in mind that you can register for only one class per time slot. If you register for a class that overlaps a second time slot (such as CMS-1500, *CPT* for Beginners, Primary Care and UB-92), you cannot register for another class until that class ends.

May 20-22, 2003
Orlando Airport Marriott
7499 Augusta National Blvd.
Orlando, FL 32822
Please contact hotel for directions and/or reservations (407) 851-9000

PLEASE MARK ONLY ONE CLASS PER TIME SLOT.

Tuesday

7:45 - 8:15
General Session (all participants)

9:00 - 10:30
- ❑ E/M Documentation/97 (B)
- ❑ Cardiology (B)
- ❑ Global Surgery (B)
- ❑ CMS-1500 (B)
  (This class lasts until 12:15 p.m.)
- ❑ *CPT* for Beginners (A/B)
  (This class lasts until 12:00 p.m.)
- ❑ Fraud & Abuse (A/B)
- ❑ Reason Code Resolution (A)

10:45 - 12:15
- ❑ ARNP (B)
- ❑ Reimbursement Efficiency (B)
- ❑ Medical Review/Data Analysis (A/B)
- ❑ ICD-9-CM Update (A/B)
- ❑ HOPPS (A)

1:30 - 3:00
- ❑ Provider Enrollment (B)
- ❑ Medicare Secondary Payer (B)
- ❑ Primary Care (B)
  (This class lasts until 5:00 p.m.)
- ❑ Part A Modifiers (A)
- ❑ UB-92/DDE (A)
  (This class lasts until 5:00 p.m.)
- ❑ Physical Medicine (B)

3:30 - 5:00
- ❑ E/M Coding (B)
- ❑ Vision (B)
- ❑ Anesthesia (B)
- ❑ Inquiries, Appeals & Overpayments (B)
- ❑ CORF/ORF (A)

Wednesday

8:30 - 10:00
- ❑ Radiology (B)
- ❑ Global Surgery (B)
- ❑ Inquiries, Appeals & Overpayments (B)
- ❑ Primary Care (B)
  (This class lasts until 12:00 p.m.)
- ❑ Fraud & Abuse (A/B)
- ❑ UB-92/DDE (A)
  (This class lasts until 12:00 p.m.)
- ❑ Medicare Secondary Payer (A)

10:30 - 12:00
- ❑ Cardiology (B)
- ❑ Reimbursement Efficiency (B)
- ❑ Medical Review/Data Analysis (A/B)
- ❑ Quality Improvement Organization (Formerly known as the PRO)
- ❑ Physical Medicine (B)

1:30 - 3:00
- ❑ E/M Coding (B)
- ❑ Vision (B)
- ❑ Oncology (B)
- ❑ CMS-1500 (B)
  (This class lasts until 5:00 p.m.)
- ❑ ICD-9-CM Update (A/B)
- ❑ *CPT* for Beginners (A/B)
  (This class lasts until 12:00 p.m.)
- ❑ Reason Code Resolution (A)

3:30 - 5:00
- ❑ E/M Documentation/97 (B)
- ❑ Mental Health (B)
- ❑ Dermatology (B)
- ❑ Orthopedics (B)
- ❑ Reimbursement Efficiency (A)

Thursday

8:30 - 10:00
- ❑ E/M Coding (B)
- ❑ Provider Enrollment (A/B)
- ❑ Global Surgery (B)
- ❑ Inquiries, Appeals & Overpayments (B)
- ❑ *CPT* for Beginners (A/B)
  (This class lasts until 12:00 p.m.)
- ❑ Fraud & Abuse (A/B)
- ❑ Medicare Secondary Payer (A)

10:30 - 12:00
- ❑ E/M Documentation/97 (B)
- ❑ Reimbursement Efficiency (B)
- ❑ Medicare Secondary Payer (B)
- ❑ ICD-9-CM Update (A/B)
- ❑ Part A Modifiers (A)
- ❑ Reimbursement Efficiency (A)

1:30 - 3:00
- ❑ HIPAA-AS (A/B)

Class Designations are:
Medicare Part A - (A)
Medicare Part B - (B)
Both - (A/B)

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_____
Attendee Name

_____
Provider Name

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Billing Provider Number

For complete class descriptors, please visit our Web site at *www.floridamedicare.com*

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For registration information, please visit our Web site at *www.floridamedicare.com* or call our registration hotline at (904) 791-8103.

Registration is on a first come, first served basis. Please register as soon as possible.

FCSO Announces *Free* Online Education

During the months of April through September 2003, First Coast Service Options, Inc. (FCSO) will offer live online instructor-led educational sessions, at no charge, through our Florida provider education Web site (*www.floridamedicare*.com).

The educational sessions may be accessed from any location, including the provider's office or residence, which eliminates travel time and other related expenses. A personal computer (PC) with an Internet connection via telephone or other modem device, plus an additional telephone connection to listen to the audio portion, is required for participation.

Registration for these events will occur through the Florida provider education Web site. FCSO is in the process of creating a schedule and list of topics, for these 60 to 90-minute sessions. As soon as the schedule is finalized, it will be posted to the Web site, published in future issues of the *Medicare A Bulletin*, and communicated through the *FCSO eNews* electronic mailing lists.

Providers should continue to monitor our Web site for more information in the coming months. If you have not already done so, subscribe to the *eNews* electronic mailing list so you can receive automatic notification of important updates to this information. ❖

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www.FloridaMedicare.com —
Florida Medicare's Provider Education Web Site

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

New Releases
Pages within the site containing information of immediate interest.

- ***What's New*** - Recent additions to specific areas within the site as well as other pertinent Medicare program change headlines and highlights.
- ***HIPAA*** - Information about the Health Insurance Portability and Accountability Act.

Content–Part A and B
Both areas contain the following:

- ***Special Release Articles*** - Articles of immediate interest that will also be published in the next regularly scheduled quarterly publication.
- ***Bulletins/Publications*** - FCSO Medicare quarterly and special issue publications (*Medicare A Bulletin* and *Medicare B Update!*).
- ***CMS/DHHS Publications*** - Publications issued by the Centers for Medicare & Medicaid Services (CMS), and Department of Health and Human Services (DHHS).
- ***Medical Policy*** - FCSO Medicare final and draft local medical review policies (LMRP), FCSO's list of self-administered drugs, links to CMS national coverage files, and more.
- ***Fraud, Abuse, and Waste*** - Articles and resources relative to Medicare providers.
- ***Self-Administered Drugs*** - Medicare payment for drugs and biologicals furnished incident to a physician's service.

Part A
Additional information found within the Part A area of the site (not inclusive).

- ***PPS*** - Prospective payment systems.
- ***Issues*** - Document containing a status of the most commonly reported Part A claim and system issues.
- ***Reason Codes*** - Part A reason codes.

Part B
Additional information found within the Part B area of the site (not inclusive).

- ***Crossovers/Medigap*** - A listing of Medigap insurers and supplemental insurers (automatic crossover), and other helpful information.

MCS
- Contains publications relative to FCSO's conversion to the Multi-Carrier System (MCS). Also includes the Part B System Issues Log.

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Provides information shared by Part A and Part B providers.

- ***Education & Training*** - Educational resources and calendar of events featuring online registration capabilities.
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- ***FAQs*** - Providers' most frequently asked questions and answers.
- ***Fee Schedules*** - Medicare physicians fee schedule files and links to CMS files for download for Medicare payment systems.
- ***Forms*** - Various FCSO and CMS enrollment applications and forms.
- ***General Info*** - Information about other Medicare topics (not inclusive):
- ***COB/MSP*** - Coordination of Benefits/Medicare Secondary Payer.
- ***Medicare Enrollment*** - Medicare provider enrollment applications and forms with instructions, which include paper and electronic versions of the CMS-855s.
- ***MEDPARD*** - Medicare Participating Physician and Supplier Directory.
- ***UPIN*** - Access to FCSO and national UPIN (unique physician identification number) directories.

Extras
- ***eNews*** - FCSO electronic mailing list. Sign up to receive automatic email notification when new or updated information is posted to Florida Medicare's provider education Web site.
- ***Search*** - Enables visitors to search the entire site or individual areas within the site for specific topics or subjects.
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93224: Electrocardiographic Monitoring of
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93350: Stress Echocardiography ..... 1st Qtr 2002 54
93501: Cardiac Catheterization, Revision to
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93724: Electronic Analysis of Pacemaker
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93784: Ambulatory Blood Pressure Monitoring ... 4th Qtr 2002 76
93975-93979: Duplex Scanning ..... 4th Qtr 2002 97
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94620: Pulmonary Stress Test ..... 4th Qtr 2002 98
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94664: Diagnostic Aerosol or Vapor Inhalation .... 4th Qtr 2002 98
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95900: Nerve Conduction Studies ..... 4th Qtr 2002 98
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97010: Physical Medicine and Rehabilitation ..... 2nd Qtr 2002 47
97110: Complex Decongestive Physiotherapy .... 2nd Qtr 2002 60

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Addresses

CLAIMS STATUS

Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

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

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

FRAUD AND ABUSE

Medicare Anti-fraud Branch
P. O. Box 45087
Jacksonville, FL 32232-5087

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

MEDICARE REGISTRATION

American Diabetes Association Certificates
Medicare Registration – ADA
P. O. Box 2078
Jacksonville, FL 32231-2078

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

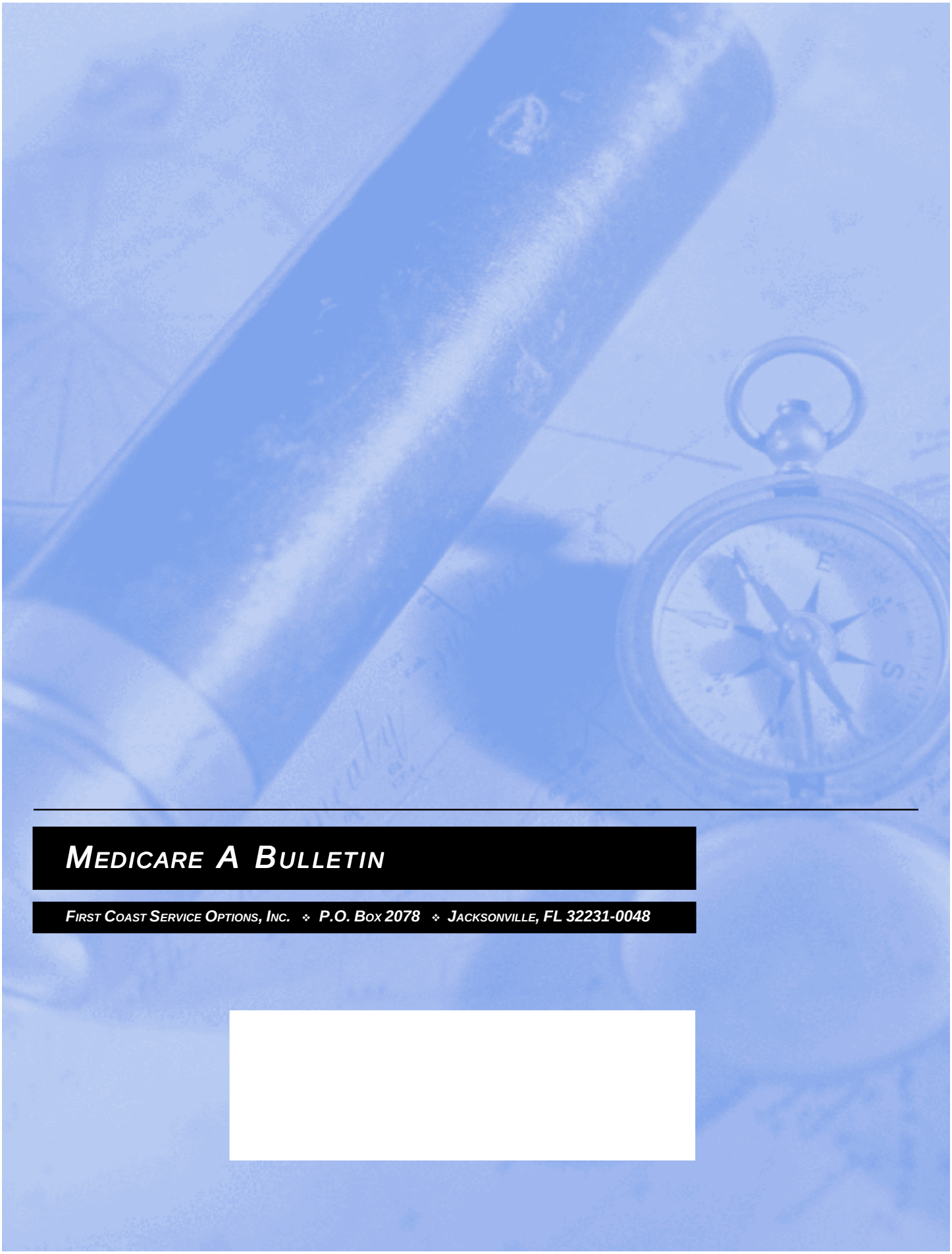
Medicare Web Sites

PROVIDERS

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

BENEFICIARIES

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



MEDICARE A BULLETIN

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