March/April 1997 Medicare Part B Update! Publication
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HCFA
Health Care Financing Administration
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FIRST COAST SERVICE OPTIONS, INC.
A HCFA Contracted Carrier and Intermediary
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1997 HCPCS Grace Period Ends April 1, 1997

The grace period for use of procedure codes deleted/invalid for 1997 ends on April 1, 1997. Claims received on or after this date billed using deleted or invalid procedure codes will be returned as unprocessable. Providers will be notified that an invalid procedure code was submitted and the claim must be resubmitted with a valid procedure code. Providers should refer to their 1997 procedure coding manual or the December 1996 HCPCS Special Update! for a list of deleted/invalid procedure codes and their replacements.

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Claim Denials Are on the Rise

A recent review of claims data has identified over 200,000 unnecessary claim denials during a recent one-month period. The five most common reasons for denials were:

Diagnosis not payable for service billed;

Diagnosis reference code not indicated;

Didn't indicate the UPIN of the referring/ordering physician;

Didn't indicate if service was purchased;

Allowance included in payment made of surgery/procedure.

See pages 79-80 for information on how you can avoid unnecessary denials of your claims!

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Revised Tampa Medifest Dates: April 15-17

The Medifest dates for the April Tampa Medifest have been revised. The new dates are April 15-17, 1997. As published previously, the event will be held at the Camberley Plaza, and all other Medifestinformation applies. See pages 5-10 for additional information.

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A Physician's Focus

Letter from the Medical Director

As Medicare Part B of Florida implements new Local Medical Review Policies (LMRPs), screens designed to review the medical necessity for affected procedures will be implemented. These new screens result in an increase in the number of claims denied due to predetermined frequencies for the procedure being exceeded or the diagnosis submitted not supporting the medical necessity for the procedure. Each LMRP describes the medical necessity requirements which must be met for coverage of a particular service (see the November/December 1996 "Physician's Focus" for more details) and the documentation needed for review of services which are denied. I believe it is important that providers understand the appeals process and the various methods available to them, and a brief description of these methods follows.

The first step is a formal request for review of a denied service. Although reviews can be conducted over the telephone, reviews for most claims denied due to a lack of medical necessity

must be submitted in writing with documentation supporting the need for the service (see page 24 for exceptions which may be filed electronically). You have six months from the date of the original Provider Remittance Notice to submit your request for a review, and a decision is normally made within 45 days. One tip to minimize the need to file written reviews: if you believe a service may be denied due to an LMRP limitation screen, you can submit all supporting documentation with the original paper claim to allow for a coverage decision to be made during the original processing of the claim.

If you are dissatisfied with the decision made on your review request, you may request a hearing. A request for a hearing must be made in writing, signed, and express dissatisfaction with the review decision. The request for a hearing must be made within six months of the date of the review decision and the aggregate amount in question must be at least $100. A Hearing Officer who was not involved in either the original processing of the claim or the review will determine whether Medicare guidelines were followed in previous decisions. The hearing decision will normally be made within 120 days. There are three types of hearings: on-the record decisions based on the facts in the file, telephone hearings between the requesting party and a hearing officer, or in person hearings at a mutually convenient location.

The results of the hearing are final and binding unless the amount in question is at least $500. However, if $500 or more is in question, an Administrative Law Judge (ALJ) can be asked to provide further consideration. An ALJ hearing must be requested in writing (per instructions provided with the hearing decision) within 60 days of the hearing decision. You should indicate whether you would like to attend this hearing. The ALJ will contact you regarding hearing preparation procedures and scheduling.

If at least $1,000 remains in controversy following the ALJ decision, you are entitled to a judicial review before a Federal District Court Judge. The ALJ decision will include instructions for requesting a judicial review.

While I hope none of our LMRP screens require a provider to exhaust these resources, I believe it is important for the carrier to ensure our providers possess a basic understanding of appeal procedures available to them. For complete information on the appeals process, see the "A Closer Look" section of the November/December 1996 Medicare B Update! publication.

Sincerely,

Sidney R. Sewell, M.D.

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Advance Notice Requirement

Medicare Part B allows coverage for services and items which are medically reasonable and necessary for the treatment/diagnosis of the patient. For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this is not an inclusive list):

Coverage for a service or item may be allowed only for specific diagnoses/conditions.

Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.

Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (utilization screen - i.e., there is a specified number of services within a specified timeframe for which the service may be covered).

In cases where the provider believes that the service or item may not be covered as medically reasonable and necessary, an acceptable advance notice of Medicare's possible denial of payment must be given to the patient if the provider does not want to accept financial responsibility for the service or item. The advance notice must meet the following requirements:

The notice must be given in writing, in advance of furnishing the service or item.

The notice must include the patient's name, date(s) and description of the service or item, and the reason(s) why the service or item may not be considered medically reasonable and necessary (e.g., service is not covered based on the diagnosis of the patient, the frequency of the service was furnished in excess of the utilization screen, etc.).

The notice must be signed and dated by the patient indicating that the patient assumes financial responsibility for the service if it is denied payment as not medically reasonable and necessary for the reason(s) indicated on the advance notice.

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting procedure code modifier GA with the service or item. The advance notice form should be maintained with the patient's medical record.

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Note: The following information applies to all articles in this publication referencing services which must meet medical necessity requirements (e.g., services with specific diagnosis requirements). Providers should refer to this information for those articles which indicate that "advance notice" applies.

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General Information About the Medicare B Update!

Articles included in each Update! represent formal notice that specific coverage policies either 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 B of Florida maintains copies of the mailing lists for each issue, and 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.

The Coverage/Reimbursement section includes information on general and specific Part B coverage guidelines. A General Information section includes the latest information on topics which apply to all providers such as limiting charge, correct coding initiative, etc. The remainder of this section includes information for specific procedure codes and is structured in the same format as the Physician's CPT book (i.e., in procedure code order) using the following categories: HCPCS Codes (A0000-Z9999), Anesthesia/Surgery (00100-69999), Diagnostic Tests (70000-89999), and Medicine (90000-99999).

Distribution of the Update! is limited to individual providers and PA groups who bill at least one claim to Medicare Part B of Florida for processing during the six months prior to the release of each issue. Providers who meet this criteria are sent one complimentary copy of that issue. Production, distribution, and postage costs prohibit us from distributing a copy of each issue to each provider's practice settings. This primarily affects members of PA groups; one copy of each issue is sent to the group. The group is responsible for dissemination of each copy to its members. If additional copies are needed, there are two options: purchase a separate annual subscription for $125 (order form on page 88), or download the text version from our on-line service, the B LINE BBS (see page 89 for more information).

Medicare Part B of Florida uses the same mailing address for all correspondence, and cannot designate that each issue of the Update! be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, a Change of Address form must be completed in the event of relocation. See page 87 for a copy of this form.

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General Information

Correct Coding Initiative

The Correct Coding Initiative was established to ensure that uniform payment is made for services on a national level. With the policy, payment is not made for a service which is considered a component of a more comprehensive service when they are furnished on the same day by the same provider. Payment for the component service is bundled into the payment for the comprehensive service. Therefore, the component service should not be billed in addition to the comprehensive service.

Use of GB and 59 Modifiers

As a result of the 1997 HCPCS update, procedure code modifier GB (Distinct procedural service) has been deleted and replaced with procedure code modifier 59 (Distinct procedural service) effective for services furnished on and after January 1, 1997. However, modifier GB may still be used through the HCPCS grace period (claims for services with 1997 dates of service which are received prior to April 1, 1997). Claims for 1997 dates of service received on and after April 1, 1997 which include the GB modifier will be processed as if no GB modifier were reported.

As a reminder, modifier 59 should be used only for those procedures listed in the correct coding relationships which are otherwise distinct and separately identifiable from the comprehensive procedure and for which there is no other modifier which can be used to identify the service as distinct and separate.

Procedure code modifiers GB/59 are not valid for procedure codes 99201-99499 (evaluation and managenment services) and procedure codes 77419-77430 (weekly radiation therapy services).

Dispute of CCI Relationships

Providers who have concerns regarding the appropriateness of a particular CCI relationship should contact AdminaStar Federal, Inc. at the following address:

National Correct Coding Initiative

AdminaStar Federal, Inc.

P.O. Box 50469

Indianapolis, IN 46250-0469

Providers who question if a particular procedure should have been denied payment as a correct coding relationship should contact Medicare Part B of Florida at (904) 634-4994 or write to:

Medicare Part B
P.O. Box 2360
Jacksonville, FL 32231-0018

Deleted Relationships

The following correct coding relationships have been deleted effective for claims processed March 31, 1997 and after. These deletions have been reviewed and approved by the American Medical Association. Payment for the procedure in Column II (Component Code) is no longer included in the payment for the procedure in Column I (Comprehensive Code) when they are billed for the same date of service by the same provider.

Although these correct coding relationships have been deleted, some of them may be reevaluated and, therefore, may be re-added as correct coding relationships in the future.

Claims for deleted CCI relationships will be automatically adjusted for payment. It is not necessary to request a review or resubmit the claim.

Restricted Use of CCI Modifiers

Effective for claims processed March 31, 1997, and after, the national CCI policy has been expanded to define code pairs for which CCI modifiers will not be allowed. The use of CCI modifiers with these code pairs will not bypass the CCI edits. A listing of the CCI modifiers can be found on page 19. The majority of the procedure code pairs, which restrict the use of CCI modifiers, contain Evaluation and Management services as the component code.

Under no circumstances will payment be made for the component service. In addition, no additional payment will be made for denied component services at the appeals level.

Due to the volume of code pairs affected by this policy revision, this information will be made available on the B LINE BBS. For additional information on the B LINE BBS, refer to page 89.

Note: The following five-digit. numeric codes are Current Procedural Terminology (CPT) codes. CPT codes and descriptions only are copyright 1998 American Medical Association (or other such date of publication of CPT). Applicable FARS/DFARS.

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Chapter: 3
Description: Surgery: Integumentary System (10000-19999)
Order #: PB97-990311

Chapter: 4
Description: Surgery: Musculoskeletal System (20000-29999)
Order #: PB97-990411

Chapter: 5
Description: Surgery: Respiratory, Cardiovascular, Hemic, and Lymphatic System (30000-39999)
Order #: PB97-990511

Chapter: 6
Description: Surgery: Digestive System (40000-49999)
Order #: PB97-990611

Chapter: 7
Description: Surgery: Urinary, Male & Female Genital, Maternity Care, and Delivery System (50000-59999)
Order #: PB97-990711

Chapter: 8
Description: Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, Auditory System (60000-69999)
Order #: PB97-990811

Chapter: 9
Description: Radiology Services (70000-79999)
Order #: PB97-990911

Chapter: 10
Description: Pathology and Laboratory Services (80000-89999)
Order #: PB97-991011

Chapter: 11
Description: Medicine, Evaluation, and Management Services (90000-99999)
Order #: PB97-991111

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Correct Coding Combinations

Background

In August of 1994, the Health Care Financing Administration awarded a contract to AdminiStar Federal to define correct coding practices that would be the basis of national Medicare policy for payment of claims using the American Medical Association Physicians' Current Procedural Terminology (CPT) system.

AdminiStar Federal developed correct coding combinations based upon review of CPT code descriptions, CPT coding instructions, review of existing local and national coding edits and review of Medicare billing history.

After reviewing and incorporating the comments and receiving HCFA's approval, AdminiStar Federal developed a code matrix-correct coding combinations. This matrix, based on the correct coding policy, automatically identifies inappropriate CPT code combinations and determines payment.

Frequently Misused Codes

The procedure code pairs listed below represent the most frequently misused codes by Medicare providers. These codes are classified as "Comprehensive and Component Code Combinations."

The CPT procedure code definition, or descriptor, is based upon the procedure being consistent with current medical practice. Therefore, codes describing components of a comprehensive code should not be billed in addition to the comprehensive code. We urge you to use this information to appropriately code claims submitted to Medicare Part B.

The top inappropriate procedure code pairs are listed below. However, in some cases these procedure code pairs may be billed together provided the procedures are distinct procedural services*.

Comprehensive Code	Component Code
93010	93042
71020	71010
93000	93040
94060	94200
85025	85595
93015	93000
93018	93010

The use of CCI modifiers is restricted for the following procedure code pairs. Under no circumstances will payment be made for the component code.

Comprehensive Code	Component Code
94060	94375
94010	94375

Distinct Procedural Services*

In many cases, multiple services provided to a patient on the same day by the same provider may appear to be incorrectly coded, when in fact, the services may have been performed as reported.

Because Medicare carriers cannot easily identify these circumstances, procedure code modifier 59 was established.

The use of modifier 59 with a procedure indicates that the procedure represents a "distinct procedure or service from others billed on the same date of service." It may represent a different session, different surgery, different anatomical site, different agent, different lesion, different injury or area of injury. The 59 modifier should be used only in those instances where another modifier does not exist to indicate a separate procedure (i.e.,, RT, LT, E1-E4, FA, F1-F9, 24, 25, 58, TA and T1-T9).

Example

A patient receives a single view, frontal chest x-ray (procedure code 71010) in the morning. Later in the day, additional problems arose and the patient receives an additional two view (frontal and lateral) chest x-ray (procedure code 71020). The claim should be billed as follows:

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Coverage Under the "Incident to" Guidelines

Medicare Part B allows coverage for services and supplies furnished by a physician's personnel when they are furnished "incident to" the physician's professional services. To be covered "incident to" the services of a physician, the services and supplies must meet the following requirements:

The services/supplies are an integral, although incidental, part of the physician's professional services.

The services/supplies are of a type that are commonly furnished in a physician's office or clinic.

The services/supplies are furnished under the physician's direct personal supervision.

The services/supplies are furnished by an individual who qualifies as an employee of the physician.

Services/supplies which are furnished as incident to a physician's service may be billed as if the physician personally performed the service. The requirements for the "incident to" provision are outlined in detail as follows:

Incident to a Physician's Professional Services

Incident to a physician's professional services means that the services/supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an illness or injury.

This does not mean, however, that the service of the physician's employee must be incident to the actual rendition of a personal service by the physician. Such a service/supply could be considered to be incident to when furnished during the course of treatment of an illness/injury where the physician performs an initial service and subsequent services of a frequency which reflects his/her active participation in and management of the course of treatment.

Commonly Furnished in Physicians' Offices

Services and supplies commonly furnished in physicians' offices are covered under the "incident to" provision. Where supplies are clearly of a type a physician is not expected to have on hand in the office or where services are of a type not considered medically appropriate to provide in the office setting, they would not be covered under the "incident to" provision.

Direct Personal Supervision

Coverage of service/supplies incident to the professional services of a physician is limited to situations in which there is direct personal physician supervision. This applies to services of auxiliary personnel employed by the physician and working under his/her supervision (e.g., nurses, technicians, therapists, other aides, etc.). Thus, where a physician employs auxiliary personnel to assist in rendering services, the services of such personnel are considered incident to the physician's services if there is a physician's service rendered to which the services of such personnel are an incidental part and there is direct personal supervision by the physician.

Direct personal supervision in the office setting does not mean that the physician must be present in the same room with the aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services.

Employment

To be considered an employee, the nonphysician performing the services may be a part-time, full-time, or leased employee of the supervising physician, group practice, or legal entity that employs the physician who provides direct personal supervision. A leased employee is a nonphysician working under a written employee leasing agreement which provides that:

The nonphysician, although employed by the leasing company or working as an independent contractor, provides services as the leased employee of the physician or other entity; and

The physician or other entity exercises control over all actions taken by the leased employee with regard to the rendering of medical services to the same extent as the physician or other entity would exercise such control if the leased employee were directly employed by the physician or other entity.

Services provided by auxiliary personnel not in the employ (either direct or leased) of the physician, group or other entity, even if provided on the physician's order or included in the physician's bill are not covered as incident to the physician's services.

Services of Nonphysician Practitioners

In addition to the coverage of services by nonphysician personnel (e.g., nurses, technicians, etc.), a physician may also have the services of certain nonphysician practitioners (e.g., physician assistants, nurse practitioners, clinical psychologists, etc.) covered as services incident to a physician's professional services.

Services performed by these nonphysician practitioners incident to a physician's professional services include not only services ordinarily furnished by a physician's office staff, but also services ordinarily performed by the physician (e.g., minor surgery, reading x-rays, and other activities that involve evaluation or treatment of a patient's condition). However, the nonphyician practitioner must be licensed or certified to provide such services and the services must meet all the requirements under the "incident to" provision (i.e., direct supervision, incident to the physician's services, etc.).

A nonphysician practitioner such as a physician assistant or nurse practitioner may be licensed under state law to perform a specific medical procedure and may be able to perform the procedure without direct physician supervision and have the services covered by Medicare as a nonphysician practitioner's service. However, in order to have that same service covered as incident to a physician's service, it must be performed under the direct personal supervision of the physician as an incidental part of the physician's personal in-office service. This does not mean that each occasion of an incidental service by the nonphysician practitioner must always be the occasion of a service actually rendered by the physician. It does mean that there must have been a direct, personal, professional service by the physician to initiate the course of treatment of which the service being performed by the nonphysician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects his/her active participation in and management of the course of treatment. In

addition, the physician must be in the office suite and immediately available to render assistance during the time the nonphysician practitioner is furnishing services which are incident to the physician's
services.

Services in a Clinic

Services and supplies incident to a physician's service in a physician directed clinic or group are generally the same as a physician in independent practice.

A physician directed clinic is one where:

A physician or a number of physicians is present to perform medical services at all times the clinic is open;

Each patient is under the care of a clinic physician; and

The nonphysician services are under direct medical supervision.

In physician directed clinics or groups, direct personal physician supervision may be the responsibility of several physicians as opposed to an individual attending physician. In this situation, medical management of all services provided in the clinic is assured. The physician ordering a particular service need not be the physician who is supervising the service. Therefore, services performed by nonphysician personnel are covered even though they are performed in another department of the clinic as long as there is direct physician supervision in that department.

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Implementation of PAYERID

The cover of the January/February 1997 Medicare B Update! discussed the implementation of PAYERID. That article indicated that PAYERID will be effective April 1, 1997 for Medicare only, on a voluntary basis for providers.

Unfortunately, that article was published in error as an implementation date for PAYERID has yet to be finalized. Providers should disregard that information pertaining to PAYERID until an implementation date is published.

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Non-Covered Devices Under Medicare

Providers continue to ask if waiver of liability is necessary for procedures that are denied payment as non-covered for one of the following reasons:

The procedure is investigational or experimental;

The procedure is not approved by the Food and Drug Administration (FDA), or;

There is a lack of scientific and clinical evidence to support the procedure's safety and effectiveness.

An advance notice of Medicare's denial of payment must be provided to the patient when the provider does not want to accept financial responsibility for a service that is considered investigational/experimental, or is not approved by the FDA, or because there is a lack of scientific and clinical evidence to support the procedure's safety and effectiveness.

The following is a non-inclusive list that outlines some common procedures that fall into this category:

Descriptor: Cryosurgical Ablation of the Prostate
Code: A9270
Update! Article: N/A

Descriptor: Posturography
Code: 92548
Update! Article: Jan/Feb. 1997, p.19

Descriptor: Decongestive Physiotherapy
Code: A9270
Update! Article: Nov./Dec. 1996, p.8

Descriptor: Transendental Meditation
Code: A9270
Update! Article: Jul./Aug. 1996, p. 30 and Mar./Apr. 1996, p. 43

Descriptor: Lung Volume Reduction Surgery
Code: A9270
Update! Article: Mar./Apr. 1997 p. 35

Descriptor: Vertebral axial decompression (VAX-D)
Code: A9270
Update! Article: Nov./Dec. 1995, p. 12

Descriptor: External counterpulsation (ECP)
Code: A9270
Update! Article: N/A

Descriptor: CA 27-29/Truquant BR RIA
Code: A9270
Update! Article: N/A

Descriptor: Transurethral Needle Ablation (TUNA)
Code: A9270
Update! Article: N/A

Descriptor: Laser Assisted Uvulopalatoplasty (LAUP)
Code: A9270
Update! Article: N/A

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Effective Date for National Provider Identifier

The cover of the September/October 1996 Medicare B Update! outlined the implementation of the National Provider Identifier (NPI) which will be replacing Medicare carrier-assigned provider numbers as well as Unique Provider Identification Numbers (UPINs).

The NPI will be used to report the performing and/or billing provider and the ordering/referring physician for services which are furnished on the order/referral of a physician.

The implementation of NPI is scheduled for December 1997. However, this date is subject to change. In addition, it is expected that there will not be a grace period for reporting the NPI on Medicare claims. Therefore, when NPI is implemented, claims which are filed using Medicare-assigned provider numbers and/or UPINs may be denied payment.

Providers should watch for future issues of the Update! for more information regarding NPI.

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Revaccination of Beneficiaries Who Received Recalled Influenza Virus Vaccine

In November 1996, the Parke-Davis division of Warner-Lambert Company voluntarily recalled 11 lots of their trivalent influenza virus vaccine (Fluogen) because of decreased potency of the A/Nanchang/933/95 (H3N2) component. The recalled lots were 00176P, 00276P, 00576P, 00586P, 00676P, 00686P, 00786P, 00886P, 00966P, 00986P, and 1066P. Doses from these lots were administered to approximately five to seven percent of all those who received the 1996-97 influenza virus vaccine.

A study of elderly nursing home residents vaccinated with Fluogen from the recalled lots has shown that because of the reduced potency of the vaccine they received, they are at somewhat greater risk of acquiring serious influenza illness from the A/Nanchang influenza strain or developing a clinical complication if they become ill with influenza. Therefore, the CDC and the FDA have recommended that high risk individuals who received Fluogen

from the lots recalled by Parke-Davis should be revaccinated with theremaining supplies of influenza vaccine. High risk individuals include all persons age 65 years of age and older, especially those with underlying chronic medical conditions such as cardiac or pulmonary disease.

Medicare covers medically necessary revaccination of beneficiaries with the influenza virus vaccine and, therefore, will make payment for revaccination of beneficiaries who received Fluogen from the recalled lots. Providers may file claims for revaccinations using their normal filing methods (either paper or electronic).

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Provider-Based Designation

Background:

The term or designation "provider-based" is an outgrowth of the Medicare cost reimbursement system. The main purpose of the provider or facility-based designation is to accommodate the appropriate accounting and allocation of costs where there is more than one type of provider-activity taking place within the same facility/organization, e.g., a hospital-based skilled nursing facility. This cost allocation and cost reimbursement more often than not results in Medicare program payments that exceed what would have been paid for if the same services were rendered by a free-standing entity.

With the growth of integrated delivery systems, HCFA has received numerous requests from entities requesting provider-based status. These requests, if approved, increase the portion of the facility's general and administrative costs that are supported by the Medicare program with no commensurate benefit to Medicare and its beneficiaries. Therefore, it is critical that HCFA designate only those entities that are unquestionably qualified as provider-based.

For example, some hospitals are purchasing physicians' clinics and multiple clinics in areas far from the licensed hospital and designating the clinics as "outpatient departments" of the hospital. If Medicare are to approve such designation as an "outpatient department" the hospital would then be allowed to increase Medicare payments by shifting overhead costs to the "outpatient department" and by increasing payments for indirect medical education. In addition to the payment impact, the Medicare coverage of "incident-to" services would also be affected if a physician's office is redesignated as a hospital outpatient department.

Medicare beneficiaries are also subject to an increased financial liability. In the example above of a hospital acquired physician practice, the beneficiary pays the usual deductible and co-insurance for physician services which are capped by the physician fee schedule. He is also responsible for a second

deductible and co-insurance for a "clinic visit" or "facility fee" to the hospital. These charges are not subject to the Medicare allowable charge or limiting charge restrictions of a physician's office.

Moreover, it should be noted that it is the intent of existing statutory and regulatory criteria for Medicare to operate as a prudent purchaser of services that enhance the care of beneficiaries. Medicare must comply with Congressional intent as reflected in 1861(v)(1)(A) of the Social Security Act to pay only for those costs that are necessary for the efficient delivery of needed health services. The statute at 1861(v)(1)(A) also provides general and specific criteria for developing payment rules to carry out the basic intent of the law as well as provisions when aggregate reimbursement produced by existing methodologies proves to be inadequate or excessive.

Policy Statement:

It is HCFA's policy that the following applicable requirements must be met before an entity can be designated as part of a provider for payment purposes:

1. The entity is physically located in close proximity of the provider where it is based, and both facilities serve the same patient population (e.g. from the same service, or catchment, area);

2. The entity is an integral and subordinate part of the provider where it is based, and as such, is operated with other departments of that provider under common licensure (except in situations where the State separately licenses the provider-based entity);

3. The entity is included under the accreditation of the provider where it is based (if the provider is accredited by a national accrediting body), and the accrediting body recognizes the entity as part of the provider;

4. The entity is operated under common ownership and control (i.e., common governance) by the provider where it is based, as evidenced by the following:

The entity is subject to common bylaws and operating decisions of the governing body of the provider where it is based;

The provider has final responsibility for administrative decisions, final approval for personnel actions, and final approval for medical staff appointments in the provider-based entity; and

The entity functions as a department of the provider where it is based with significant common resource usage of buildings, equipment and service personnel on a daily basis.

5. The entity director is under the direct day-to-day supervision of the provider where it is located, as evidenced by the following:

The entity director or individual responsible for day-to-day operations at the entity maintains a daily reporting relationship and is accountable to the Chief Executive Officer of the provider and reports through that individual to the governing body of the provider where the entity is based; and

Administrative functions of the entity, e.g., records, billing, laundry, housekeeping and purchasing, are integrated with those of the provider where the entity is based.

6. Clinical services of the entity and the provider where it is located are integrated as evidenced by the following:

Professional staff of the provider-based entity have clinical privileges in the provider where it is based;

The medical director of the entity (if the entity has a medical director) maintains a day-to-day reporting relationship to the Chief Medical Officer or other similar official of the provider where it is based;

All medical staff committees or other professional committees at the provider where the entity is based are responsible for all medical activities in the provider-based entity;

Medical records for patients treated in the provider-based entity are integrated into the unified records system of the provider where the entity is based;

Patients treated at the provider-based entity are considered patients of the provider and have full access to all provider services; and

Patient services provided in the entity are integrated into corresponding inpatient and/or outpatient services, as appropriate, by the provider where it is based.

7. The entity is held out to the public as part of the provider where it is based (e.g., patients know they are entering the provider and will be billed accordingly);

8. The entity and the provider where it is based are financially integrated as evidenced by the following:

The entity and the provider where it is based have an agreement for the sharing of income and expenses; and

The entity reports its cost in the cost report of the provider where it is based using the same accounting system for the same cost reporting period as the provider where it is based.

Determinations:

Determinations concerning whether an entity is provider-based (e.g., common licensure, governance, professional supervision criteria, reimbursement and accounting information) will be made by the appropriate HCFA RO components, i.e., the RO Division of Health Standards and Quality and the RO Division of Medicare with the assistance of the State survey agencies and the fiscal intermediary.

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Supplying Documentation with Overutilized Services

Medicare Part B provides payment for services which are considered reasonable and necessary for the treatment/diagnosis of the patient. To ensure that Part B benefits are properly used for medically necessary services, utilization "screens" are established which allows the carrier to ensure that the services a reasonable and necessary for the patient's condition/illness. These utilization screens may be established by one of the following methods:

A policy may be implemented by the Health Care Financing Administration to ensure that services are allowed on a consistent level nationally; or

As a result of the Focused Medical Review process, a screen may be implemented for a particular specialty or for all specialties in Florida because the utilization level of a particular service may be considerably higher per 1000 beneficiaries in Florida when compared to national averages.

Payment could be made for services furnished in excess of the established screen if the patient's medical record (e.g., office/progress notes, test results, etc.) clearly demonstrates the need for the service(s).

If you have reason to believe a service (in excess of the established utilization screen) is medically necessary, the claim must be submitted as a paper claim* with the appropriate documentation attached.

* Certain procedures (e.g., Routine footcare [procedure code M0101], nail debridement [procedure codes 11720, 11721] and chiropractic manipulative treatment [procedure codes 98940-98942]) performed in excess of the established utilization screen may be submitted electronically using a Certificate of Medical Necessity (CMN). If you are unsure if your software has the ability to submit a CMN electronically, contact your vendor.

A general guide listing the documentation requirements for services subject to utilization screens can be found on page 29 of the November/December 1996 Medicare B Update! More specific policy information can be found in other Medicare B Update! publications, or by contacting our Provider Customer Service department at (904) 634-4994.

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Bilateral Procedures During the Post-Operative Period

When billing for a bilateral, separately identifiable/unrelated surgical procedure performed during the post-operative period of another surgical procedure, procedure code modifiers RT (right) and LT (left) must be indicated on each claim as appropriate. In addition, procedure code modifier 79 (Unrelated procedure or service by the same physician during the postoperative period) must be indicated on the subsequent claim.

Example A

If a patient has cataract surgery on the left eye on January 3, and a cataract surgery on the right eye performed during the 90 post-operative period (March 24), the claim should be billed as follows:

Example B

If a patient has right total hip replacement on January 31, and a left total hip replacement performed during the 90 post-operative period (April 4), the claim should be billed as follows:

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Acupuncture Treatments Not Covered Under Medicare Part B

An article which recently appeared in The Florida Acupuncturist erroneously implied that Medicare Part B payment can be made for acupuncture services under the "incident to" provision. Acupuncture treatment is not covered by the Medicare program under any circumstances or billing arrangements. That is, acupuncture is not covered when billed by an acupuncturist or a physician who employs and supervises an acupuncturist. While the "incident to" provision does allow coverage for certain services rendered by a physician's employees in his office under his supervision, acupuncture does not qualify as one of these services. For more information on the "incident to" provision, please see page 20 of this issue.

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Proper Use of Procedure Code Modifier 58

Under the global surgery rules, separate payment is not made for a procedure performed during the postoperative period of another procedure unless certain exceptions exist (e.g., procedures are not related, the second procedure is a result of complications from the first procedure, etc.).

For staged or related procedures, separate payment may be made if the following requirements are met:

Staged Procedures - The decision to stage the procedure is made prospectively or at the time of the first procedure.

Related Procedures - The performance of the procedure is neither staged nor the result of complications from the first procedure (e.g., a breast biopsy is performed and, as a result, it is determined that a mastectomy is required and performed during the postoperative period of the biopsy).

If the requirements are met for either staged or related procedures, procedure code modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) should be reported with the procedure. Payment for these procedures will not be reduced and a new post-operative period will begin with the next procedure.

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HCPCS Codes

Revisions to the 1997 MPFSDB

The Medicare Physician Fee Schedule Data Base (MPFSDB) is updated annually with the Health Care Financing Administration's Common Procedural Coding System (HCPCS) update. The MFSDB revisions for 1997 were outlined in the December 1996 Medicare B Update! Special Issue: 1997 HCPCS and MPFSDB Update (pages 22 through 58).

Throughout the year, the MPFSDB is re-evaluated by the Health Care Financing Administration to ensure that services are appropriately reimbursed based on the specific payment rules they are subject to. This reevaluation is generally performed on a quarterly basis and, as a result, some revisions to the MPFSDB are required. The following information is a result of latest revisions to the MPFSDB effective for services furnished January 1, 1997, and after:

The malpractice expense relative value units for the following procedures have been revised and, as a result, the fee schedule allowances have been revised:

Physician Fee Schedule

Procedure Code (G0084)
Participating Fees (Par)
Non-Participating Fees (NonPar)
Limiting Charge (LC)
Loc (Locality)

	Loc 01/02	Loc 03	Loc 04
G0084 (Par)	63.61	66.54	69.06
(NonPar)	60.43	63.21	65.61
(LC)	69.49	72.69	75.45
G0089(Par)	63.50	67.57	71.13
(NonPar)	60.33	64.19	67.57
(LC)	69.37	73.82	77.71
G0090	(Par) 76.84	81.20	85.00
(NonPar)	73.00	77.14	80.75
(LC)	83.95	88.71	92.86
G0091	(Par)	86.24	90.80	94.78
(NonPar)	81.93	86.26	90.04
(LC)	94.22	99.20	103.55
G0092	(Par)	96.24	101.02	105.18
(NonPar)	91.43	95.97	99.92
(LC)	105.14	110.36	114.91
G0093	(Par)	123.84	129.21	133.88
(NonPar)	117.65	122.75	127.19
(LC)	135.30	141.16	146.26
G0094	(Par)	138.39	144.08	149.01
(NonPar)	131.47	136.88	141.56

(LC) 151.19 157.41 162.79

Clinical Psychologist Fee Schedule

Procedure Code	Loc 01/02	Loc 03	Loc 04
G0089	63.50	67.57	71.13
G0091	86.24	90.80	94.78
G0093	123.84	129.21	133.88

The malpractice and practice expense relative value units for the following procedure code have been revised and, as a result, the fee schedule allowance has been revised:

Physician Fee Schedule

Procedure Code	Participating Fees		Non-Participating Fees		
90901	46.78	51.13	54.43	44.44	48.57	51.71

Clinical Psychologist Fee Scheudule

Procedure Code	Loc 01/02	Loc 03	Loc 04
90901	46.78	51.13	54.43

See page 28 for fee schedule information for Licensed Clinical Social Workers (LCSWs) rendering new psychotherapy codes.

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G0053: Payment Rules

Effective for services performed January 1, 1997, and after, procedure code G0053 [Destruction by any method, including laser, with or without surgical curettement of all benign or premalignant lesions (e.g., actinic keratosis), other than skin tags or cutaneous vascular proliferation lesions, including local anesthesia; 15 lesions or more] will be subject to standard multiple surgery rules. In addition, this procedure has 10 follow-up days.

Multiple surgical procedures performed on the same day or during the same operative session by the same physician are covered and their allowance is based on:

100 percent of the fee schedule amount for the primary procedure (procedure with the highest relative value);

50 percent of the fee schedule for the second through fifth procedures; and

"by report" for the sixth and subsequent procedures.

Note: When procedure codes G0051 and G0052 are performed on the same day, the multiple surgery rules do not apply.

For more information on the use of procedure codes G0051-G0053, refer to page 14 of the January/February 1997 Medicare B Update!

Important Note: All claims for procedure code G0053 must be submitted as a paper claim with the following documentation:

progress notes/office records

For specific information on Medicare Part B's coverage policy for benign or premalignant skin lesion removal, refer to page 8 of the October1996 Medicare B Update! Special Issue: New Local Medical Review and Focused Medical Review Policies.

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Procedure Code G0063 Not Covered by Portable X-ray Suppliers

Effective for claims processed April 14, 1997 and after, procedure code G0063 (Central skeletal bone mineral density studies [e.g., spine, pelvis]) will not be covered when billed by portable x-ray suppliers. Procedure code G0063 replaced procedure code 76075 (Dual energy x-ray absorptiometry [DEXA], bone density study)which was classified as invalid for Medicare purposes effective for services furnished on and after January 1, 1997.

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Clarification: Licensed Clinical Social Worker Guidelines

Appropriate Use of New Psychotherapy Procedure Codes

As a result of the 1997 HCPCS Update, a series of new alpha-numeric "G" codes were developed to report psychotherapy services. A comprehensive article which included the descriptors for the new psychotherapy codes was published on page 15 of the January/February 1997 Medicare B Update! The purpose of this article is to provide additional clarification.

In reporting psychotherapy, the appropriate code is chosen on the basis of:

the type of psychotherapy (insight oriented, behavior modifying and/or supportive vs. interactive)

the place of service (office or outpatient vs. inpatient hospital, partial hospital or residential facility)

the face-to-face time spent with the patient.

Note: LCSWs will not be reimbursed for alpha-numeric "G" codes which include a medical evaluation and management component (G0072, G0074, G0076, G0078, G0080, G0082, G0084, G0086, G0088, G0090, G0092 and G0094).

Office or Other Outpatient Psychotherapy

(G0071, G0073, G0075, G0077, G0079, and G0081)

In most cases, the services of LCSWs are reported using the alpha-numeric "G" codes under the category, "Office or Other Outpatient Psychotherapy". Services rendered in places of service 12 (Home), 32 (Nursing Home), and 33 (Adult Congregate Living Facility) fall under the "other outpatient" category and should be reported using the above-mentioned procedure codes.

Inpatient Hospital, Partial Hospital or Residential Care Facilities

(G0083, G0085, G0087, G0089, G0091, and G0093)

There are also restrictions on the use of alpha-numeric "G" codes under the category, "Inpatient Hospital, Partial Hospital or Residential Care Facilities" for LCSWs. LCSW's may not bill directly for services rendered to hospital inpatients or partial hospitalization patients.

Under the LCSW benefit, a Skilled Nursing Facility (SNF) (place of service 31) is considered to be a residential care setting. However, when billing for LCSW services in an SNF, special consideration must be given to the type of service rendered to the patient. As part of the SNF requirements for participation, Medicare Part A reimburses SNF facilities on a per diem basis for social services provided by a CSW with at least bachelor-level training. In an SNF setting, Medicare Part B only provides coverage for services which meet the definition of psychotherapy, and fall within the licensure of a LCSW.

Listed below are the 1997 fee schedule amounts for LCSWs services rendered in an SNF setting. These codes were originally published as noncovered in error.

Procedure Code	Loc 01/02	Loc 03	Loc 04	
G0083	38.39	40.38	42.10	
G0085	59.94	63.06	65.77	
G0087	100.83	106.51	111.40	
G0089*	47.63	50.68	53.35	
G0091*	64.68	68.10	71.09	
G0093*	92.88	96.91	100.41	

* The fees for these procedures have been revised based on the latest revisions to the MPFSDB (see page 26).

The fees for procedure code 90901 (Biofeedback training by any modality) have also been revised based on the latest revisions to the MPFSDB. Listed below are the revised fees:

Procedure Code	Loc 01/02	Loc 03	Loc 04
90901	35.09	38.35	40.82

Place Of Service Restrictions

The following table is intended to clarify the place of service restrictions for Licensed Clinical Social Workers.

Location: Inpatient
Place of Service Code: 21, 51, 61
Coverage: Services by LCSW not covered under Part B. Part A reimburses the hospital under DRG for employees, and may include LCSW services.

Location: Community Mental Health Center
Place of Service Code: 53
Coverage: Facility bills to Medicare Part A

Location: Partial Hospitalization Program
Place of Service Code 52
Coverage: Whether the LCSW is an employee or not, the hospital bills Part A

Location: Skilled Nursing Facility
Place of Service Code: 31
Coverage: If the services are required under Part A requirements for SNFs, the services are not covered by Part B. If the services are not part of the contract, the services may be billed to Part B by the LCSW.

Location: Home, Nursing Home
Place of Service Code: 12, 32
Coverage: LCSW can bill Part B directly.

Location: Other Outpatient Settings (e.g., Office, ACLF)
Place of Service Code: 11, 33
Coverage: LCSW can bill Part B directly.

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Pricing for Injectable Drugs

Reimbursement amounts for most drugs are updated quarterly, except for chemotherapy drugs, which are updated monthly. Payment for drugs is made at the median of the average wholesale price (AWP) for generic drugs, which is based on the Drug Topics Red Book.

The following table includes a complete list of injectable drugs, in procedure code order, with the description, maximum allowance, non-participating allowance, and limiting charge amounts. This information is effective for claims processed on or after January 1, 1997.

As a reminder, if the injectable drug billed does not appear on this list, it must be submitted using the unlisted procedure code J3490 (for non-chemotherapy agents) or J9999 (for chemotherapy agents). Paper and electronic claims must include the name of the drug, its strength, dosage, and number of injections.

Code: J0120 Description: Injection, Tetracycline, up to 250 mg.
Par Allowance: 12.17
NonPar Allowance: 11.56
Limiting Charge: 13.29

Code: J0150 Description: Injection, Adenosine, 6 mg.
Par Allowance: 26.66
NonPar Allowance: 25.33
Limiting Charge: 29.13

Code: J0170 Description: Injection, Adrenalin, Epinephrine, up to 1 ml. Ampule
Par Allowance: 1.45
NonPar Allowance: 1.38
Limiting Charge: 1.59

Code: J0190 Description: Injection, Biperiden, per 5 mg.
Par Allowance: 3.33
NonPar Allowance: 3.16
Limiting Charge: 3.63

Code: J0205 Description: Injection, Alglucerase, per 10 units
Par Allowance: 38.50
NonPar Allowance: 36.58
Limiting Charge: 42.07

Code: J0210 Description: Injection, Methyldopate HCl, up to 250 mg.
Par Allowance: 8.70
NonPar Allowance: 8.27
Limiting Charge: 9.51

Code: J0256 Description: Injection, Alpha 1-Proteinase Inhibitor-Human, per 500 mg.
Par Allowance: 95.00
NonPar Allowance: 90.25
Limiting Charge: 103.79

Code: J0270 Description: Injection, Alprostadil, per 1.25 mcg. procedure code added 1/1/97
Par Allowance: 2.17
NonPar Allowance: 2.06
Limiting Charge: 2.37

Code: J0280 Description: Injection, Aminophylline, up to 250 mg.
Par Allowance: 1.10
NonPar Allowance: 1.05
Limiting Charge: 1.21

Code: J0290 Description: Injection, Ampicillin Sodium, up to 500 mg.
Par Allowance: 1.86
NonPar Allowance: 1.77
Limiting Charge: 2.04

Code: J0295 Description: Injection, Ampicillin Sodium/Sulbactam Sodium, per 1.5 gm.
Par Allowance: 7.26
NonPar Allowance: 6.90
Limiting Charge: 7.94

Code: J0300 Description: Injection, Amobarbital, up to 125 mg.
Par Allowance: 2.24
NonPar Allowance: 2.13
Limiting Charge: 2.45

Code: J0330 Description: Injection, Succinycholine Chloride, up to 20 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J0340 Description: Injection, Nandrolone Phenpropionate, up to 50 mg.
Par Allowance: 5.96
NonPar Allowance: 5.66
Limiting Charge: 6.51

Code: J0350 Description: Injection, Anistreplase, per 30 units
Par Allowance: 2,438.75
NonPar Allowance: 2,316.81
Limiting Charge: 2,664.33

Code: J0360 Description: Injection, Hydralazine HCl, up to 20 mg.
Par Allowance: 9.75
NonPar Allowance: 9.26
Limiting Charge: 10.65

Code: J0380 Description: Injection, Metaraminol Bitartrate, per 10mg.
Par Allowance: 1.23
NonPar Allowance: 1.17
Limiting Charge: 1.35

Code: J0390 Description: Injection, Chloroquine Hydrochloride, up to 250 mg.
Par Allowance: 14.87
NonPar Allowance: 14.13
Limiting Charge: 16.25

Code: J0400 Description: Injection, Trimethaphan Camsylate, up to 500 mg.
Par Allowance: 28.60
NonPar Allowance: 27.17
Limiting Charge: 31.25

Code: J0460 Description: Injection, Atropine Sulfate, up to 0.3 mg.
Par Allowance: 1.33
NonPar Allowance: 1.26
Limiting Charge: 1.45

Code: J0470 Description: Injection, Dimercaprol, per 100 mg.
Par Allowance: 11.00
NonPar Allowance: 10.45
Limiting Charge: 12.02

Code: J0475 Description: Injection, Baclofen, 10 mg.
Par Allowance: 208.00
NonPar Allowance: 197.60
Limiting Charge: 227.24

Code: J0500 Description: Injection, Dicyclomine HCl, up to 20 mg.
Par Allowance: 2.96
NonPar Allowance: 2.81
Limiting Charge: 3.23

Code: J0510 Description: Injection, Benzquinamide HCl, up to 50 mg.
Par Allowance: 5.76
NonPar Allowance: 5.47
Limiting Charge: 6.29

Code: J0515 Description: Injection, Benztropine Mesylate, per 1 mg.
Par Allowance: 3.50
NonPar Allowance: 3.33
Limiting Charge: 3.83

Code: J0520 Description: Injection, Bethanechol Chloride, Myotonachol or Urecholine, up to 5 mg.
Par Allowance: 5.33
NonPar Allowance: 5.06
Limiting Charge: 5.82

Code: J0530 Description: Injection, Penicillin G Benzathine and Penicillin G Procaine, up to 600,000 Units
Par Allowance: 6.58
NonPar Allowance: 6.25
Limiting Charge: 7.19

Code: J0540 Description: Injection, Penicillin G Benzathine and Penicillin G Procaine, up to 1,200,000 Units
Par Allowance: 13.17
NonPar Allowance: 12.51
Limiting Charge: 14.39

Code: J0550 Description: Injection, Penicillin G Benzathine and Penicillin G Procaine, up to 2,400,000 Units
Par Allowance: 26.34
NonPar Allowance: 25.02
Limiting Charge: 28.77

Code: J0560 Description: Injection, Penicillin G Benzathine, up to 600,000 Units
Par Allowance: 6.57
NonPar Allowance: 6.24
Limiting Charge: 7.18

Code: J0570 Description: Injection, Penicillin G Benzathine, up to 1,200,000 Units
Par Allowance: 10.14
NonPar Allowance: 9.63
Limiting Charge: 11.07

Code: J0580 Description: Injection, Penicillin G Benzathine, up to 2,400,000 units
Par Allowance: 28.64
Nonpar allowance: 27.21
Limiting Charge: 31.29

Code: J0585 Description: Botulinum Toxin Type A, per Unit descriptor change 1/1/97 (old per 100 units)
Par Allowance: 3.99
NonPar Allowanc 3.79
Limiting Charg 4.36

Code: J0590 Description: Injection, Ethylnorepinephrine HCI 1 ml.
Par Allowance: 4.39
NonPar allowance: 4.17
Limiting Charg 4.80

Code: J0600 Description: Injection, Edetate Calcium Disodium, up to 1000 mg.
Par allowance: 33,21
NonPar: 31.55
Limiting Charg 36.28

Code: J0610 Description: Injection, Calcium Gluconate, per 10mg
Par: 1.29
NonPar: 1.23
Limiting Charge: 1.41

Code: J0620 Description: Injection, Calcium Glycerophosphate and Calcium Lactate, per 10 ml.
Par: 3.05
NonPar: 2.90
Limiting Charge: 3.34

Code: J0630 Description: Injection, Calcitonin Salmon, up to 400mg
Par: N.C.
NonPar: N.C.
Limiting Charge: N.C.

Code: J0635 Description: Injection, Calcitriol, 1 mcg. amp.
Par: 12.74
NonPar:12.10
Limiting Charge: 13.92

Code: J0640 Description: Injection, Leucovorin Calcium, per 50mg
Par: 21.53
NonPar: 20.45
Limiting Charge: 23.52

Code: J0670 Description: Injection, Mepivacaine Hydrochloride, per 10 ml.
Par: N.C.
NonPar: N.C.
Limiting Charge: N.C.

Code: J0690 Description: Injection, Cefazolin Sodium, up to 500 mg
Par: 3.01
Nonpar: 2.86
Limiting Charge: 3.29

Code: J0694 Description: Injection, Cefoxitin Sodium, 1 gm.
Par: 9.91
NonPar: 9.41
Limiting Charge: 10.82

Code: J0695 Description: Injection, Cefonicid Sodium 1 gram
Par: 26.10
NonPar: 24.80
Limiting Charge: 28.52

Code: J0696 Description: Injection, Ceftriaxone Sodium, per 250 mg.
Par: 12.17
NonPar: 11.56
Limiting Charge: 13.29

Code: J0697 Description: Injection, Sterile Cefuroxime Sodium, per 750mg
Par: 6.24
NonPar: 5.93
Limiting Charge: 6.82

Code: J0698 Description: Cefotaxime Sodium, per gm.
Par: 11.27
NonPar: 10.71
Limiting Charge: 12.32

Code: J0702 Description: Injection, Betamethasone Acetate and Betamethasone Sodium Phosphate, per 3mg
Par: 4.24
Nonpar: 4.03
Limiting Charge: 4.63

Code: J0704 Description: Injection, Betamethasone Sodium Phosphate, per 4 mg.
Par: 2.54
Nonpar: 2.41
Limiting Charge: 2.77

Code: J0710 Description: Injection, Cephapirin Sodium, up 1 gm
Par: 1.64
NonPar: 1.56
Limiting Charge: 1.79

Code: J0713 Description: Injection, Ceftazidime, per 500 mg.
Par: 7.51
NonPar: 7.13
Limiting Charge: 8.20

Code: J0715 Description: Injection, Ceftizoxime Sodium, per 500mg
Par: 6.48
NonPar: 6.16
Limiting Charge: 7.08

Code: J0720 Description: Injection, Chloramphenicol Sodium Succinate, up to 1 gm.
Par: 6.60
NonPar: 6.27
Limiting Charge: 7.21

Code: J0725 Description: Injection, Chorionic Gonadotropin, per 1,000 USP units
Par: 3.60
NonPar: 3.42
Limiting Charge: 3.93

Code: J0730 Description: Injection, Chlorpheniramine Maleate, per 10 mg.
Par: 1.00
NonPar: 0.95
Limiting Charge: 1.09

Code: J0743 Description: Injection, Cilastatin Sodium; Imipenem, per 250mg
Par: 15.16
NonPar: 14.40
Limiting Charge: 16.56

Code: J0745 Description: Injection, Codeine Phosphate, per 30 mg.
Par: 1.00
NonPar: 0.95
Limiting Charge: 1.09

Code: J0760 Description: Injection, Colchicine, per 1mg
Par: 5.04
NonPar: 4.79
Limiting Charge: 5.51

Code: J0770 Description: Injection, Colistimethate Sodium, up to 150 mg.

Par: 34.02
NonPar: 32.32
0Limiting Charg 37.17

Code: J0780 Description: Injection, Prochlorperazine, up to 10mg
Par: 2.60
NonPar: 2.47
Limiting Charge: 2.84

Code: J0800 Description: Injection, Corticotropin, up to 40 Units
Par: 30.60
NonPar: 29.07
Limiting Charge: 33.43

Code: J0810 Description: Injection, Cortisone, up to 50mg
Par: 1.00
NonPar: 0.95
Limiting charge: 1.09

Code: J0835 Description: Injection, Cosyntropin, per 0.25 mg.
Par: 13.10
NonPar: 12.45
Limiting Charge: 14.32

Code: J0850 Description: Injection, Cytomegalovirus Immune Intravenous (Human),per vial
Par: 413.30
NonPar: 392.64
Limiting Charg 451.54

Code: J0895 Description: Injection, Deferoxamine Mesylate, 500 mg. per 5 cc
Par: 10.77
NonPar: 10.23
Limiting Charge: 11.76

Code: J0900 Description: Injection, Testosterone Enanthate and Estradiol Valerate, up to 1cc
Par: 1.48
NonPar: 1.41
Limiting Charge: 1.62

Code: J0945 Description: Injection, Brompheniramine Maleate, per 10 mg.
Par: 1.00
NonPar: 0.95
Limiting Charge: 1.09

Code: J0970 Description: Injection, Estradiol Valerate, up to 40 mg
Par: 1.48
NonPar: 1.41
Limiting Charge: 1.62

Code: J1000 Description: up to 5 mg.
Par: 2.96

NonPar: 2.81
Limiting Charge: 3.23

Code: J1020 Description: Injection, Methylprednisolone Acetate 20 mg
Par: 1.00
Nonpar: 0.95
Limiting Charge: 1.09

Code: J1030 Description: Injection, Methylprednisolone Acetate, 40 mg.
Par: 2.07
NonPar: 1.97
Limiting Charge: 2.27

Code: J1040 Description: Injection, Methylprednisolone Acetate 80 mg
Par: 3.09
Nonpar: 2.94
Limiting Charge: 3.38

Code: J1050 Description: Injection, Medroxyprogesterone Acetate, 100 mg.
Par: 9.65
NonPar: 9.17
Limiting Charge: 10.55

Code: J1055 Description: Injection, Medroxyprogesterone Acetate for Contraceptive use,150 mg
Par: N.C.
Nonpar: N.C.
Limiting Charge: N.C.

Code: J1060 Description: Injection, Testosterone Cypionate and Estradiol Cypionate, up to 1 ml.
Par: 1.38
NonPar: 1.31
Limiting Charge: 1.51

Code: J1070 Description: Injection, Testosterone Cypionate, up to 100 mg
Par: 1.37
NonPar: 1.30
Limiting Charge: 1.50

Code: J1080 Description: Injection, Testosterone Cypionate, 1 cc, 200 mg.
Par: 2.05
NonPar: 1.95
Limiting Charge: 2.24

Code: J1090 Description: Injection, Testosterone Cypionate, 1cc, 50mg
Par: 1.01
Nonpar: 0.96
Limiting Charge: 1.10

Code: J1095 Description: Injection, Dexamethasone Acetate, per 8 mg.
Par: 4.89
NonPar Allowance: 4.65
Limiting Charge: 5.35

Code: J1100 Description: Injection, Dexamethosone Sodium Phosplate, up to 4 mg/ml
Par Allowance: 1.00
NonPar: .095
Limiting Charg 1.09

Code: J1110 Description: Injection, Dihydroergotamine Mesylate, per 1 mg.
Par Allowance: 11.32
NonPar AllowaNonPar Allowanc 10.75
0Limiting Charg 12.36

Code: J1120 Description: Injection, Acetazolamide Sodium, up to Limiting Char
Par Allowance: 36.59
NonPar Allowance: 34.76
Limiting Charge: 39.97

Code: J1160 Description: Injection, Digoxin, up to 0.5 mg.
Par Allowance: 2.53
NonPar Allowance: 2.40
Limiting Charge: 2.76

Code: J1165 Description: Injection, Phenytoin Sodium, per 50 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J1170 Description: Injection, Hydromorphone, up to 4 mg.
Par Allowance: 1.32
NonPar Allowance: 1.25
Limiting Charge: 1.44

Code: J1180 Description: Injection, Dyphylline, up to 500 mg.
Par Allowance: 4.65
NonPar Allowance: 4.42
Limiting Charge: 5.08

Code: J1190 Description: Injection, Dexrazoxane Hydrochloride, per 250 mg. <R>procedure code added 1/1/97
Par Allowance: 134.38
NonPar Allowance: 127.66
Limiting Charge: 146.81

Code: J1200 Description: Injection, Diphenhydramine HCl, up to 50 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J1205 Description: Injection, Chlorothiazide Sodium, per 500 mg.
Par Allowance: 9.18
NonPar Allowance: 8.72
Limiting Charge: 10.03

Code: J1212 Description: Injection, DMSO, Dimethyl Sulfoxide, 50%, 50 ml.
Par Allowance: 36.50
NonPar Allowance: 34.68
Limiting Charge: 39.88

Code: J1230 Description: Injection, Methadone HCl, up to 10 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J1240 Description: Injection, Dimenhydrinate, up to 50 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J1245 Description: Injection, Dipyridamole, per 10 mg.
Par Allowance: 30.00
NonPar Allowance: 28.50
Limiting Charge: 32.78

Code: J1250 Description: Injection, Dobutamine Hydrochloride, per 250 mg.
Par Allowance: 49.41
NonPar Allowance: 46.94
Limiting Charge: 53.98

Code: J1320 Description: Injection, Amitriptyline HCl, up to 20 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J1330 Description: Injection, Ergonovine Maleate, up to 0.2 mg.
Par Allowance: 3.47
NonPar Allowance: 3.30
Limiting Charge: 3.80

Code: J1362 Description: Injection, Erythromycin Gluceptate, per 250 mg.
Par Allowance: 6.09
NonPar Allowance: 5.79
Limiting Charge: 6.66

Code: J1364 Description: Injection, Erythromycin Lactobionate, per 500 mg.
Par Allowance: 6.25
NonPar Allowance: 5.94
Limiting Charge: 6.83

Code: J1380 Description: Injection, Estradiol Valerate, up to 10 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J1390 Description: Injection, Estradiol Valerate, up to 20 mg.
Par Allowance: 1.34
NonPar Allowance: 1.27
Limiting Charge: 1.46

Code: J1410 Description: Injection, Estrogen Conjugated, per 25 mg.
Par Allowance: 36.39
NonPar Allowance: 34.57
Limiting Charge: 39.76

Code: J1435 Description: Injection, Estrone, per 1 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J1436 Description: Injection, Etidronate Disodium, per 300 mg.
Par Allowance: 63.60
NonPar Allowance: 60.42
Limiting Charge: 69.48

Code: J1440 Description: Injection, Filgrastim (G-CSF), 300 mcg.
Par Allowance: 156.10
NonPar Allowance: 148.30
Limiting Charge: 170.55

Code: J1441 Description: Injection, Filgrastim (G-CSF), 480 mcg.
Par Allowance: 248.60
NonPar Allowance: 236.17
Limiting Charge: 271.60

Code: J1455 Description: Injection, Foscarnet Sodium, per 1000 mg.
Par Allowance: 12.21
NonPar Allowance: 11.60
Limiting Charge: 13.34

Code: J1460 Description: Injection, Gamma Globulin, Intramuscular, 1 cc
Par Allowance: 2.19
NonPar Allowance: 2.08
Limiting Charge: 2.39

Code: J1470 Description: Injection, Gamma Globulin, Intramuscular, 2 cc
Par Allowance: 4.38
NonPar Allowance: 4.16
Limiting Charge: 4.78

Code: J1480 Description: Injection, Gamma Globulin, Intramuscular, 3 cc
Par Allowance: 6.56
NonPar Allowance: 6.23
Limiting Charge: 7.16

Code: J1490 Description: Injection, Gamma Globulin, Intramuscular, 4 cc
Par Allowance: 8.75
NonPar Allowance: 8.31
Limiting Charge: 9.56

Code: J1500 Description: Injection, Gamma Globulin, Intramuscular, 5 cc
Par Allowance: 10.94
NonPar Allowance: 10.39
Limiting Charge: 11.95

Code: J1510 Description: Injection, Gamma Globulin, Intramuscular, 6 cc
Par Allowance: 13.13
NonPar Allowance: 12.47
Limiting Charge: 14.34

Code: J1520 Description: Injection, Gamma Globulin, Intramuscular, 7 cc
Par Allowance: 15.32
NonPar Allowance: 14.55
Limiting Charge: 16.73

Code: J1530 Description: Injection, Gamma Globulin, Intramuscular, 8 cc
Par Allowance: 17.50
NonPar Allowance: 16.63
Limiting Charge: 19.12

Code: J1540 Description: Injection, Gamma Globulin, Intramuscular, 9 cc
Par Allowance: 19.69
NonPar Allowance: 18.71
Limiting Charge: 21.52

Code: J1550 Description: Injection, Gamma Globulin, Intramuscular, 10 cc
Par Allowance: 21.88
NonPar Allowance: 20.79
Limiting Charge: 23.91

Code: J1560 Description: Injection, Gamma Globulin, Intramuscular, over 10 cc
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: J1561 Description: Injection, Immune Globulin, Intravenous, per 500 mg.
Par Allowance: 40.31

NonPar Allowance: 38.29
Limiting Charge: 44.03

Code: J1562 Description: Immune Globulin Intravenous (Human), 10%, per 500 mg.
Par Allowance: 37.25
NonPar Allowance: 35.39
Limiting Charge: 40.70

Code: J1570 Description: Injection, Ganciclovir Sodium, 500 mg.
Par Allowance: 34.80
NonPar Allowance: 33.06
Limiting Charge: 38.02

Code: J1580 Description: Injection, Garamycin, Gentamicin, up to 80 mg.
Par Allowance: 3.05
NonPar Allowance: 2.90
Limiting Charge: 3.34

Code: J1600 Description: Injection, Gold Sodium Thiomalate, up to 50 mg.
Par Allowance: 16.75
NonPar Allowance: 15.91
Limiting Charge: 18.30

Code: J1610 Description: Injection, Glucagon Hydrochloride, per 1 mg.
Par Allowance: 35.07
NonPar Allowance: 33.32
Limiting Charge: 38.32

Code: J1620 Description: Injection, Gonadorelin Hydrochloride, per 100 mcg.
Par Allowance: 70.09
NonPar Allowance: 66.59
Limiting Charge: 76.58

Code: J1625 Description: Injection, Granisetron Hydrochloride, per 1 mg.
Par Allowance: 173.95
NonPar Allowance: 165.25
Limiting Charge: 190.04

Code: J1630 Description: Injection, Haloperidol, up to 5 mg.
Par Allowance: 3.75
NonPar Allowance: 3.56
Limiting Charge: 4.09

Code: J1631 Description: Injection, Haloperidol Decanoate, per 50 mg.
Par Allowance: 27.95
NonPar Allowance: 26.55
Limiting Charge: 30.53

Code: J1642 Description: Injection, Heparin Sodium, (Heparin Lock Flush), per 10 units

Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J1644 Description: Injection, Heparin Sodium, per 1000 units
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J1645 Description: Injection, Dalteparin Sodium, per 2500 IU procedure code added 1/1/97
Par Allowance: 13.95
NonPar Allowance: 13.25
Limiting Charge: 15.24

Code: J1650 Description: Injection, Enoxaparin Sodium, 30 mg.
Par Allowance: 16.16
NonPar Allowance: 15.35
Limiting Charge: 17.65

Code: J1670 Description: Injection, Tetanus Immune Globulin, Human, up to 250 Units
Par Allowance: 26.25
NonPar Allowance: 24.94
Limiting Charge: 28.68

Code: J1690 Description: Injection, Prednisolone Tebutate, up to 20 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J1700 Description: Injection, Hydrocortisone Acetate, up to 25 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J1710 Description: Injection, Hydrocortisone Sodium Phosphate, up to 50 mg.
Par Allowance: 5.40
NonPar Allowance: 5.13
Limiting Charge: 5.90

Code: J1720 Description: Injection, Hydrocortisone Sodium Succinate, up to 100 mg.
Par Allowance: 3.75
NonPar Allowance: 3.56
Limiting Charge: 4.09

Code: J1730 Description: Injection, Diazoxide, up to 300 mg.
Par Allowance: 97.90
NonPar Allowance: 93.01
Limiting Charge: 106.96

Code: J1739 Description: Injection, Hydroxyprogesterone Caproate, 125 mg./ml.
Par Allowance: 1.13
NonPar Allowance: 1.07
Limiting Charge: 1.23

Code: J1741 Description: Injection, Hydroxyprogesterone Caproate, 250 mg./ml.
Par Allowance: 3.00
NonPar Allowance: 2.85
Limiting Charge: 3.28

Code: J1760 Description: Injection, Iron Dextran, 2 cc
Par Allowance: 37.70
NonPar Allowance: 35.82
Limiting Charge: 41.19

Code: J1770 Description: Injection, Iron Dextran, 5 cc
Par Allowance: 94.26
NonPar Allowance: 89.55
Limiting Charge: 102.98

Code: J1780 Description: Injection, Iron Dextran, 10 cc
Par Allowance: 188.52
NonPar Allowance: 179.09
Limiting Charge: 205.95

Code: J1785 Description: Injection, Imiglucerase, per unit
Par Allowance: 3.85
NonPar Allowance: 3.66
Limiting Charge: 4.21

Code: J1790 Description: Injection, Droperidol, up to 5 mg.
Par Allowance: 3.97
NonPar Allowance: 3.77
Limiting Charge: 4.34

Code: J1800 Description: Injection, Propranolol HCl, up to 1 mg.
Par Allowance: 6.25
NonPar Allowance: 5.94
Limiting Charge: 6.83

Code: J1810 Description: Injection, Droperidol and Fentanyl Citrate, up to 2 ml. Ampule
Par Allowance: 10.25
NonPar Allowance: 9.74
Limiting Charge: 11.20

Code: J1820 Description: Injection, Insulin, up to 100 Units
Par Allowance: 1.89
NonPar Allowance: 1.80
Limiting Charge: 2.07

Code: J1830 Description: Injection, Interferon Beta-1b, per 0.25 mg.
Par Allowance: 72.00
NonPar Allowance: 68.40

Limiting Charge: 78.66

Code: J1840 Description: Injection, Kanamycin Sulfate, up to 500 mg.
Par Allowance: 6.69
NonPar Allowance: 6.36
Limiting Charge: 7.31

Code: J1850 Description: Injection, Kanamycin Sulfate, up to 75 mg.
Par Allowance: 3.53
NonPar Allowance: 3.35
Limiting Charge: 3.85

Code: J1885 Description: Injection, Ketorolac Tromethamine, per 15 mg.
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: J1890 Description: Injection, Cephalothin Sodium, up to 1 gm.
Par Allowance: 10.80
NonPar Allowance: 10.26
Limiting Charge: 11.80

Code: J1910 Description: Injection, Kutapressin, up to 2 ml.
Par Allowance: 10.98
NonPar Allowance: 10.43
Limiting Charge: 11.99

Code: J1930 Description: Injection, Propiomazine HCl, up to 20 mg.
Par Allowance: 4.15
NonPar Allowance: 3.94
Limiting Charge: 4.53

Code: J1940 Description: Injection, Furosemide, up to 20 mg.
Par Allowance: 1.11
NonPar Allowance: 1.05
Limiting Charge: 1.21

Code: J1950 Description: Injection, Leuprolide Acetate (For Depot Suspension) per 3.75 mg.
Par Allowance: 416.25
NonPar Allowance: 395.44
Limiting Charge: 454.76

Code: J1955 Description: Injection, Levocarnitine, per 1 gm.
Par Allowance: 36.00
NonPar Allowance: 34.20
Limiting Charge: 39.33

Code: J1960 Description: Injection, Levorphanol Tartrate, up to 2 mg.
Par Allowance: 2.59
NonPar Allowance: 2.46

Limiting Charge: 2.83

Code: J1970 Description: Injection, Methotrimeprazine, up to 20 mg.
Par Allowance: 22.69
NonPar Allowance: 21.56
Limiting Charge: 24.79

Code: J1980 Description: Injection, Hyoscyamine Sulfate, up to 0.25 mg.
Par Allowance: 4.00
NonPar Allowance: 3.80
Limiting Charge: 4.37

Code: J1990 Description: Injection, Chlordiazepoxide HCl, up to 100 mg.
Par Allowance: 8.07
NonPar Allowance: 7.67
Limiting Charge: 8.82

Code: J2000 Description: Injection, Lidocaine HCl, 50 cc
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J2010 Description: Injection, Lincomycin HCl, up to 300 mg.
Par Allowance: 1.61
NonPar Allowance: 1.53
Limiting Charge: 1.76

Code: J2050 Description: Injection, Liver, up to 20 mcg.<R>code deleted 1/1/97, see J3490
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J2060 Description: Injection, Lorazepam, 2 mg.
Par Allowance: 9.78
NonPar Allowance: 9.29
Limiting Charge: 10.68

Code: J2150 Description: Injection, Mannitol, 25% in 50 ml.
Par Allowance: 2.93
NonPar Allowance: 2.78
Limiting Charge: 3.20

Code: J2175 Description: Injection, Meperidine Hydrochloride, per 100 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J2180 Description: Injection, Meperidine and Promethazine Hcl, up to 50 mg.
Par Allowance: 3.12
NonPar Allowance: 2.96
Limiting Charge: 3.40

Code: J2210 Description: Injection, Methylergonovine Maleate, up to 0.2 mg.
Par Allowance: 3.04
NonPar Allowance: 2.89
Limiting Charge: 3.32

Code: J2240 Description: Injection, Metocurine Iodide, up to 2 mg.
Par Allowance: 1.31
NonPar Allowance: 1.24
Limiting Charge: 1.43

Code: J2250 Description: Injection, Midazolam Hydrochloride, per 1 mg.
Par Allowance: 1.96
NonPar Allowance: 1.86
Limiting Charge: 2.14

Code: J2260 Description: Injection, Milrinone Lactate, per 5 ml
Par Allowance: 31.59
NonPar Allowance: 30.01
Limiting Charge: 34.51

Code: J2270 Description: Injection, Morphine Sulfate, up to 10 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J2275 Description: Injection, Morphine Sulfate (Preservative- Free Sterile Solution), per 10 mg.
Par Allowance: 11.90
NonPar Allowance: 11.31
Limiting Charge: 13.01

Code: J2300 Description: Injection, Nalbuphine Hydrochloride, per 10 mg.
Par Allowance: 2.33
NonPar Allowance: 2.21
Limiting Charge: 2.54

Code: J2310 Description: Injection, Naloxone Hydrochloride, per 1 mg.
Par Allowance: 2.99
NonPar Allowance: 2.84
Limiting Charge: 3.27

Code: J2320 Description: Injection, Nandrolone Decanoate, up to 50 mg.
Par Allowance: 5.46
NonPar Allowance: 5.19
Limiting Charge: 5.97

Code: J2321 Description: Injection, Nandrolone Decanoate, up to 100 mg.
Par Allowance: 7.80

NonPar Allowance: 7.41
Limiting Charge: 8.52

Code: J2322 Description: Injection, Nandrolone Decanoate, up to 200 mg.
Par Allowance: 11.25
NonPar Allowance: 10.69
Limiting Charge: 12.29

Code: J2330 Description: Injection, Thiothixene, up to 4 mg.
Par Allowance: 14.14
NonPar Allowance: 13.43
Limiting Charge: 15.44

Code: J2350 Description: Injection, Niacinamide, Niacin, up to 100 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J2360 Description: Injection, Orphenadrine Citrate, up to 60 mg.
Par Allowance: 2.47
NonPar Allowance: 2.35
Limiting Charge: 2.70

Code: J2370 Description: Injection, Phenylephrine HCl, up to 1 ml.
Par Allowance: 3.10
NonPar Allowance: 2.95
Limiting Charge: 3.39

Code: J2400 Description: Injection, Chloroprocaine Hydrochloride, per 30 ml.
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J2405 Description: Injection, Ondansetron Hydrochloride, per 1 mg.
Par Allowance: 6.11
NonPar Allowance: 5.80
Limiting Charge: 6.67

Code: J2410 Description: Injection, Oxymorphone HCl, up to 1 mg.
Par Allowance: 3.72
NonPar Allowance: 3.53
Limiting Charge: 4.06

Code: J2430 Description: Injection, Pamidronate Disodium, per 30 mg.
Par Allowance: 191.68
NonPar Allowance: 182.10
Limiting Charge: 209.42

Code: J2440 Description: Injection, Papaverine HCl, up to 60 mg.
Par Allowance: 3.75

NonPar Allowance: 3.56
Limiting Charge: 4.09

Code: J2460 Description: Injection, Oxytetracycline HCl, up to 50 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J2480 Description: Injection, Hydrochlorides of Opium Alkaloids, up to 20 mg.
Par Allowance: 3.41
NonPar Allowance: 3.24
Limiting Charge: 3.73

Code: J2510 Description: up to 600,000 Units
Par Allowance: 2.71
NonPar Allowance: 2.57
Limiting Charge: 2.96

Code: J2512 Description: Injection, Pentagastrin, per 2 ml.
Par Allowance: 36.13
NonPar Allowance: 34.32
Limiting Charge: 39.47

Code: J2515 Description: Injection, Pentobarbital Sodium, per 50 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J2540 Description: Injection, Penicillin G Potassium, up to 600,000 Units
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J2545 Description: Pentamidine Isethionate, inhalation solution, per 300 mg. administered thru DME
Par Allowance: 98.75
NonPar Allowance: 93.81
Limiting Charge: 107.88

Code: J2550 Description: Injection, Promethazine HCl, up to 50 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J2560 Description: Injection, Phenobarbital Sodium, up to 120 mg.
Par Allowance: 5.11
NonPar Allowance: 4.85
Limiting Charge: 5.58

Code: J2590 Description: Injection, Oxytocin, up to 10 Units
Par Allowance: 1.22

NonPar Allowance: 1.16
Limiting Charge: 1.33

Code: J2597 Description: Injection, Desmopressin Acetate, per 1 mcg.<R>descriptor change 1/1/97 (old 4 mcg.)
Par Allowance: 5.50
NonPar Allowance: 5.23
Limiting Charge: 6.01

Code: J2640 Description: Injection, Prednisolone Sodium Phosphate, to 20 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J2650 Description: Injection, Prednisolone Acetate, up to 1 ml.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J2670 Description: Injection, Tolazoline HCl, up to 25 mg.
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J2675 Description: Injection, Progesterone, per 50 mg.
Par Allowance: 1.64
NonPar Allowance: 1.56
Limiting Charge: 1.79

Code: J2680 Description: Injection, Fluphenazine Decanoate, up to 25 mg.
Par Allowance: 15.42
NonPar Allowance: 14.65
Limiting Charge: 16.85

Code: J2690 Description: Injection, Procainamide HCl, up to 1 gm.
Par Allowance: 11.61
NonPar Allowance: 11.03
Limiting Charge: 12.68

Code: J2700 Description: Injection, Oxacillin Sodium, up to 250 mg.
Par Allowance: 1.40
NonPar Allowance: 1.33
Limiting Charge: 1.53

Code: J2710 Description: Injection, Neostigmine Methylsulfate, up to 0.5 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J2720 Description: Injection, Protamine Sulfate, per 10 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95

Limiting Charge: 1.09

Code: J2725 Description: Injection, Protirelin, per 250 mcg.
Par Allowance: 18.44
NonPar Allowance: 17.52
Limiting Charge: 20.15

Code: J2730 Description: Injection, Pralidoxime Chloride, up to 1 gm.
Par Allowance: 28.86
NonPar Allowance: 27.42
Limiting Charge: 31.53

Code: J2760 Description: Injection, Phentolamine Mesylate, up to 5 mg.
Par Allowance: 30.44
NonPar Allowance: 28.92
Limiting Charge: 33.26

Code: J2765 Description: Injection, Metoclopramide HCl, up to 10 mg.
Par Allowance: 2.35
NonPar Allowance: 2.23
Limiting Charge: 2.56

Code: J2790 Description: Injection, Rho D Immune Globulin, Human, One Dose Package
Par Allowance: 45.00
NonPar Allowance: 42.75
Limiting Charge: 49.16

Code: J2800 Description: Injection, Methocarbamol, up to 10 ml.
Par Allowance: 4.00
NonPar Allowance: 3.80
Limiting Charge: 4.37

Code: J2810 Description: Injection, Theophylline, per 40 mg.
Par Allowance: 1.41
NonPar Allowance: 1.34
Limiting Charge: 1.54

Code: J2820 Description: Injection, Sargramostim (CM-CSF), 50 mcg. descriptor change 1/1/97 (old 250 mcg.)
Par Allowance: 23.56
NonPar Allowance: 22.38
Limiting Charge: 25.74

Code: J2860 Description: Injection, Secobarbital Sodium, up to 250 mg.
Par Allowance: 7.75
NonPar Allowance: 7.36
Limiting Charge: 8.46

Code: J2910 Description: Injection, Aurothioglucose, up to 50 mg.
Par Allowance: 12.68
NonPar Allowance: 12.05
Limiting Charge: 13.86

Code: J2912 Description: Injection, Sodium Chloride, 0.9%, per 2 ml.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J2920 Description: Injection, Methylprednisolone Sodium Succinate, up to 40 mg.
Par Allowance: 4.00
NonPar Allowance: 3.80
Limiting Charge: 4.37

Code: J2930 Description: Injection, Methylprednisolone Sodium Succinate, up to 125 mg.
Par Allowance: 12.50
NonPar Allowance: 11.88
Limiting Charge: 13.66

Code: J2950 Description: Injection, Promazine HCl, up to 25 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J2970 Description: Injection, Methicillin Sodium, up to 1 gm.
Par Allowance: 5.53
NonPar Allowance: 5.25
Limiting Charge: 6.04

Code: J2995 Description: Injection, Streptokinase, per 250,000 IU
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J2996 Description: Injection, Alteplase Recombinant, per 10 mg.
Par Allowance: 275.00
NonPar Allowance: 261.25
Limiting Charge: 300.44

Code: J3000 Description: Injection, Streptomycin, up to 1 gm.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J3005 Description: Injection, Strontium-89 Chloride, per 10 ml.
Par Allowance: 2,032.80
NonPar Allowance: 1,931.16
Limiting Charge: 2,220.83

Code: J3010 Description: Injection, Fentanyl Citrate, up to 2 ml.
Par Allowance: 2.06
NonPar Allowance: 1.96
Limiting Charge: 2.25

Code: J3030 Description: Injection, Sumatriptan Succinate, 6 mg.
Par Allowance: 36.29
NonPar Allowance: 34.48
Limiting Charge: 39.65

Code: J3070 Description: Injection, Pentazocine HCl, up to 30 mg.
Par Allowance: 4.07
NonPar Allowance: 3.87
Limiting Charge: 4.45

Code: J3080 Description: Injection, Chlorprothixene, up to 50 mg.
Par Allowance: 5.13
NonPar Allowance: 4.87
Limiting Charge: 5.60

Code: J3105 Description: Injection, Terbutaline Sulfate, up to 1 mg.
Par Allowance: 2.43
NonPar Allowance: 2.31
Limiting Charge: 2.66

Code: J3120 Description: Injection, Testosterone Enanthate, up to 100 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J3130 Description: Injection, Testosterone Enanthate, up to 200 mg.
Par Allowance: 1.58
NonPar Allowance: 1.50
Limiting Charge: 1.73

Code: J3140 Description: Injection, Testosterone Suspension, up to 50 mg.
Par Allowance: 1.03
NonPar Allowance: 0.98
Limiting Charge: 1.13

Code: J3150 Description: Injection, Testosterone Propionate, up to 100 mg.
Par Allowance: 1.59
NonPar Allowance: 1.51
Limiting Charge: 1.74

Code: J3230 Description: Injection, Chlorpromazine HCl, up to 50 mg.
Par Allowance: 2.05
NonPar Allowance: 1.95
Limiting Charge: 2.24

Code: J3240 Description: Injection, Thyrotropin, up to 10 I.U.
Par Allowance: 200.19
NonPar Allowance: 190.18
Limiting Charge: 218.71

Code: J3250 Description: Injection, Trimethobenzamide HCl, up to 200 mg.
Par Allowance: 1.35
NonPar Allowance: 1.28
Limiting Charge: 1.47

Code: J3260 Description: Injection, Tobramycin Sulfate, up to 80 mg.
Par Allowance: 6.74
NonPar Allowance: 6.40
Limiting Charge: 7.36

Code: J3265 Description: Injection, Torsemide, 10 mg./ml.
Par Allowance: 1.88
NonPar Allowance: 1.79
Limiting Charge: 2.06

Code: J3270 Description: Injection, Imipramine HCl, up to 25 mg.
Par Allowance: 2.33
NonPar Allowance: 2.21
Limiting Charge: 2.54

Code: J3280 Description: Injection, Thiethylperazine Maleate, up to 10 mg.
Par Allowance: 5.28
NonPar Allowance: 5.02
Limiting Charge: 5.77

Code: J3301 Description: Injection Triamcinolone Acetonide, per 10 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J3302 Description: Injection Triamcinolone Diacetate, per 5 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J3303 Description: Injection Triamcinolone Hexacetonide, per 5 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J3305 Description: Injection, Trimetrexate Glucoronate, per 25 mg.
Par Allowance: 60.84
NonPar Allowance: 57.80
Limiting Charge: 66.47

Code: J3310 Description: Injection, Perphenazine, up to 5 mg.
Par Allowance: 5.68
NonPar Allowance: 5.40
Limiting Charge: 6.21

Code: J3320 Description: Injection, Spectinomycin Dihydrochloride, up to 2 gm.
Par Allowance: 18.34
NonPar Allowance: 17.42
Limiting Charge: 20.03

Code: J3350 Description: Injection, Urea, up to 40 gm.
Par Allowance: 73.77
NonPar Allowance: 70.08
Limiting Charge: 80.59

Code: J3360 Description: Injection, Diazepam, up to 5 mg.
Par Allowance: 1.21
NonPar Allowance: 1.15
Limiting Charge: 1.32

Code: J3364 Description: Injection, Urokinase, 5000 I.U. vial
Par Allowance: 56.26
NonPar Allowance: 53.45
Limiting Charge: 61.47

Code: J3365 Description: Injection, IV, Urokinase, 250,000 I.U. vial
Par Allowance: 433.31
NonPar Allowance: 411.64
Limiting Charge: 473.39

Code: J3370 Description: Injection, Vancomycin HCl, up to 500 mg.
Par Allowance: 12.91
NonPar Allowance: 12.26
Limiting Charge: 14.10

Code: J3390 Description: Injection, Methoxamine HCl, up to 20 mg.
Par Allowance: 24.42
NonPar Allowance: 23.20
Limiting Charge: 26.68

Code: J3400 Description: Injection, Triflupromazine HCl, up to 20 mg.
Par Allowance: 12.48
NonPar Allowance: 11.86
Limiting Charge: 13.64

Code: J3410 Description: Injection, Hydroxyzine HCl, up to 25 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J3420 Description: Injection, Vitamin B-12, Cyanocobalamin, up to 1,000 mcg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J3430 Description: Injection, Phytonadione, (Vitamin K), per 1 mg.
Par Allowance: 2.61

NonPar Allowance: 2.48
Limiting Charge: 2.85

Code: J3450 Description: Injection, Mephentermine Sulfate, up to 30 mg.
Par Allowance: 1.81
NonPar Allowance: 1.72
Limiting Charge: 1.98

Code: J3470 Description: Injection, Hyaluronidase, up to 150 Units
Par Allowance: 7.99
NonPar Allowance: 7.59
Limiting Charge: 8.73

Code: J3475 Description: Injection, Magnesium Sulfate, per 500 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J3480 Description: Injection, Potassium Chloride, per 2 mEq.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J3490 Description: Unclassified Drugs
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: J3520 Description: Edetate Disodium, per 150 mg.
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J3530 Description: Nasal Vaccine Inhalation
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J3535 Description: Drug Administered through a metered dose inhaler
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J3570 Description: Laetrile, Amygdalin, Vitamin B-17
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J6015 Description: Typhus
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J7030 Description: Infusion, Normal Saline Solution, 1000 cc
Par Allowance: 11.50
NonPar Allowance: 10.93
Limiting Charge: 12.57

Code: J7040 Description: Infusion, Normal Saline Solution, Sterile, (500 ml. = 1 Unit)
Par Allowance: 10.76
NonPar Allowance: 10.22
Limiting Charge: 11.75

Code: J7042 Description: 5% Dextrose/Normal Saline (500 ml = 1 Unit)
Par Allowance: 10.96
NonPar Allowance: 10.41
Limiting Charge: 11.97

Code: J7050 Description: Infusion, Normal Saline Solution, 250 cc
Par Allowance: 10.03
NonPar Allowance: 9.53
Limiting Charge: 10.96

Code: J7051 Description: Sterile Saline or Water, up to 5 cc
Par Allowance: 1.04
NonPar Allowance: 0.99
Limiting Charge: 1.14

Code: J7060 Description: 5% Dextrose/Water (500 ml. = 1 Unit)
Par Allowance: 10.71
NonPar Allowance: 10.17
Limiting Charge: 11.70

Code: J7070 Description: Infusion, D5W, 1000 cc
Par Allowance: 11.99
NonPar Allowance: 11.39
Limiting Charge: 13.10

Code: J7100 Description: Infusion, Dextran 40, 500 ml.
Par Allowance: 142.04
NonPar Allowance: 134.94
Limiting Charge: 155.18

Code: J7110 Description: Infusion, Dextran 75, 500 ml.
Par Allowance: 86.70
NonPar Allowance: 82.37
Limiting Charge: 94.73

Code: J7120 Description: Ringers Lactate Infusion, up to 1000 cc
Par Allowance: 13.34
NonPar Allowance: 12.67
Limiting Charge: 14.57

Code: J7130 Description: Hypertonic Saline Solution, 50 or 100 mEq., 20 cc vial
Par Allowance: 4.18

NonPar Allowance: 3.97
Limiting Charge: 4.57

Code: J7140 Description: Prescription Drug, Oral, Dispensed in Physician s Office<R>code deleted 1/1/97, see A9270
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J7150 Description: Prescription Drug, Oral Chemotherapy for Malignant Disease<R>code deleted 1/1/97, see A9270
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J7190 Description: Factor VIII, [Anti-Hemophilic Factor (Human)], per I.U.
Par Allowance: 0.90
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: J7191 Description: Factor VIII, [Anti-Hemophilic Factor (Porcine)], per I.U.
Par Allowance: 1.74
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: J7192 Description: Factor VIII [Antihemophilic Factor (Recombinant)], per I.U.
Par Allowance: 1.18
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: J7194 Description: Factor IX, Complex, Per I.U.
Par Allowance: 0.55
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: J7196 Description: Other Hemophilia Clotting Factors, (e.g. Anti-Inhibitors), per I.U.
Par Allowance: 1.30
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: J7197 Description: Antithrombin III (Human), per I.U.
Par Allowance: 1.06
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: J7300 Description: Intrauterine Copper Contraceptive
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J7310 Description: Ganciclovir, 4.5 mg., Long-Acting Implant procedure code added 1/1/97
Par Allowance: 4,000.00

NonPar Allowance: 3,800.00
Limiting Charge: 4,370.00

Code: J7500 Description: Azathioprine - Oral, Tab, 50 mg., 100s, ea.
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J7501 Description: Azathioprine - Parenteral, Vial, 100 mg., 20 ml., ea.
Par Allowance: 96.46
NonPar Allowance: Not Applicable
Limiting Charge:

Code: J7502 Description: Cyclosporine - Oral, Sol; 100 mg./ml., 50 ml., ea.<R>code deleted 1/1/97, see J7599
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J7503 Description: Cyclosporine - Parenteral, per 50 mg.
Par Allowance: 5.50
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: J7504 Description: Lymphocyte Immune Globulin, Antitymocyte Globulin - Parenteral, Amp., 50 mg./ml., 5 ml., ea.
Par Allowance: 262.24
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: J7505 Description: Monoclonal Antibodies - Parenteral, 5 mg.
Par Allowance: 672.00
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: J7506 Description: Prednisolone, Oral, per 5 mg.
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J7507 Description: Tacrolimus, Oral, per 1 mg.
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: J7508 Description: Tacrolimus, Oral, per 5 mg.
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: J7509 Description: Methylprednisolone, Oral, per 4 mg
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: J7510 Description: Prednisolone, Oral, per 5 mg.
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: J7599 Description: Immunosuppressive Drug, Not Otherwise Classified
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: J7699 Description: Not Otherwise Classified Drugs, inhalation solution administered through DME
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: J7799 Description: Not Otherwise Classified Drugs, other than inhalation drugs, administered through DME
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: J8499 Description: Prescription Drug, Oral, Non Chemotherapeutic, NOS
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: J8530 Description: Cyclophosphamide; Oral, 25 mg.
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: J8560 Description: Etoposide; Oral, 50 mg.
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: J8600 Description: Melphalan; Oral, 2 mg.
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: J8610 Description: Methotrexate; Oral, 2.5 mg.
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: J8999 Description: Prescription Drug, Oral, Chemotherapeutic NOS
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: J9000 Description: Doxorubicin HCl, 10 mg.

Par Allowance: 45.50
NonPar Allowance: 43.23
Limiting Charge: 49.71

Code: J9010 Description: Doxorubicin HCl, 50 mg. <R>code deleted 1/1/97, see J9000
Par Allowance: 227.50
NonPar Allowance: 216.13
Limiting Charge: 248.55

Code: J9015 Description: Aldesleukin, per single use vial
Par Allowance: 415.00
NonPar Allowance: 394.25
Limiting Charge: 453.39

Code: J9020 Description: Asparaginase, 10,000 Units
Par Allowance: 54.68
NonPar Allowance: 51.95
Limiting Charge: 59.74

Code: J9031 Description: BCG (intravesical) per instillation
Par Allowance: 155.97
NonPar Allowance: 148.17
Limiting Charge: 170.40

Code: J9040 Description: Bleomycin Sulfate, 15 Units
Par Allowance: 304.60
NonPar Allowance: 289.37
Limiting Charge: 332.78

Code: J9045 Description: Carboplatin, 50 mg.
Par Allowance: 88.59
NonPar Allowance: 84.16
Limiting Charge: 96.78

Code: J9050 Description: Carmustine, 100 mg.
Par Allowance: 88.94
NonPar Allowance: 84.49
Limiting Charge: 97.16

Code: J9060 Description: Cisplatin, powder or solution, per 10 mg.
Par Allowance: 34.66
NonPar Allowance: 32.93
Limiting Charge: 37.87

Code: J9062 Description: Cisplatin, 50 mg.
Par Allowance: 184.84
NonPar Allowance: 175.60
Limiting Charge: 201.94

Code: J9065 Description: Injection, Cladribine, per 1 mg.
Par Allowance: 48.00
NonPar Allowance: 45.60
Limiting Charge: 52.44

Code: J9070 Description: Cyclophosphamide, 100 mg.

Par Allowance: 5.39
NonPar Allowance: 5.12
Limiting Charge: 5.89

Code: J9080 Description: Cyclophosphamide, 200 mg.
Par Allowance: 10.24
NonPar Allowance: 9.73
Limiting Charge: 11.19

Code: J9090 Description: Cyclophosphamide, 500 mg.
Par Allowance: 21.50
NonPar Allowance: 20.43
Limiting Charge: 23.49

Code: J9091 Description: Cyclophosphamide, 1.0 gram
Par Allowance: 43.01
NonPar Allowance: 40.86
Limiting Charge: 46.99

Code: J9092 Description: Cyclophosphamide, 2.0 gram
Par Allowance: 86.00
NonPar Allowance: 81.70
Limiting Charge: 93.96

Code: J9093 Description: Cyclophosphamide, Lyophilized, 100 mg.
Par Allowance: 6.45
NonPar Allowance: 6.13
Limiting Charge: 7.05

Code: J9094 Description: Cyclophosphamide, Lyophilized, 200 mg.
Par Allowance: 12.25
NonPar Allowance: 11.64
Limiting Charge: 13.39

Code: J9095 Description: Cyclophosphamide, Lyophilized, 500 mg.
Par Allowance: 25.71
NonPar Allowance: 24.42
Limiting Charge: 28.08

Code: J9096 Description: Cyclophosphamide, Lyophilized, 1.0 gram
Par Allowance: 51.43
NonPar Allowance: 48.86
Limiting Charge: 56.19

Code: J9097 Description: Cyclophosphamide, Lyophilized, 2.0 gram
Par Allowance: 102.89
NonPar Allowance: 97.75
Limiting Charge: 112.41

Code: J9100 Description: Cytarabine, 100 mg.
Par Allowance: 6.25
NonPar Allowance: 5.94
Limiting Charge: 6.83

Code: J9110 Description: Cytarabine, 500 mg.
Par Allowance: 25.00
NonPar Allowance: 23.75

Limiting Charge: 27.31

Code: J9120 Description: Dactinomycin, 0.5 mg.
Par Allowance: 12.13
NonPar Allowance: 11.52
Limiting Charge: 13.25

Code: J9130 Description: Dacarbazine, 100 mg.
Par Allowance: 13.83
NonPar Allowance: 13.14
Limiting Charge: 15.11

Code: J9140 Description: Dacarbazine, 200 mg.
Par Allowance: 22.23
NonPar Allowance: 21.12
Limiting Charge: 24.29

Code: J9150 Description: Daunorubicin Hydrochloride, 10 mg.
Par Allowance: 85.06
NonPar Allowance: 80.81
Limiting Charge: 92.93

Code: J9165 Description: Diethylstilbestrol Diphosphate, 250 mg.
Par Allowance: 13.67
NonPar Allowance: 12.99
Limiting Charge: 14.94

Code: J9181 Description: Etoposide, 10 mg.
Par Allowance: 14.20
NonPar Allowance: 13.49
Limiting Charge: 15.51

Code: J9182 Description: Etoposide, 100 mg.
Par Allowance: 141.97
NonPar Allowance: 134.87
Limiting Charge: 155.10

Code: J9185 Description: Fludarabine Phosphate, 50 mg.
Par Allowance: 188.04
NonPar Allowance: 178.64
Limiting Charge: 205.44

Code: J9190 Description: Fluorouracil, 500 mg.
Par Allowance: 1.55
NonPar Allowance: 1.47
Limiting Charge: 1.69

Code: J9200 Description: Floxuridine, 500 mg.
Par Allowance: 129.17
NonPar Allowance: 122.71
Limiting Charge: 141.12

Code: J9202 Description: Goserelin Acetate Implant, per 3.6 mg.
Par Allowance: 410.51
NonPar Allowance: 389.98
Limiting Charge: 448.48

Code: J9208 Description: Ifosfamide, 1 gm.
Par Allowance: 119.85
NonPar Allowance: 113.86
Limiting Charge: 130.94

Code: J9209 Description: Mesna, 200 mg.
Par Allowance: 31.14
NonPar Allowance: 29.58
Limiting Charge: 34.02

Code: J9211 Description: Idarubicin Hydrochloride, 5 mg.
Par Allowance: 261.25
NonPar Allowance: 248.19
Limiting Charge: 285.42

Code: J9213 Description: Interferon, Alfa-2A, Recombinant, 3 million units
Par Allowance: 32.94
NonPar Allowance: 31.29
Limiting Charge: 35.98

Code: J9214 Description: Interferon, Alfa-2B, Recombinant, 1 million units
Par Allowance: 10.98
NonPar Allowance: 10.43
Limiting Charge: 11.99

Code: J9215 Description: Interferon, Alfa-N3, (Human Leukocyte Derived), 250,000 IU
Par Allowance: 7.96
NonPar Allowance: 7.56
Limiting Charge: 8.69

Code: J9216 Description: Interferon, Gamma 1-B, 3 million units
Par Allowance: 140.00
NonPar Allowance: 133.00
Limiting Charge: 152.95

Code: J9217 Description: Leuprolide Acetate (For Depot Suspension), 7.5 mg.
Par Allowance: 515.63
NonPar Allowance: 489.85
Limiting Charge: 563.33

Code: J9218 Description: Leuprolide Acetate, per 1 mg.
Par Allowance: 58.38
NonPar Allowance: 55.46
Limiting Charge: 63.78

Code: J9230 Description: Mechlorethamine Hydrochloride, (Nitrogen Mustard), 10 mg.
Par Allowance: 10.48
NonPar Allowance: 9.96
Limiting Charge: 11.45

Code: J9245 Description: Injection, Melphalan Hydrochloride, 50 mg.

Par Allowance: 272.83
NonPar Allowance: 259.19
Limiting Charge: 298.07

Code: J9250 Description: Methotrexate Sodium, 5 mg.
Par Allowance: 1.00
NonPar Allowance: 0.95
Limiting Charge: 1.09

Code: J9260 Description: Methotrexate Sodium, 50 mg.
Par Allowance: 4.75
NonPar Allowance: 4.51
Limiting Charge: 5.19

Code: J9265 Description: Paclitaxel, 30 mg.
Par Allowance: 182.63
NonPar Allowance: 173.50
Limiting Charge: 199.53

Code: J9266 Description: Pegaspargase, per single dose vial
Par Allowance: 1,274.00
NonPar Allowance: 1,210.30
Limiting Charge: 1,391.85

Code: J9268 Description: Pentostatin, per 10 mg.
Par Allowance: 1,440.00
NonPar Allowance: 1,368.00
Limiting Charge: 1,573.20

Code: J9270 Description: Plicamycin 2.5 mg.
Par Allowance: 85.56
NonPar Allowance: 81.28
Limiting Charge: 93.47

Code: J9280 Description: Mitomycin, 5 mg.
Par Allowance: 134.11
NonPar Allowance: 127.40
Limiting Charge: 146.51

Code: J9290 Description: Mitomycin, 20 mg.
Par Allowance: 452.91
NonPar Allowance: 430.26
Limiting Charge: 494.80

Code: J9291 Description: Mitomycin, 40 mg.
Par Allowance: 915.09
NonPar Allowance: 869.34
Limiting Charge: 999.74

Code: J9293 Description: Injection, Mitoxantrone Hydrochloride, per 5 mg.
Par Allowance: 180.01
NonPar Allowance: 171.01
Limiting Charge: 196.66

Code: J9320 Description: Streptozocin, 1 gm.
Par Allowance: 68.84

NonPar Allowance: 65.40
Limiting Charge: 75.21

Code: J9340 Description: Thiotepa, 15 mg.
Par Allowance: 78.45
NonPar Allowance: 74.53
Limiting Charge: 85.71

Code: J9360 Description: Vinblastine Sulfate, 1 mg.
Par Allowance: 4.04
NonPar Allowance: 3.84
Limiting Charge: 4.42

Code: J9370 Description: Vincristine Sulfate, 1 mg.
Par Allowance: 30.96
NonPar Allowance: 29.41
Limiting Charge: 33.82

Code: J9375 Description: Vincristine Sulfate, 2 mg.
Par Allowance: 38.25
NonPar Allowance: 36.34
Limiting Charge: 41.79

Code: J9380 Description: Vincristine Sulfate, 5 mg.
Par Allowance: 162.71
NonPar Allowance: 154.57
Limiting Charge: 177.76

Code: J9390 Description: Vinorelbine Tartrate, per 10 mg.
Par Allowance: 56.55
NonPar Allowance: 53.72
Limiting Charge: 61.78

Code: J9999 Description: Not Otherwise Classified, Antineoplastic Drugs
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: Q0136 Description: Injection Epoetin Alpha, (for non ESRD use), per 1000 units
Par Allowance: 12.00
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: Q0144 Description: Azithromycin Dihydrate, Oral, Capsules/Powder, 1 gram<R>procedure code added 1/1/97
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: Q0156 Description: Infusion, Albumin (Human), 5%, 500 ml.<R>***descriptor change 1/1/97 (old per ml.)
Par Allowance: 180.00
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: Q0157 Description: Infusion, Albumin (Human), 25%, 50 ml.<R>***descriptor change 1/1/97 (old per ml.)
Par Allowance: 65.00
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: Q9920 Description: Injection of EPO, per 1,000 units, at patient HCT of 20 or less
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9921 Description: Injection of EPO, per 1,000 units, at patient HCT of 21
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9922 Description: Injection of EPO, per 1,000 units, at patient HCT of 22
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9923 Description: Injection of EPO, per 1,000 units, at patient HCT of 23
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9924 Description: Injection of EPO, per 1,000 units, at patient HCT of 24
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9925 Description: Injection of EPO, per 1,000 units, at patient HCT of 25
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9926 Description: Injection of EPO, per 1,000 units, at patient HCT of 26
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9927 Description: Injection of EPO, per 1,000 units, at patient HCT of 27
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9928 Description: Injection of EPO, per 1,000 units, at patient HCT of 28
Par Allowance: 12.00

NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9929 Description: Injection of EPO, per 1,000 units, at patient HCT of 29
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9930 Description: Injection of EPO, per 1,000 units, at patient HCT of 30
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9931 Description: Injection of EPO, per 1,000 units, at patient HCT of 31
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9932 Description: Injection of EPO, per 1,000 units, at patient HCT of 32
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9933 Description: Injection of EPO, per 1,000 units, at patient HCT of 33
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9934 Description: Injection of EPO, per 1,000 units, at patient HCT of 34
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9935 Description: Injection of EPO, per 1,000 units, at patient HCT of 35
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9936 Description: Injection of EPO, per 1,000 units, at patient HCT of 36
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9937 Description: Injection of EPO, per 1,000 units, at patient HCT of 37
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9938 Description: Injection of EPO, per 1,000 units, at patient HCT of 38
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9939 Description: Injection of EPO, per 1,000 units, at patient HCT of 39
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: Q9940 Description: Injection of EPO, per 1,000 units, at patient HCT of 40 or above
Par Allowance: 12.00
NonPar Allowance: 11.40
Limiting Charge: 13.11

Code: 90700 Description: Immunization, Active; Diphtheria, Tetanus Toxoids, and Acellular Pertussis Vaccine (DtaP)
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90701 Description: Immunization, Active, Diphtheria and Tetanus Toxoids and Pertussis Vaccine (DTP)
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90702 Description: Immunization, Active, Diphtheria and Tetanus Toxoids (DT)
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90703 Description: Immunization, Active Tetanus Toxoid Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90704 Description: Immunization, Active, Mumps Virus Vaccine, Live
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90705 Description: Immunization, Active, Measles Virus Vaccine, Live, Attenuated
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90706 Description: Immunization, Active, Rubella Virus Vaccine, Live
Par Allowance: N.C.
NonPar Allowance: N.C.

Limiting Charge: N.C.

Code: 90707 Description: Immunization, Active, Measles, Mumps, and Rubella Virus Vaccine, Live
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90708 Description: Immunization, Active, Measles and Rubella Virus Vaccine, Live
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90709 Description: Immunization, Active, Rubella and Mumps Virus Vaccine, Live
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90710 Description: Immunization, Active; Measles, Mumps, Rubella, and Varicella Vaccine
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90711 Description: Immunization, Active; Diphtheria, Tetanus, and Pertussis (DTP) and Injectable Poliomyelitis Vaccine
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90712 Description: Immunization, Active, Poliovirus Vaccine, Live, Oral [any type(s)] Vaccine
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90713 Description: Immunization, Active, Poliomyelitis Vaccine
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90714 Description: Immunization, Active, Typhoid Vaccine
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90716 Description: Immunization, Active; Varicella (Chicken Pox) Vaccine
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90717 Description: Immunization, Active, Yellow Fever Vaccine

Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90718 Description: Immunization, Active, Tetanus and Diphtheria Toxoids Absorbed, for Adult Use (TD)
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90719 Description: Immunization, Active, Diphtheria Toxoid
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90720 Description: Immunization, Active; Diphtheria, Tetanus Toxoids, and Pertussis (DTP) and Hemophilus Influenza B (Hib) Vaccine
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90721 Description: Immunization, Active; Diphtheria, Tetanus Toxoids, and Acellular Pertussis Vaccine (DTaP), and Hemophilus Influenza B (Hib) Vaccine
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90724 Description: Immunization, Active, Influenza Virus Vaccine
Par Allowance: 4.06
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: 90725 Description: Immunization, Active, Cholera Vaccine
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90726 Description: Immunization, Active, Rabies Vaccine
Par Allowance: 140.56
NonPar Allowance: 133.53
Limiting Charge: 153.56

Code: 90727 Description: Immunization, Active, Plague Vaccine
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90728 Description: Immunization, Active, BCG Vaccine
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90730 Description: Immunization, Active; Hepatitis A Vaccine

Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90732 Description: Immunization, Active; Pneumococcal Vaccine, Polyvalent
Par Allowance: 13.28
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: 90733 Description: Immunization, Active, Meningococcal Polysaccharide Vaccine [any group(s)]
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90735 Description: Immunization, Active; Encephalitis Virus Vaccine
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90737 Description: Immunization, Active, Hemophilus Influenza B
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90741 Description: Immunization, Passive, Immune Serum Globulin, Human (ISG)
Par Allowance: N.C.
NonPar Allowance: N.C.
Limiting Charge: N.C.

Code: 90742 Description: Immunization, Passive, Specific Hyper-Immune Serum Globulin e.g.,Hepatitis B, Measles, Pertussis, Rabies, RHO (D), Tetanus, Vaccinia, Varicella-Zoster]
Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

Code: 90744 Description: Immunization, Active, Hepatitis B Vaccine; Newborn to 11 Years
Par Allowance: 22.98
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: 90745 Description: Immunization, Active, Hepatitis B Vaccine; 11 - 19 Years
Par Allowance: 41.60
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: 90746 Description: Immunization, Active, Hepatitis B Vaccine; 20 Years and Above
Par Allowance: 59.90
NonPar Allowance: Not Applicable

Limiting Charge: Not Applicable

Code: 90747 Description: Immunization, Active, Hepatitis B Vaccine; Dialysis or Immunosuppressed Patient, Any Age
Par Allowance: 108.70
NonPar Allowance: Not Applicable
Limiting Charge: Not Applicable

Code: 90749 Description: Unlisted Immunization Procedure Par Allowance: I.C.
NonPar Allowance: I.C.
Limiting Charge: I.C.

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Q9920-Q9940 Correction: Claim Filing Requirements for EPO Injections

The November/December 1996 Medicare B Update! (page 14) featured an article on claim filing requirements for Epoetin Alpha (EPO) injections. This article incorrectly stated that procedure codes Q9920-Q9940 may be reported for claims for patients with anemia due to chemotherapy, myelodysplastic syndrome or AZT (AIDS patients).

Procedure codes Q9920-Q9940 may only be reported for patients with chronic renal failure. Procedure code Q0136 should be used to report EPO therapy for patients with anemia due to chemotherapy, myelodysplastic syndrome or AZT (AIDS patients). A comprehensive article about non-ESRD EPO can be found on page 50.

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J3370: Coverage for Vancomycin HCl

Page 58 of the December 1996 Medicare B Update! Special Issue: 1997 HCPCS and MPFSDB Update listed procedure code J3370 (Vancomycin HCl, up to 500 mg) as a noncovered item. Since that publication, Medicare Part B has been notified that procedure code J3370 may be covered effective for services furnished on and after January 1, 1997. Payment may be made when billed by a physician when it is reasonable and necessary for the diagnosis or treatment of the illness or injury for which it is administered according the accepted standards of medical practice.

Note: It is not medically appropriate to administer this drug via an implantable infusion pump; therefore, it is not covered when billed by a supplier.

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Anesthesia/Surgery

Procedures Which May be Considered Either Cosmetic or Reconstructive

Certain surgical procedures may be considered either cosmetic and/or reconstructive. Claims for those services will be reviewed for medical necessity, and providers must include appropriate documentation.

A procedure is considered reconstructive if it is performed to repair an accidental injury or toimprove the functioning of a malformed body member.

A procedure is considered cosmetic if it is performed for reasons other than for the repair of accidental injury or for the improvement of the functioning of a malformed body member. A list of procedures that are always considered cosmetic can be found on page 41.

The chart below outlines coverage and documentation guidelines for procedures which may be considered either cosmetic or reconstructive.

Code: 11976
Descriptor: Removal, implantable contraceptive capsules
Documentation Required: History and Physical (H/P)
Documentation that capsules were removed as a result of infection.
Effective Date: 4/14/97

Code: 15780- 15787
Descriptor: Dermabrasion/abrasion ; face, other than face, any site
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 15788- 15793
Descriptor: Chemical peel, facial and nonfacial
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 17106-17108
Descriptor: Destruction of cutaneous vascular proliferative lesions
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 17360
Descriptor: Chemical exfoliation for acne (e.g., acne paste, acid)
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 17999
Descriptor: Unlisted procedure skin, mucous membrane and subcutaneous tissue
Documentation Required: H/P

Effective Date: Currently in effect.

Code: 19316-19325
Descriptor: Mastopexy/Mammoplasty
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 19328-19342
Descriptor: Removal of mammary implants
Documentation Required: H/P
Effective Date: 19328, 19330: Currently in effect. 19340-19342: 4/14/97

Code: 19350
Descriptor: Nipple/areola reconstruction
Documentation Required: H/P
Effective Date: 4/14/97

Code: 19355
Descriptor: Correction of inverted nipples
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 19357-19369
Descriptor: Breast reconstruction
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 19370-19371
Descriptor: Periprosthetic capsulectomy
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 19380
Descriptor: Revision of reconstructive breast
Documentation Required: H/P
Effective Date: 4/14/97

Code: 19396
Descriptor: Preparation of moulage for custom breast implant
Documentation Required: H/P
Effective Date: 4/14/97

Code: 19499
Descriptor: Unlisted procedure, breast
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 21120-21123
Descriptor: Genioplasty
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 21125-21127
Descriptor: Augmentation, mandibular body
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 21138-21139
Descriptor: Reduction of forehead
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 21141-21180, 21188
Descriptor: Reconstruction midface/orbital rim/forehead
Documentation Required: H/P
Effective Date: 21141-21143: 4/14/97 21145-21180, 21188: Currently in effect.

Code: 21193-21198
Descriptor: Reconstruction of mandibular rami
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 21206-21209
Descriptor: Osteotomy, maxilla/facial bones
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 21210-21235
Descriptor: Graft, bone; nasal/mandible/rib cartilage
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 21240-21243
Descriptor: Arthroplasty, TMJ
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 21244-21256
Descriptor: Reconstruction of mandible/ maxilla/zygomatic arch/orbit
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 21260-21268
Descriptor: Osteotomies
Documentation Required: H/P
Effective Date: Currently in effect.

Code: 30120
Descriptor: Excision or surgical planing of skin of nose for rhinophyma
Documentation Required: H/P and operative report
Effective Date: Currently in effect.

Code: 30520
Descriptor: Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
Documentation Required: H/P, preoperative photos, pathology report, admission, and discharge summary
Effective Date: 4/14/97

Code: 30620

Descriptor: Septal or other intranasal dermatoplasty (does not include obtaining graft)
Documentation Required: H/P, preoperative photos, pathology report, admission, and discharge summary
Effective Date: 4/14/97

Code: 40840-40845
Descriptor: Vestibuloplasty
Documentation Required: H/P and operative report
Effective Date: Currently in effect.

Code: 43999
Descriptor: Unlisted procedure, stomach
Documentation Required: H/P and operative report
Effective Date: Currently in effect.

Code: 43842-43843
Descriptor: Gastric restrictive procedures, without gastric by-pass
Documentation Required: H/P Operative report; and Attachment "A" (Letter No. 415-416) information follows or comparable information.
Effective Date: 4/14/97

Code: 43846-43847
Descriptor: Gastric restrictive procedures, with gastric by-pass
Documentation Required: H/P Operative report; and Attachment "A" (Letter No. 415-416) information follows or comparable information.
Effective Date: 4/14/97

Code: 43850-43855
Descriptor: Revision of gastroduodenal anastomosis
Documentation Required: H/P Operative report; and Attachment "A" (Letter No. 415-416) information follows or comparable information.
Effective Date: Currently in effect.

Code: 43860-43865
Descriptor: Revision of gastrojejunal anastomosis
Documentation Required: H/P Operative report; and Attachment "A" (Letter No. 415-416) information follows or comparable information.
Effective Date: Currently in effect.

Attachment "A"

Benefits for the treatment of "obesity" are provided by Medicare Part B only under limited conditions. To help Medicare Part B evaluate claims for the treatment of "obesity", the following information is required for review for procedure codes 43842-43843, 43846-43847, 43850-43855, 43860-43865, as noted in the preceeding chart. Send the information to:

Medicare Part B
P.O. Box 2525

Jacksonville, FL 32231-0019

Have the pressures of excess weight resulted in any physical trauma or disability?Yes ( ) No ( ) If yes, please describe in detail:

Are either pulmonary or circulatory insufficiencies present? Have pulmonary function studies been done? If so, submit documented report.

Is arteriosclerosis, diabetes, coronary disease or endocrine disease present? If so, indicate current status and extent of condition(s). If condition(s) is under current treatment, please describe:

Have electrocardiograms or similar evaluations been performed? If so, submit copy of tracing and/or documented report.

Have any specific blood chemistries been done? If so, please documented report.

Is the patient able to function normally in his work and/or home environment?Comments:

Patient's Height____ Weight____ Age____ Body Build: Small Frame, Medium Frame, Heavy Frame

How long has present level of obesity been present? (years)

Has the patient attempted weight control through diet under the supervision of a physician? Yes () No ( ). If yes, please indicate data and results obtained. (If another attending physician, please give name.)

If surgery has been (or is to be) performed in an attempt to relieve the obesity, please describe the indications for surgical intervention:

General comments

Prepared by and date

****

Procedures Considered Cosmetic Under the Medicare Program

A procedure is considered cosmetic if it is performed for reasons other than for the repair of accidental injury or for the improvement of the functioning of a malformed body member. When performed for cosmetic reasons, a procedure is always noncovered under Medicare Part B. If a provider knows that an item or procedure will be considered cosmetic, the provider may bill Medicare using procedure code A9270 (noncovered item or service). Cosmetic procedures include (but are not limited to) the following:

Procedure Code	Description
11920-11922	Tattooing
11950-11954	Injection of filling material
15775-15776	Punch graft; hair transplant
15820-15821	Blepharoplasty, lower eyelid
15824-15829	Rhytidectomy
15831-15839	Excisionof excessive skin
15876-15879	Suction assisted lipectomy
17380	Electrolysis epilation
21137	Reduction forehead, contouring only
36468-36469	Sclerosing solution, spider veins
44131	Intestinal by-pass for morbid obesity
54660-54661	Insertion of testicular prosthesis
56805	Clitoroplasty for intersex state
57335	Vaginoplasty for intersex state
69090	Ear piercing

Plastic surgery to correct moon face is not covered under the Medicare Program.

****

19100: Mammotome Breast Biopsy Device

The mammotome breast biopsy device and the ABBI needle technique are modifications of the traditional core cutting needle used for percutaneous needle biopsy of the breast and should be billed using procedure code 19100 (Biopsy of breast, needle core [separate procedure]). It should not be billed using a surgical incisional or excisional breast biopsy code. If a stereotactic breast biopsy is performed, procedure code 76095 (Stereotactic localization for breast biopsy) may also be billed in addition to 19100. Only one procedure may be billed per lesion, regardless of the number of sticks made or specimens obtained.

****

54235: Injection of Corpora Cavernosa

The injection of a vasoactive compound such as papaverine or phentolamine into the corpora cavernosa of the penis produces an erection. A test injection of a vasoactive agent into the corpora

cavernosa is an office diagnostic procedure, as well as the standard of care for beginning a patient on pharmacologic injection therapy. The procedure can be used to provide diagnostic information as to the etiology of the patient's erectile dysfunction and determine if the patient is a candidate for injection therapy. It is necessary to define the dose of medication which will give the patient a functional erection and not result in priapism (abnormal, painful and continued erection).

Medicare Part B will allow payment for the initial injection given by the physician. Based on national coverage guidelines, injections which are self-administered by the patient are not a benefit of Medicare. The injection into the corpora cavernosa normally consists of one or any combination of the following drugs; papaverine, phentolamine and/or prostaglandin (alprostadil). These drugs are normally self-administered and are, therefore, not covered by Medicare Part B.

The policy was developed in response to questions initiated by multiple providers and an in depth review of the procedure. It is effective for service dates April 14, 1997, and after. To ensure that payment is made for only medically necessary services, injection of corpora cavernosa with pharmacologic agent(s) (54235) is covered only for the following diagnoses/conditions:

302.72
607.84

The drugs being injected (J0270, J2440 and/or J2760) are normally self-administered for the listed conditions and the limitation of liability provision does not apply.

Advance Notice Requirement

Applies to diagnosis requirements for procedure code 54235 (see page 4).

****

66984: Billing for Cataract Surgery - Split-Split Care

When an ophthalmologist performs the procedure and part of the out-of-hospital follow-up care, then turns over the remainder of the follow-up care to an optometrist or another ophthalmologist, this is called split-split care. When billing for split-split care, the claim for the ophthalmologist who performed the surgery and part of the follow-up care should look like this:

Additionally, when the ophthalmologist bills for the surgery, he must use procedure code modifier 54. When he bills for the follow-up care, he must add procedure code modifier 55 to the procedure code. The date of service should be the date of surgery. Also, he must include on the claim when the patient was referred for follow-up care for co-management, and the total number of days that the beneficiary was in his care.

The claim for the ophthalmologist or optometrist providing the remainder of the follow-up care should look like this:

When the ophthalmologist or optometrist who provided the follow-up care bills for his portion of the post-operative care, he must use procedure code modifier 55, the date of surgery for the date of service, include a statement of when he assumed and relinquished care of the beneficiary and the number of days the patient was followed during that portion of follow-up care.

Note: The assumed and/or relinquished date for a global surgery claim must be entered in Item 19 of the HCFA-1500 claim form when providers share post-operative care. In addition, the specific eye treated (i.e., LT or RT) should also be indicated in Item 19.

EMC Billing Requirements

When split-split care is billed, it may be billed electronically with the appropriate procedure code modifiers added to the procedure code. In addition, providers must enter the assumed and/or relinquished dates in the narrative record. If you do not have access to the narrative record, contact your software support vendor.

****

Diagnostic Tests

82523: Collagen Cross Links - Any Method

N-telopeptide (NTX Assay) measures the rate of bone resorption (loss). Osteomark and Pyrolinx are trade names for this clinical laboratory test. Although NTX assay has FDA approval, it has been determined that there are still unresolved issues about its efficacy and clinical applicability. Therefore, procedure code 82523 (Collagen cross links - any method) is still considered experimental in nature and is not covered by Medicare Part B of Florida at this time.

Advance Notice Requirement

Applies to the experimental nature of this procedure (see page 4).

****

82270: Fecal Occult Blood Testing

The following diagnoses for which procedure code 82270 (Blood, occult; feces, 1-3 simultaneous determinations) are covered have been updated to the highest level of specificity:

070.0-070.33

569.60-569.69

864.00-864.19

A complete list of diagnoses for which procedure code 82270 is covered was published on page 25 of the July/August 1995 Medicare B Update!

Advance Notice Requirement

Applies to diagnosis requirements (see page 4)

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88150: Coverage for Diagnostic and Screening Pap Smears

The following information is to reiterate Medicare Part B's coverage guidelines and diagnosis requirements for diagnostic and screening pap smears.

According to the Medicare Carriers Manual, cervical and vaginal smears do not require interpretation by a physician unless the results are or appear to be abnormal. In such cases, a physician personally conducts a separate microscopic evaluation to determine the nature of an abnormality. This microscopic evaluation ordinarily requires performance by a physician. When medically necessary and when furnished by a physician, it is paid under the fee schedule.

Diagnostic Pap Smears

Diagnostic pap smears are those performed on beneficiaries who have experienced previous abnormal tests, findings, signs or symptoms or any significant complaint related to the female reproductive system. The procedure codes used to report diagnostic pap smears are:

(Normal smear)

88150 Cytopathology, smears, cervical or vaginal, up to three smears; screening by technician under physician supervision

(Abnormal smear)

88151 Cytopathology, smears, cervical or vaginal, up to three smears; requiring interpretation by physician

88155 Cytopathology, smears, cervical or vaginal, up to three smears; with definitive hormonal evaluation (e.g., maturation index, karyopyknotic index, estrogenic index)

88156 Cytopathology, smears, cervical or vaginal, (the Bethesda System (TBS)), up to three smears; screening by technician under physician supervision

88157 Cytopathology, smears, cervical or vaginal, (the Bethesda System (TBS)), requiring interpretation by physician

Diagnostic pap smears (procedure codes 88150, 88151, 88155, 88156, 88157) are covered by Medicare Part B when they are medically reasonable and necessary for the patient's condition. To ensure that payment is made only for medically necessary services, diagnostic pap smears are covered only for the following diagnoses. Refer to the most current version of the ICD-9-CM coding book for complete descriptions.

016.60-016.66 ; 016.70-016.76; 016.90-016.96 ; 041.00-041.09; 054.10; 054.11; 054.12; 078.0; 078.10-078.19; 090.0-099.9; 112.1; 112.2; 116.0-116.2; 117.0; 118; 120.0-120.9; 131.0-131.9; 136.1; 137.0; 137.1; 137.2; 170.6; 171.5; 171.6; 171.7 ; 171.8; 171.9; 174.0-174.9; 179; 180.0-180.9; 181; 182.0-182.8 ; 183.0-183.8; 184.0-184.9; 198.6; 198.82; 214.3; 214.8; 214.9; 215.5; 215.6; 215.8; 215.9; 217; 218.0-218.9 ; 219.0-219.9 ; 220; 221.0-221.9 ; 233.0-233.3; 233.7; 233.9; 236.0-236.3; 238.3; 238.7; 239.3; 239.5; 253.0; 253.1; 253.2; 253.3; 253.4; 253.7; 253.8; 255.0; 255.2; 255.3; 255.4; 255.6; 255.8; 255.9; 256.0-256.9; 307.1; 610.0-610.9; 611.0-611.9; 614.0-616.9; 617.0-629.9; 654.10-654.14; 792.9; 795.0; 795.1.

Advance Notice Requirement

Advance notice applies to diagnosis requirements (see page 4).

Reimbursement for Diagnostic Pap Smears

For outpatient services, diagnostic pap smears are paid under the clinical laboratory fee schedule.

For a hospital inpatient, Medicare will pay for the professional component for the interpretation of an abnormal pap smear (procedure code 88151-26) furnished to a hospital inpatient by a hospital physician or by an independent lab.

If performing an E/M visit and collection of specimen for a pap smear is the only purpose for the visit, bill only for the collection. To do so, use procedure code Q0091 (Screening papanicolaou smear, obtaining,preparing, and conveyance of cervical or vaginal smear to laboratory). Only the laboratory may bill for the actual performance of the test.

Screening Pap Smears

Screening pap smears are those performed on beneficiaries who have not had such tests during the preceding three years or whose attending physicians believe more frequent tests are necessary due to evidence that there are high risks of developing cervical cancer. The procedure codes used to report screening pap smears are:

P3000 Screening papanicolaou smear, cervical or vaginal, up to three smears by technician under physician supervision

P3001 Screening papanicolaou smear, cervical or vaginal, up to three smears requiring interpretation by physician

Screening pap smears (procedure codes P3000, P3001) are covered by Medicare Part B when they are medically reasonable and necessary for the patient's condition. To ensure that payment is made only for medically necessary services, screening pap smears are covered only for the following diagnoses. Refer to the most current version of the ICD-9-CM coding book for complete descriptions.

V15.89

V72.6

V76.2

Advance Notice Requirement

Advance notice applies to medical necessity and utilization parameters (see page 4).

Reimbursement of Screening Pap Smears

Screening pap smears (procedure codes P3000 and P3001) are payable under the clinical laboratory fee schedule.

The professional component of P3001 (modifier 26) is paid under the physician fee schedule.

Screening pap smears rendered to hospital inpatients are included in Medicare Part A reimbursement. The professional component of procedure code P3001, however, may be performed in an inpatient hospital setting and is paid under the Medicare Part B fee schedule.

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Medicine

90901:Biofeedback

Biofeedback therapy provides visual, auditory, or other evidence of the status of certain body functions so that a person can exert voluntary control over the function and thereby alleviate an abnormal bodily condition.

Biofeedback training is covered under Medicare when it is reasonable and necessary for :

muscle re-education of specific muscle groups;

treatment of pathological muscle abnormalities of spasticity;

incapacitating muscle spasm or weakness; and

more conventional treatments have not been successful.

The use of spinal cord electrical stimulators, rectal electral stimulators (including the continaid), and the bladder wall stimulators (including the Mentor Bladder Pacemaker) cannot be considered reasonable and necessary and therefore, are noncovered.

Pelvic floor stimulators, whether inserted into the vaginal canal or rectum or implanted in the pelvic area, used as a treatment for urinary incontinence either as a bladder pacer or a retraining mechanism are not covered for the reason that the safety and effectiveness of these devices are unproven. It is inappropriate to bill these services using the biofeedback codes. The appropriate procedure code for services described is (A9270).

HCFA has developed a new code to report biofeedback training. For Medicare purposes, procedure code 90901 (Biofeedback training by any modality) replaces codes 90900, 90902, 90904, 90906 1, 90908, 90910, and 90915. Due to this change in the coding structure, all claims for biofeedback (90901) will be suspended for prepayment review to ensure that payment is made only for medically necessary services. Providers must send in documentation (i.e., history and physical, office/progress notes, and treatment plan) indicating that biofeedback therapy was indeed medically necessary.

Biofeedback training, anorectal, including EMG and/or manometry (procedure code 90911) is covered only when used to treat incontinence of the sphincter ani (ICD-9 code 787.6).

In addition, Medicare Part B of Florida does not cover biofeedback for the treatment of psychiatric disorders. Therefore, procedure codes 90875 and 90876 (Individual psychophysiological therapy incorporating biofeedback training by any method [face to face with the patient]) are noncovered.

Advance Notice Requirement

Advance notice applies to medical necessity.

See page 26 for the physician and clinical psychologist fee schedules for procedure code 90901 See page 28 for Licensed Clinical Social Workers fees for procedure code 90901.

****

92978: Intravascular Ultrasound (Coronary Vessel or Graft)

Intravascular ultrasound (procedure codes 92978 and 92979) are add-on codes that should be reported in addition to the specifically listed therapeutic intervention procedures when ultrasound is being performed. Procedure codes 92978-92979 will only be allowed when billed in conjunction with the following procedure codes:

92975 Thrombolysis, coronary

92980 Placement of intracoronary stent(s)

92981 each additional

92982 Coronary balloon angioplasty

92984 each additional

92995 Coronary atherectomy

92996 each additional

If one of the above codes is not billed or allowed on the same day as the intravascular ultrasound (procedure codes 92978-92979), payment for the intravascular ultrasound (procedure codes 92978-92979) will be denied.

Billing Guidelines

Three new modifiers have been added effective for services rendered on or after January 1, 1997:

LC Left circumflex coronary artery

LD Left anterior descending coronary artery

RC Right coronary artery

The modifiers noted above must be used to identify treatment of multiple arteries.

****

94642: Pentamidine Isethionate

Pentamidine isethionate, also known as NebuPent and Pentam 300, is approved for the prevention of pneumocystis carinii pneumonia (PCP) in high risk HIV infected patients. The aerosol inhalation of pentamidine for PCP treatment or Prophylaxis is a covered service. Pentamidine should only be used when the patient has an intolerance to sulfa based drugs, as they are the preferred means of treatment. This policy is effective for service dates April 14, 1997, and after.

To ensure that payment is made for only medically necessary services, aerosol inhalation of pentamidine for pneumocystis carinii pneumonia, treatment or prophylaxis (94642) is covered only for the following diagnoses/conditions:

042

136.3

Documentation supporting the medical necessity of this procedure, such as ICD-9 codes, must be submitted with each claim. Claims submitted without such evidence will be denied as being not medically necessary.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Listed below are the fees for procedure code 94642:

Locality	Participating	Nonpar.	Limiting Charge
01/02	13.90	13.21	15.19
03	15.57	14.79	17.01
04	16.84	16.00	18.40

****

98940: Chiropractic Manipulation Procedure Codes

Effective January 1, 1997, three CPT procedures codes have been developed to replace HCPCS procedure code A2000. These codes are:

98940 Chiropractic manipulative treatment (CMT); spinal, one to two regions

98941 Chiropractic manipulative treatment (CMT); spinal, three to four regions

98942 Chiropractic manipulative treatment (CMT); spinal, five regions

CPT procedure code 98943 was also added effective January 1, 1997.This procedure code is for chiropractic extraspinal manipulations. This service is not covered by Medicare Part B.

The CPT manual lists the five spinal regions as cervical, thoracic, lumbar, sacral and pelvic. A chiropractor must use the procedure code that encompasses the entire treatment. A chiropractor may not use more than one procedure code to report spinal manipulations on the same day.

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page 47

97014: Correction

Page 30 of the September/October 1995 Medicare B Update! Indicated that electrotherapy (procedure code 97014) for the treatment of facial nerve paralysis (Bell's Palsy) is not covered. The ICD-9-CM diagnosis code for Bell's Palsy was published incorrectly. The correct diagnosis code is 351.0.

****

Antigens Prepared for Sublingual Administration

Effective for services rendered on or after November 17, 1996, Medicare does not cover antigens that are administered sublingually, (i.e., by placing drops under the patient's tongue). This kind of allergy therapy has not been proven to be safe and effective. Antigens are covered only if they are administered by injection.

Advance Notice Requirement

Advance notice applies to because this kind of therapy has not been proven to be safe and effective (see page 4).

****

99281: Payment for Hospital or Emergency Room Visits on the Same Day as Critical Care

Payment for both an emergency room visit (procedure codes 99281-99285) or a hospital visit (procedure codes 99221-99238) and a critical care visit may be allowed separately when rendered on the same day by the same physician if the emergency room/hospital visit is rendered earlier in the day and, at that time, the patient does not require critical care. In this case, claims for an emergency room/hospital visit and a critical care visit rendered on the same day by the same physician must include the following documentation:

History and physical

Progress notes

Physician's orders.

Because these claims require that documentation be submitted with them, they must be sumitted as paper claims (using the HCFA-1500 claim form).

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A Closer Look

In the Medicare B Update!, "A Closer Look" provides in-depth and comprehensive information on topics of interest to the provider community. In this issue, "A Closer Look" addresses the following topic:

Focused Medical Review

Focused Medical Review initiatives are designed to ensure the appropriateness of medical care and that the Carrier's medical policies and review guidelines are consistent with the accepted standards of medical practice. Medicare Part B of Florida evaluates carrier-specific aberrancies identified by comparing Florida's procedure code utilization against national utilization rates.

By analyzing aberrancies identified through comparison of Florida's procedure code utilization to that of the nation, Medicare Part B, through Focused Medical Review, ensures that the provision of medical care is appropriate and that Medicare's policies and review guidelines are consistent with accepted medical practice.

Effective Dates

The policies contained in section are effective for claims processed April 14, 1997, and after.

Sources of Information

The sources of information used in the development of these policies may be obtained by accessing the B LINE BBS. For additional information on the B LINE BBS, refer to page 59 of the January/February 1997 Medicare B Update!

****

M0101: Routine Foot Care

Analysis of 1995 Medicare claims data for Florida has indicated that Medicare Part B of Florida allowed significantly more reimbursement for Routine Foot Care (procedure code M0101) than Medicare allowed nationally per 1,000 Medicare beneficiaries. National Coverage Policy was enhanced in 1996 to further clarify the indications for the service and the circumstances under which Medicare will consider it to be medically reasonable, necessary, and, therefore, covered.

Medicare Part B will consider Routine Foot Care to be medically necessary when performed under the following circumstances:

In certain circumstances, services ordinarily considered to be routine may be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of ulcers, wounds or infections;

When the patient has one of the following conditions and routine foot care could pose a hazard if performed by a nonprofessional:

Diabetes mellitus*;

Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis);

Buerger's disease (thromboangitis obliterans);

Chronic thrombophlebitis*;

Peripheral neuropathies involving the feet such as those

associated with malnutrition and vitamin deficiency*,

associated with carcinoma*,

associated with diabetes mellitus*,

associated with drugs and toxins*,

associated with multiple sclerosis*,

associated with uremia (chronic renal disease)*,

associated with traumatic injury,

associated with leprosy or neurosyphilis, or

associated with hereditary disorders

Hereditary sensory radicular neuropathy

Angiokeratoma corporis diffusum (Fabry's)

Amyloid neuropathy;

In addition, two other criteria must be met and included on the claims when the complicating condition on the list is asterisked(*):

When the service is performed by a podiatrist, then the name of the attending physician (M.D. or D.O.) who is actively treating the patient's condition and

The date the patient was last seen by the M.D. or D.O. who is actively treating the condition (this date must be within six months [180 days]).

In addition to the complicating condition, the following medical information is required which describes the sign(s) and/or symptom(s) of the underlying systemic disease which are categorized in classes A, B, or C. To fulfill the medical necessity requirements for routine foot care there must be:

One Class A finding, or

Two Class B findings, or

One Class B and two Class C findings.

Class A

Nontraumatic amputation of foot or integral skeletal portion thereof.

Class B

Absent posterior tibial pulse, or

Absent dorsalis pedal pulse, or

Three of the following advanced tropic changes are required to meet one class B finding:

Hair growth (decrease or absence)

Pigmentary changes (discoloration)

Skin color (rubor and redness or blueness)

Nail changes (thickening)

Skin texture (thin, shiny)

Class C

Claudication (pain in calf when walking)

Temperature changes in the feet

Edema

Parathesias (abnormal spontaneous sensations in the feet, i.e., tingling)

Burning

Other Indications and Limitations of Coverage and/or Medical Necessity:

When an ambulatory patient presents with a wart(s) on the foot which has resulted indocumented impairment of ambulation, the wart(s) may be removed.

Services or devices directed toward care of the correction of flat foot are noncovered.

Diagnosis Requirements

To ensure that payment is made only for medically necessary services, Routine Foot Care is covered only when it is performed for the following diagnoses:

030.0-030.9; 094.0; 094.1; 094.9; 250.60-250.63*; 250.70-250.73*; 263.9*; 265.0*; 265.2*; 266.1*; 266.2*; 272.7; 277.3; 281.0*; 281.3*; 334.0; 340*; 356.0-356.9; 357.0*; 357.1*; 357.2*; 357.3*; 357.4*; 357.5*; 357.6*; 357.7*; 358.1*; 358.2*; 440.20-440.24; 443.0; 443.1; 444.22; 446.0; 446.7*; 451.0*; 451.11*; 451.19*; 579.0*; 579.1*; 579.2*; 579.3*; 579.4*; 585*; 586*

Coding Guidelines

In order for M0101 (Routine Foot Care) to be a covered service, the patient must have one or more of the diagnoses listed under the "ICD-9 That Supports Medical Necessity" section in this policy. Otherwise, the service is noncovered and should be coded as A9160 (noncovered service by a podiatrist) or A9270 noncovered item or service).

For those diagnoses which are asterisked (*), the M.D. or D.O. must be actively treating the condition and the date the patient was last seen by the actively treating M.D. or D.O. must be included on the claim.

Generally, it would not be expected to see services for nail debridements (procedure codes 11720 and 11721) and routine foot care services (procedure code M0101) billed on alternate visits. Such claims may be reviewed on a prepayment basis and denied if found to be not medically necessary or reasonable, e.g., 11720 and 11721 should not be billed to circumvent any prepayment screens in place for procedure code M0101 or vice versa.

Modifier -Q7 should be used to indicate one Class A finding; modifier -Q8 should be used to indicate two Class B findings; and -Q9 should be used to indicated one Class B and two Class C findings for Routine Foot Care (M0101).

Modifier -24 is used for unrelated evaluation and management services by the same physician during the postoperative period.

Modifier -25 should be used to indicate that a significant, separately identifiable evaluation and management services was performed by the same physician on the day of a procedure, following the initial visit.

Reasons for Denial

Any service billed with a diagnosis code(s) other than the ones listed under the "ICD-9 Codes That Support Medical Necessity" will be denied as noncovered by Medicare for routine foot care services. An advance notice of Medicare's denial of payment is not required.

Advance Notice Requirement

Applies to utilization parameter (see page 4).

Documentation Requirements

The podiatrist must document in his office/progress notes the appropriate signs and symptoms as outlined in Classes A, B and/or C of the complicating condition(s)/ICD-9.

For those complicating condition(s)/ICD-9 codes which are asterisked (*), the diagnosing M.D. or D.O. and the date the patient was last seen must be indicated on the claim form.

Services exceeding established utilization parameters for M0101 will be reviewed on a prepayment basis and may be denied.

****

Q0136: Coverage for Non-ESRD Epoetin (Procrit)

Erythropoietin is a glycoprotein which stimulates red blood cell production. It is produced in the kidneys and stimulates the division and differentiation of committed erythroid progenitors in the bone marrow.

Local medical review policy has been revised for procedure code Q0136 (Injection, epoetin alpha, [for non-ESRD use], per 1000 units). Procedure code Q0136 has been identified through the Focused Medical Review process as having been reimbursed significantly more by Medicare Part B of Florida than Medicare has paid nationally. In addition, a medical records review revealed that some beneficiaries were receiving EPO even when the patient's Hgb/Hct were normal. Also, some beneficiaries were on EPO for an extended period of time without an increase in Hbg/Hct or decrease in transfusion requirements.

This policy focuses on the definition of the service and the circumstances for which Medicare Part B of Florida will consider the service to be medically reasonable and necessary, and therefore, covered. It establishes medical review guidelines and a basis for a potential utilization screen. Epogen for Non-ESRD patients is considered medically necessary for the treatment of certain conditions including:

Anemia induced by the drug Zidovudine (AZT)

EPO is indicated in HIV infected patients to elevate or maintain the red blood cell level as manifested by an increase in the hemoglobin and/or hematocrit and to decrease the need for transfusions.

EPO therapy is indicated for the patients with endogenous serum erythropoietin levels 500m units/ml and are receiving a dose of AZT 4200 mg/wk.

EPO therapy at a dose of 100 units/kg three times a week (TIW) is effective in decreasing transfusion requirements. If after four (4) weeks of therapy the patient's hematocrit has not increased or transfusion requirements have not decreased, then EPO can be increased by 50-100 units/kg TIW. If patients have not responded satisfactorily to a dose of 300 units/kg TIW (within 12 weeks), EPO should be discontinued.

*EPO is not indicated for patients with an endogenous serum erythropoietin level of500 mu/ml or treatment of anemia in HIV-infected patients due to factors such as iron or folate deficiencies, hemolysis or gastrointestinal bleeding.

Anemia in cancer patients receiving chemotherapy for nonmyeloid malignancies

The use of EPO has been shown to be effective in treatment of anemia in patients with malignancies where anemia is due to the effect of concomitantly administered chemotherapy. EPO should be discontinued when the patient is no longer receiving chemotherapy.

EPO is indicated to decrease the need for transfusions in patients who will be receiving concomitant chemotherapy for a minimum of two months.

EPO is indicated for patients who had chemotherapy for a non-myeloid malignancy within the past year and presents post-chemo with anemia (i.e., permanent damage resulting from chemo). Documentation should support that the anemia was a result of a chemotherapy agent.

EPO therapy is indicated for patients with a serum erythropoietin level of 500 mu/ml.

Recommended starting dose is 150 units/kg TIW. If after 4 weeks the patient is not responding (increase H&H or decrease transfusion requirements), increase dose up to 300 u/kg TIW. If patient has not responded after 12 weeks (defined as increase in Hgb by 2g or decrease in transfusion requirements), discontinue EPO.

Anemia associated with myelodysplastic syndrome (MDS)

EPO therapy is indicated for patients with a serum erythropoietin level below 500 mu/ml.

Same dosage as cancer patients on chemotherapy.

The patient presents with variable clinical features depending on the MDS classification and the degree of disordered hematopoiesis with anemia. Common complaints or symptoms are fatigue, pallor, infection and bleeding or bruising. Diagnosis is usually confirmed by bone marrow aspiration and/or biopsy.

Chronic anemia associated with Rheumatoid Arthritis (RA)

The patient must have been previously diagnosed with RA using the American College of Rheumatology criteria

Usually these patients are on an antimetabolite (i.e., Methotrexate) which are causing the anemia

Same recommended dosages as cancer patients on chemo therapy and MDS patients

General indications and limitations for all non-ESRD patients:

Prior to and during EPO therapy, the patient's iron status, including transferrin saturation and serum ferritin must be

evaluated. Transferrin saturation should be at least 20% and ferritin should be at least 100 ng/ml. Virtually all patients will eventually require supplemental iron to increase or maintain transferr in saturation to levels which adequately support EPO stimulated erythropoiesis.

To initiate EPO therapy, the patient must have a documented anemia as evidenced by symptoms and a hematocrit (HCT) of less than 30% or a HGB 10g/dl unless there is medical documentation showing the need for EPO despite a HCT 29.9 or a HGB9.9g/dl. After reaching a target H & H of 36 or 12, the EPO should be tapered down to maintain the patient at this level. Normally, dosage is reduced by 25% when lowering the dose. If the dosage is decreased to minimum dosages and the patient's H & H continues to increase, the EPO should be discontinued. Documentation should support the medical necessity of continuing the same dosage. It may be necessary to initiate and/or maintain patients at higher H/H levels if the documented symptoms of anemia require the initiation or maintenance at a higher level.

Note: The standards of care regarding EPO dosing has changed from per kg to a standard starting total dose of 30000 u/wk (as divided doses TIW or BIW). If the EPO dose must be increased after 4 weeks, then it is not recommended to exceed the dosage indicated under
the applicable indication.

Diagnosis Requirements

To ensure that payment is made only for medically necessary services, Non-ESRD Epoetin is covered when it is performed for the following diagnosis:

042
238.7
285.8
285.9
714.0
995.2
V58.1

Epoetin is not covered when given to increase the amount of blood which can be drawn for auto-donation prior to surgery, for blood loss in patients who refuse transfusions for religious or other reasons, or to prime a patient prior to surgery.

Epoetin given for renal patients should be billed utilizing procedure codes Q9920-Q9940.

Documentation Requirements

All EPO claims must contain the following ICD-9 information:

Report the appropriate ICD-9-CM diagnosis causing the anemia from the following list and the anemia code (285.8 or 285.9) in block 21 of the HCFA-1500 claim form or the equivalent field for electronic claims. Report the reference number of the ICD-9-CM diagnosis code for anemia (285.8 or 285.9) from block 21 in block 24e.

For patients currently receiving chemotherapy, diagnosis code V58.1 must be coded as the secondary diagnosis to indicate that the anemic condition is chemotherapy-induced. These patients must currently be on a course of chemotherapy for a non-myeloid malignancy.

For patients with post-chemo anemia, a secondary diagnosis of 995.2 must be coded. These patients must have received chemo within the last year.

For patients with anemia related to Rheumatoid arthritis, a secondary diagnosis of 714.0 must be coded.

For AZT-related service, a secondary diagnosis of AIDS (042) must be coded. These patients must have an endogenous serum erythropoietin level 500 mg units/ml and receiving a dose of AZT 4200 mg/week.

A diagnosis of myelodysplastic syndrome (ICD 238.7) must be coded as secondary for these patients.

The physician must clearly document in the patient's medical records (i.e., progress/office notes) the medical necessity for the use of Procrit, including covered diagnosis, appropriate laboratory studies, dosage, route of administration, frequency and duration of the treatment and the patient's response to the therapy. For claims suspending for medical review (services performed in excess of acceptable limits) on a prepayment basis the following documentation is required:

The date and results of the most recent (tests obtained within last month) HGB/HCT levels obtained prior to the current therapy

Office/progress notes indicating medical necessity as described above

Note: If the recommended starting dosage of 30000 u/wk or 100 units/kg TIW for AZT patients or 150 units/kg TIW for chemotherapy and MDS patients and the recommended maximum dose of 300 units/kg TIW is exceeded, include the reason for exceeding the recommended dosage. In addition, if starting EPO when the HCT/HGB levels are equal to or higher than 30%/10 and/or EPO level is 500 m units/ml, include the reason for starting therapy at this level.

In event of a postpayment medical review, the documentation must support the information on the claim (i.e., ICD-9 codes), anemia symptomatology, and all other requirements for initiation of therapy.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

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00142: Cataract Anesthesia Services

Over the past year, Medicare has received several questions from anesthesiologists and CRNAs regarding the appropriate way to bill anesthesia time. In 1995, procedure code 00142 (anesthesia for procedures on eye; lens surgery) was determined to be an aberrancy after comparing Florida's utilization per 1,000 beneficiaries with the nation per 1,000 beneficiaries. After a review of a sample of medical records, it was determined that there were inconsistencies in the way the time for anesthesia was billed.

For personally performed services, it is appropriate to start counting anesthesia time when the anesthesiologist/CRNA administers the sedative agent, e.g. IV Brevitat or Versed, followed by the retrobulbar block and then continues to monitor the patient until and through surgery. The anesthesia monitoring must be constant monitoring, i.e., the anesthesiologist/CRNA can not leave the patient's bedside.

In addition, for personally performed services, if the anesthesiologist/CRNA administers the IV sedative and the retrobulbar block, monitors the patient for five minutes and then leaves the bedside, this time cannot be included in anesthesia time. In other words, blocks of time can not be added together to determine anesthesia time. For personally performed services, anesthesia time includes only the time that the anesthesiologist/CRNA is constantly monitoring the patient. Therefore, the five minutes could not be added to OR time to calculate anesthesia time.

Lastly, cataract anesthesia is almost always done under monitored anesthesia care (MAC), therefore, the QS modifier should be billed with the procedure code. If a CRNA is performing the MAC, the QS modifier should be used in addition to the appropriate modifier for a medically directed or non-medically directed service.

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11720-11721: Nail Debridement

Analysis of 1995 Medicare claims data for Florida has indicated that Medicare Part B of Florida allowed significantly more reimbursement for nail debridement (procedure code 11700) than Medicare paid nationally per 1,000 beneficiaries. National coverage policy was enhanced to further clarify the indications for the service and the circumstances under which Medicare will consider it to be medically reasonable, necessary, and, therefore, covered.

Policy enhancements have been developed for the following procedure codes:

11720 Debridement of nail(s), by any method(s); one to five

11721 Debridement of nail(s), by any method(s); six or more

Medicare Part B will consider the treatment of fungal (mycotic) infection of the toenails a covered service when the medical record substantiates the following:

Clinical evidence of mycosis of the toenail, by generally accepted clinical findings such as discoloration, onycholysis, subungual debris, thickening, or secondary skin infection;

Medical evidence documenting that either:

the ambulatory patient has a marked limitation in ambulation, pain, or secondary infection resulting from the thickening and dystrophy, or

the non-ambulatory patient suffers from pain, or secondary infection resulting from the thickening and dystrophy of the infected nail plate(s); and

Appropriate anti-fungal treatment is necessary to qualify nail debridement as a medically necessary and reimbursable service.

Patients need not have an underlying systemic condition to be covered for mycotic nail care.

MCM 4120.2 directs that for debridement of a mycotic lesion of the toenail, carriers must use a 60-day claims processing screen for identifying excessive follow-up services for the patient (i.e., the presumption would be that only one follow-up visit is covered every 60 days following the end of the initial treatment period unless medical documentation is submitted that supports more frequent visits).

Diagnosis Requirements

To ensure that payment is made only for medically necessary services, nail debridement is covered only when performed for the following diagnoses:

110.1
112.3
117.0-117.9

Coding Guidelines

Generally, it would not be expected to see services for nail debridements (procedure codes 11720-11721) and routine foot care services (procedure code M0101) billed on alternate visits. Such claims may be reviewed on a prepayment basis and denied if found to be not medically necessary or reasonable or if documentation does not indicate that a nail debridement(s) as described in this policy was performed, e.g., 11720 and 11721 should not be billed to circumvent any prepayment screens in place for procedure codeM0101 or vice versa.

The Health Care Financing Administration (HCFA) has mandated a screen which identifies claims involving an unusually large amount of nail debridements.

If the patient has five or fewer mycotic nails, it is only appropriate to bill with CPT 11720 indicating the first five digits. This is true without regard to whether five or fewer nails are located on one or both feet. Care of the other non-mycotic nails would be a noncovered service, and therefore noncovered guidelines would apply.

The physician should document the appearance of the infected toe(s) when billing a debridement code and if documentation requirements are met, including results of fungal culture, if warranted. In order to be reimbursed for nail debridement (11720-11721), one of the criteria in the "Indications and Limitations of Coverage and/or Medical Necessity" should be met without compromising any of the Reasons of Denial. If the criteria are not met, then the nail care would be considered part of A9160 (Routine Foot Care) and would be noncovered.

Modifier -Q1 should be used when billing nail debridement services (procedure codes 11720-11721) on ambulatory or nonambulatory patients when the coverage criteria has been met as described in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy, and the provider retains a medical record available for medical review which documents the medical necessity for one or both of these codes.

Note: Effective May 1, 1997, the language for procedure code modifier Q1 has been revised to read as follows:

Documentation is on file verifying the presence of markedly thickened toenail(s) resulting in soft tissue infection (paronychia) and pain, requiring toenail debridement.

Modifier -24 is used for unrelated evaluation and management services by the same physician on the day of a procedure, following the initial visit.

Modifier -25 should be used to indicate that a significant, separately identifiable evaluation and management service was performed by the same physician on the day of a procedure, following the initial visit.

Medical site of service reduction applies when the service(s) (procedure codes 11720 and 11721) is performed in an outpatient hospital setting, emergency room, or comprehensive outpatient rehabilitation facility.

Therefore, claims for these services may be reviewed on a prepayment basis and, if found to be not medically necessary or reasonable, or if the documentation does not support that a nail debridement(s) was performed as described in this policy, the service(s) may be denied.

Reasons for Denial

Non-conformity to the Indications and Limitations of Coverage and/or Medical Necessity.

In the absence of localized symptoms nail debridement will be denied unless performed in the presence of a qualifying underlying medical condition of sufficient severity to qualify (Q7, Q8, or Q9 modifiers), making the patient at risk for non-professional foot care.

Per Indications and Limitations of Coverage, unless an ambulatory patient with a mycotic toenail(s) is experiencing marked limitation of ambulation, pain, or secondary infection resulting from thickening and dystrophy of the infected toenail(s) and the physician has removed the infected nail/surrounding tissue and has debrided, to tolerance, to an area of healthy tissue, procedure codes 11720 and 11721 would not be reimbursable.

Per Indications and Limitations Coverage, unless a non-ambulatory patient presents with a mycotic nail(s) which is causing pain or in which a secondary infection resulting from thickening and dystrophy of the infected toenail has occurred and the physician has removed the infected nail/surrounding tissue and has debrided, to tolerance, to an area of healthy tissue, procedure codes 11720 and 11721 would not be reimbursable.

The diagnosis of mycosis of the toenail alone is insufficient to meet coverage criteria for nail debridement. In addition, the statement "painful nails" will not suffice in meeting coverage criteria.

Advance Notice Requirement

Applies to the utilization parameter (see page 4).

Documentation Requirements

The provider of the service(s) should document the affected toe(s), including the clinical evidence of mycosis, the manner in which and to what extent the nail(s) were debrided, and the antifungal agent used in the office note/progress note. In addition, a brief description of the qualifying symptoms, i.e., marked limitation in walking, pain or secondary infection should be documented.

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70450-70470: Computerized Tomography Scans of the Head

Analysis of 1995 Medicare claims data for Florida indicated that Medicare Part B of Florida allowed significantly more reimbursement for Computerized Tomography Scan of the Head (procedure code 70450) for the specialties of Neurology and Radiology than Medicare has paid nationally per 1,000 Medicare beneficiaries for the same specialties. In addition, analysis of data indicated that this procedure was being billed using nonspecific diagnoses and/or diagnoses that do not substantiate medical necessity. Local medical review policy was developed, defining the service and the circumstances under which Medicare will consider it to be medically reasonable and necessary, and to establish guidelines for medical review, as well as, a diagnosis to procedure code edit.

Medicare Part B will only consider computerized tomography scans to be reasonable and necessary when performed for documented cases of illness or injury.

Computerized tomography scan of the head is used in the differential diagnosis and monitoring of treatment for intracranial neoplasms, cerebral infarctions, ventricular displacement or enlargement, cortical atrophy, cerebral aneurysms, intracranial hemorrhage and hematoma, infection, edema, degenerative processes, cyst formation, multiple sclerosis, seizure disorders, head trauma, congenital abnormalities, presence of foreign body, and radiation treatment planning.

Local medical review policy has been developed for the following procedure codes:

70450 Computerized axial tomography, head or brain; without contrast material

70460 with contrast material(s)

70470 without contrast material, followed by contrast material(s) and further sections

Diagnosis Requirements

Medicare Part B will consider computerized tomography scan of the head to be medically reasonable and necessary when performed to establish a diagnosis or to monitor treatment for the following conditions:

006.5; 013.00-013.36; 013.60-013.96; 036.0-036.2; 042; 046.0-046.9; 047.0-047.9; 049.0-049.9; 052.0; 053.0; 054.3; 054.72; 055.0; 056.01; 062.0-062.9; 063.0-063.9; 064; 072.1-072.2; 090.40-090.49; 094.0-094.9; 112.83; 114.2; 115.01; 115.11; 115.91; 130.0; 170.0; 191.0-191.9; 192.0.192.1; 194.3-194.4; 195.0; 196.0; 198.3-198.5; 199.0-199.1; 200.11; 200.21; 201.11; 201.21; 201.41; 201.51; 201.61; 201.71; 201.91; 213.0; 225.0-225.2; 225.8; 227.3-227.4; 237.0-237.1; 237.5-237.9; 239.6-239.7; 250.2; 250.3; 253.0-253.9; 255.0-255.9; 290.0-290.9; 293.0-293.83; 294.0-294.9; 298.9; 310.0-310.9; 320.0-326; 330.0-334.9; 341.0-341.9; 342.00-342.92; 343.0-343.9; 344.00-344.9; 345.00-345.91; 348.0-348.9; 349.1-349.9; 350.1-350.9; 351.0-351.9; 352.0-352.9; 368.11; 368.12; 368.2; 368.40; 368.8; 368.9; 374.31; 377.00-377.01; 377.51-377.52; 377.61; 377.71; 378.51-378.56; 386.2; 388.2; 388.5; 430-438; 572.2; 674.00-674.04; 738.10-738.19; 740.0-740.2; 742.0-742.4; 742.8; 742.9; 747.81; 756.0; 759.2-759.9; 765.0-765.1; 767.0; 767.1; 767.3; 768.5; 768.6; 768.9; 770.8; 772.1-772.2; 779.0-779.2; 780.01-780.09; 780.1; 780.2; 780.3; 780.4; 780.6; 780.9; 781.0-781.9; 784.0*; 784.2; 784.3; 784.5; 784.60-784.69; 793.0; 794.00-794.09; 800.00-804.99; 850.0-854.19; 873.0-873.1; 873.9; 950.0-950.9; 951.0-951.9; 996.2; 997.00-997.09; V10.85; V10.86; V10.88; V45.2; V67.1; V67.2.

* Coverage for headache should only be for the following situations:

1. Patient suffering from headaches after a head injury. Head CT is performed to rule out the possibility of a bleed.

2. Patient suffering from headaches unusual in duration and not responding to medical therapy. Head CT is performed to rule out the possibility of a tumor.

3. Patient suffering from headaches characterized by sudden onset and severity. Head CT is performed to rule out possibility of aneurysm and/or arteriovendes malformation.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Documentation Requirements

The medical record should support the medical necessity and frequency of this treatment. Documentation, including office/progress notes, history and physical, and a copy of the CT report should be maintained in the patient's medical records.

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70551-70553: Magnetic Resonance Imaging of the Brain

Analysis of 1995 Medicare claims data for Florida has indicated that Medicare Part B of Florida allowed significantly more reimbursement for Magnetic Resonance Imaging of the Brain (procedure code 70551) for the specialties of Neurology, Diagnostic Radiology, and Interventional Radiology than Medicare has paid nationally per 1,000 Medicare beneficiaries for the same specialties. Local medical review policy was developed defining the service and the circumstances under which Medicare will consider it to be medically reasonable and necessary, and, to establish guidelines for medical review, as well as, a diagnosis to procedure code edit.

Local medical review policy has been developed for the following procedure codes:

70551 Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material

70552 with contrast material

70553 without contrast material, followed by contrast material(s) and further sequences

Medicare Part B will consider Magnetic Resonance Imaging of the Brain to be medically necessary when used to aid in the diagnosis of lesions of the brain and to assist in therapeutic decision making in the following conditions:

For detection or evaluation of extra-axial tumors, A-V malformations, cavernous hemangiomas, small intracranial aneurysms, cranial nerve lesions, demyelination disorders including multiple sclerosis, lesions near dense bone, acoustic neuromas, pituitary lesions, and brain radiation injuries;

For developmental abnormalities of the brain, including neuroectodermal dysplasia;

Subacute central nervous system hemorrhage or hematoma;

Acute cerebrovascular accidents;

Complex partial seizures, seizures refractory to therapy, temporal lobe epilepsy, or other atypical seizure disorders;

MRI is usually not the procedure of choice in patients who have acute head trauma, acute intracranial bleeding, or in the investigation of skull fracture or other bone abnormality, or as follow-up for hydrocephalus. However, an MRI may be necessary in the patient whose presentation indicates a focal problem, or who has had a recent significant change in symptomatology.

For brain infections;

Where soft tissue contrast is necessary;

When bone artifacts limit CT, or coronal, coronosagittal or parasagittal images are desired;

For procedures in which iodinated contrast material is contraindicated.

Diagnosis Requirements

To ensure that payment is made only for medically necessary services, magnetic resonance imaging of the brain is covered only when it is performed for the following diagnoses:

006.5

013.0-013.3; 013.60-013.96; 036.0-036.2; 042; 046.0-046.9; 047.0-047.9; 049.0-049.9; 052.0; 053.0; 054.3; 054.72; 055.0; 056.01; 062.0-062.9; 063.0-063.9; 064; 072.1-072.2; 090.40-090.49; 094.0-094.9; 112.83; 114.2; 115.01; 115.11; 115.91; 130.0; 191.0-191.9; 192.0.192.1; 194.3-194.4; 196.0; 198.3-198.5; 225.0-225.2; 225.8; 227.3-227.4; 228.02; 237.0-237.1; 237.5-237.9; 239.6-239.7; 253.0-253.9; 298.9; 310.0-310.9; 320.0-326; 330.0-334.9; 340; 341.0-341.9; 342.00-342.92; 343.0-343.9; 344.00-344.9; 345.00-345.91; 348.0-348.9; 352.0-352.9; 358.0-358.1; 349.1-349.9; 350.1-350.9; 351.0-351.9; 352.0-352.9; 358.0-358.1; 368.11; 368.12; 368.2; 368.40; 368.8; 368.9; 374.31; 377.00-377.01; 377.51-377.52; 377.61; 377.71; 378.51-378.56; 386.2; 388.2; 388.5; 430-438; 572.2; 739.0; 742.0-742.4; 742.8; 742.9; 747.81; 759.2-759.9; 767.0; 768.5; 768.6; 768.9; 772.1-772.2; 780.01-780.09; 780.1; 780.2; 780.3; 780.4; 780.6; 780.9; 781.0-781.9; 784.2; 784.3; 784.5; 784.60-784.69; 793.0; 794.00-794.09; 800.00-801.99; 850.0-854.19; 950.0-950.9;

951.0-951.9; 996.2; 997.00-997.09; V10.85; V10.86; V10.88; V45.2; V67.1; V67.2.

Coding Guidelines

If the procedure is performed using contrast only, procedure code 70552 should be billed. If the procedure is performed initially without contrast, followed by contrast, then procedure code 70553 should be billed. Procedure codes 70551, 70552, and/or 70553 should not be billed on the same day for the same patient.

Reasons for Denial

Magnetic Resonance Imaging is considered investigational when medical record documents that the test was performed only for one of the following:

measurement of blood flow and spectroscopy,

imaging of cortical bone and calcifications, and

procedures involving spatial resolution of bone or calcifications

When Magnetic Resonance Imaging is used for an investigational purpose, an acceptable advance notice of Medicare's denial of payment must be given to the patient when the provider does not want to accept financial responsibility for the service.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Documentation Requirements

The medical record should support the medical necessity and frequency of this treatment. Documentation including office/progress notes, history and physical, and a copy of the MRI report should be maintained in the patient's medical record.

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71010-71035: Chest X-Rays

In the October 1996 Medicare B Update! Special Issue: New Local Medical Review and Focused Medical Review Policies, the indications and covered diagnoses for chest x-rays (procedure codes 71010-71035) was published. Since that time, an additional covered diagnosis range has been added. Diagnoses code range V58.81-V58.89 (Other specified procedures and aftercare) should be billed when a chest x-ray is performed following an invasive procedure to check placement of a catheter (i.e. central line,

PICC, etc.). Please refer to the October 1996 Special Issue for a complete list of covered ICD-9 codes.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Applies to the utilization parameter (see page 4).

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72141-72158: MRI of the Spine

Analysis of 1995 Medicare claims data for Florida has indicated that Medicare Part B of Florida allowed significantly more reimbursement for Magnetic Resonance Imaging of the Spine (procedure code 72141) for the specialties of Neurology, Diagnostic Radiology, and Interventional Radiology than Medicare has paid nationally per 1,000 Medicare beneficiaries for the same specialties. Local medical review policy was developed, defining the service and the circumstances under which Medicare will consider it to be medically reasonable and necessary, and to establish guidelines for medical review, as well as, a diagnosis to procedure code edit.

Local medical review policy has been developed for the following procedure codes:

72141 Magnetic resonance (e.g., proton) imaging, spinal canal and contents, cervical; without contrast material

72142 with contrast material(s) (For cervical spinal canal imaging without contrast material followed by contrast material, use 72156)

72146 Magnetic resonance (e.g., proton) imaging, spinal canal and contents, thoracic,without contrast material

72147 with contrast material(s)(For thoracic spinal canal imaging without contrast material followed by contrast material, use 72157)

72148 Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material

72149 with contrast material (For lumbar spinal canal imaging without contrast material followed by contrast material, use 72158)

72156 Magnetic resonance (e.g., proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical

72157 thoracic

72158 lumbar

Medicare Part B will consider Magnetic Resonance Imaging of the Spine to be medically necessary when used to aid in the diagnosis and to assist in therapeutic decision making of the following:

Lesions in the spinal cord

Syringomyelia

Spinal cord demyelination or inflammation

Tumors of the spine and spinal cord

Spinal cord infarcts

Spinal trauma

Discitis and osteomyelitis

Epidural abscess

Spinal dysraphism and other developmental abnormalities of the spine

Spinal stenosis

Spinal cord compression and post-operative scarring

Herniation of disc

Where soft tissue contrast is necessary

When bone artifacts limit CT, or coronal, coronosagittal or parasagittal images are desired, and

For procedures in which iodinated contrast material are contraindicated

Diagnosis Requirements

To ensure that payment is made only for medically necessary services, magnetic resonance imaging of the spine is covered only when it is performed for the following diagnoses:

015.0; 170.2; 170.6; 195.8; 198.3; 198.4; 198.5; 198.89; 200.00-208.91; 213.2; 213.6; 215.7; 225.3-225.4; 228.00-228.1; 229.0-229.9; 238.0-238.2; 239.8; 320.0-320.9; 321.0-321.8; 322.0-322.9; ; 324.1; 324.9; 335.0-335.9; 336.0-336.9; 337.0-337.9; 340; 341.0-341.9; 344.00-344.9; 353.0-353.4; 353.8; 353.9; 357.0; 715.18; 715.28; 715.38; 720.0-720.9; 721.1-721.91; 722.0-722.93; 723.0-723.4; 723.9; 724.00-724.7; 724.9; 730.08; 730.18; 730.28; 730.98;

733.00-733.09; 733.10, 733.13; 733.40; 737.10; 737.30-737.9; 738.4; 738.5; 739.1-739.4; 741.00-741.93; 742.51-742.59; 742.9; 756.10-756.19; 781.0-781.9; 792.0; 793.9; 794.10; 794.17; 796.1; 805.00-805.9; 806.00-806.9; 839.00-839.59; 952.00-952.9; 953.0-953.9; V10.81; V10.86.

Reasons for Denial

Magnetic Resonance Imaging is considered investigational when medical records document the service was performed only for one of the following:

measurement of blood flow and spectroscopy

imaging of cortical bone and calcifications, and

procedures involving spatial resolution of bone or calcifications

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Documentation Requirements

The medical record should support the medical necessity and frequency of this treatment. Documentation, including office/progress notes, history and physical, and a copy of the MRI report should be maintained in the patient's medical records.

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72192-72194: Computed Tomography of the Pelvis

As part of the Focused Medical Review process, procedure code 72193 (computerized axial tomography, pelvis; with contrast material) has been identified as an aberrancy for Medicare Part B of Florida in 1996. Analysis of January through June 1995 Medicare claims data for Florida has indicated that Medicare Part B of Florida allowed significantly more reimbursement per 1,000 beneficiaries for specialties 30 (Diagnostic Radiology) and 94 (Interventional Radiology) than the nation per 1,000 beneficiaries. Additional analysis indicated that this procedure was being billed with nonspecific diagnoses and/or diagnoses that do not substantiate medical necessity. As part of a corrective action, local medical review policy has been developed to define the service and circumstances under which Medicare will consider it to be medically reasonable and necessary, and to establish guidelines for medical review, as well as a diagnosis to procedure code edit.

Local medical review policy has been developed for the following procedure codes;

72192 Computerized axial tomography, pelvis; without contrast material

72193 Computerized axial tomography, pelvis; with contrast material

72194 Computerized axial tomography, pelvis; without contrast material, followed by contrast material(s) and further sections

Medicare Part B will consider computerized axial tomography scan of the pelvis to be medically necessary when used to assist in the diagnosis and therapeutic decision making for the following:

To evaluate cysts, tumors, or masses of the pelvic structure, i.e. that which lies at or below the pelvic brim, or true pelvis;

To evaluate metastasis of primary cancers of this region;

To evaluate inflammatory processes of this region;

To evaluate abnormalities of pelvic vascular structures;

To evaluate lymphadenopathies of this region;

To evaluate lower abdominal, generalized abdominal or pelvic pain;

To evaluate other genitorurinary disorders in which the physician can not make a diagnosis on physical examination and/or by utrasound;

To evaluate trauma to the pelvic structure/organs; and, or

To evaluate the effectiveness of a radiation treatment plan

Diagnosis Requirements

Computerized axial tomography scans of the pelvis are covered when they are performed for the following conditions/diagnoses:

015.00-015.06; 016.10-016.96; 153.0-153.9; 154.0-154.8; 171.6; 179; 180.0-180.9; 182.0-182.8; 183.0-183.9; 184.0; 184.8; 184.9; 185; 186.0-186.9; 187.8; 187.9; 188.0-188.9; 189.2; 189.3; 189.8; 189.9; 195.3;

196.2; 196.5; 196.6; 197.6; 198.1; 198.5; 198.6; 200.00; 200.05; 200.06; 200.08; 200.10; 200.15; 200.16; 200.18; 200.20; 200.25; 200.26; 200.28; 201.00-201.98; 202.80; 202.85; 202.86; 202.88; 211.3; 211.4; 211.8; 215.6; 218.0-218.9; 219.0-219.9; 220; 221.0; 228.04; 228.1; 230.4; 233.1-233.9; 235.2; 235.4; 236.0-236.2; 236.5; 236.7; 236.90; 239.4-239.5; 256.4; 441.3; 441.4; 442.2; 444.0; 457.1; 540.0; 540.1; 543.9; 552.21; 553.8; 553.9; 555.0; 555.1; 555.2; 555.9; 557.0-557.9; 560.0; 560.81; 560.9; 562.10; 562.11; 566; 567.2; 567.9; 568.0; 568.81; 568.82; 568.89; 569.41-569.5; 569.60-569.69; 569.83; 569.89; 578.1; 591; 593.3; 593.4; 593.5; 593.82; 593.89; 596.0; 596.6; 596.8; 599.1; 599.7; 614.0-614.9; 615.0-615.9; 617.0-617.9; 619.0-619.9; 620.0-620.9; 621.4; 621.8; 625.8; 626.6; 639.0; 639.1; 665.10; 665.40; 665.50; 670.00-670.04; 682.2; 682.5; 682.9; 719.4; 751.0; 752.0; 752.10-752.19; 752.3; 752.40; 752.51-752.52; 752.8; 753.0-753.9; 780.6; 785.6; 789.05; 789.07; 789.09; 789.33-789.35; 789.5; 789.63-789.65; 789.67; 789.9; 793.5; 793.6; 793.9; 863.89; 876.0-876.1; 877.0-877.1; 879.2; 879.4; 879.5; 879.6; 879.7; 958.4; 958.5; 995.5; 995.81; 996.1; 996.30-996.39; 996.8; 996.89; 997.5; 998.2; 998.4; 998.51-998.59; V42.0; V44.3; V44.5.

Coding Guidelines

If the procedure is performed using contrast only, procedure code 72193 should be billed. If the procedure is performed initially without contrast, followed by contrast, then procedure code 72194 should be billed. Procedure codes 72192, 72193, and/or 72194 should not be billed on the same day for the same patient.

Reasons for Denial

In the absence of signs and symptoms of a disorder as described in the "Indications and Limitations" section of the policy, the procedure will be considered not medically necessary and, therefore, not reimbursable by Medicare.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Documentation Requirements

The reason for the procedure should be documented in the physician's progress notes. In addition, test results should be included in the documentation. If the CT scan is the primary diagnostic tool, and physical examination and/or another test, such as echography, could have been performed to determine the patient's status or diagnosis, the rationale for using the CT scan should also be documented.

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85007-85031: Additional Diagnosis Requirements for Complete Blood Count

As a result of an inquiry regarding (Complete Blood Counts) CBCs for rheumatoid arthritis patients being treated with many different types of medications that affect the patient's blood count (e.g., Methotrexate, Imuran, Gold, etc.), the local medical review policy has been revised.

Effective immediately, CBCs (procedure codes 85007-85031) performed for rheumatoid arthritis patients that are being treated with antineoplastic and/or immunosuppressive drugs such as Methotrexate and Imuran should be submitted with diagnosis code E933.1 (Anti neoplastic and immunosuppressive drugs). CBCs for patients on medications that are not classified as antineoplastic and/or immunosuppressive drugs (i.e., Gold Salts, NSAID's, corticosteroids, etc.), should not be billed using diagnosis code E933.1.

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82784: Gammaglobulin; IgA, IgD, IgG, IgM, Each

Analysis of 1995 Medicare claims data for Florida has indicated that Medicare Part B of Florida allowed significantly more reimbursement for Gammaglobulin (procedure code 82784) than Medicare has paid nationally per 1,000 Medicare beneficiaries. Local medical review policy was developed in 1996, defining the service and the circumstances under which Medicare will consider it to be medically reasonable, necessary, and, therefore, covered.

Medicare Part B will consider Gammaglobulin to be medically necessary when used in the following circumstances:

When the patient has had repeated infections, a serum IgA, an IgG and an IgM could be performed to determine whether a Immunodeficiency disorder exists.

When the patient presents with signs and symptoms of multiple myeloma which include, but are not limited to, the following:

anemia,

hypercalcemia,

increased susceptibility to infection, and/or

bone pain

Serum IgA, IgG, or IgD levels are performed to monitor myeloma therapy after initially diagnosing and determining the gammaglobulin which is increased.

When the patient presents with signs and symptoms of autoimmune disorders such as rheumatoid arthritis or systemic lupus erythematoses, serum gammaglobulin levels could be performed to assist with diagnosis.

When the patient presents with signs and symptoms of Lyme's Disease.

When the patient is suspected of having hypogammaglobulinemia or agammaglobulinemia. The following patient conditions/circumstances may lead to either of these conditions:

Long-term and/or high-dose steroid use,

Nephrotic syndrome,

Patients with overwhelming infections,

Chronic lymphocytic leukemia,

Lymphocytic lymphoma,

Multiple myeloma, or

Protein-losing enteropathy

Patients who are receiving intravenous (IV) Immune Globulin could have serum gammaglobulin (IgG) levels performed every three to six months to monitor their response to this therapy.

When the patient is suspected of having Waldenstrom's macroglobulinemia (a small-cell lymphocytic lymphoma that produces monoclonal IgM). This disease characteristically occurs in the elderly. Signs and symptoms may include, but are not limited to, the following:

Retinal hemorrhages, visual impairment and transient neurologic deficits(usually associated with the high viscosity serum);

Bleeding diatheses or hemolytic anemia (associated with the macroglobulin complexes with coagulation factors or binds to the surface of red blood cells);

Raynaud's phenomenon and peripheral vascular occlusions (associated with cold-insoluble proteins [cryoglobulins]); and/or

Splenomegaly on examination.

* This disease is differentiated from chronic lymphocytic leukemia and multiple myeloma by bone marrow morphology and the finding of the IgM spike in macroglobulinemia. Serum IgM levels are useful in diagnosing and monitoring therapy for this disorder.

When the patient presents with signs and symptoms of inflammatory bowel disease; gastrointestinal or hepatobiliary tract carcinoma; or cirrhosis, an IgA could be performed to assist with diagnosis (an elevation is usually seen with these disease processes).

When the patient is at high risk of infection related to an ineffective immune response such as that associated with chronic lymphocytic leukemia, malignant lymphomas, other bone marrow disorders, corticosteroid treatments, chemotherapy, or radiation therapy, the gammaglobulins may be markedly reduced or absent, therefore, periodic monitoring of the gammaglobulins could be performed.

When the patient presents with frequent and recurrent infections of the paranasal sinuses, bronchi and/or lungs, a serum IgA could be performed to determine whether Selective IgA Defiency exists.

Gammaglobulins could be performed to assist in determining how extensive tissue necrosis is with myocardial infarctions or in severe burn cases.

When the patient is suspected of having Subacute Bacterial Endocarditis (SBE), serum gammaglobulin levels may be performed to assist with diagnosis.

When the patient is suspected of having polyarteritis nodosa, serum gammaglobulins could be performed to assist in diagnosis.

When the patient is suspected of having a paraproteinemia, serum gammaglobulin levels could be performed to assist with diagnosis.

When the patient is suspected of having biliary cirrhosis, a serum IgA, an IgG, and an IgM may assist with diagnosis. Typically, serum IgAs and IgGs are decreased while serum IgMs are increased.

When patients are receiving plasmapheresis therapy, more than one IgM could be performed per day.

Generally, the following disorders may result in abnormalities in at least one or more of the serum gammaglobulins:

Liver dysfunctions;

Acute or chronic infections;

Severe malnutrition;

Lymphoproliferative disorders;

Myelomas (polyclonal or monoclonal);

Autoimmune disorders/collagen disorders;

Lyme's Disease;

Waldenstrom's macroglobulinemia;

Tissue necrosis;

Leukemia and other cancers;* and

Immune deficiency disorders (congenital and/or acquired)

However, after diagnosis, performing serum gammaglobulin tests may not be medically necessary or reasonable, except in cases of monitoring a patient's propensity to infection; monitoring therapy such as is done with myelomas (particularly IgG or IgA myeloma) or Immune Globulin Therapy; or monitoring the advancement of a disease. Therefore, those tests performed at unusually frequent intervals may be reviewed on a prepayment basis and denied if found not to have a contributory impact on the patient's care or are found not to have been performed to monitor therapy or propensity to infection.

After diagnosis of IgA or IgG myelomas, it would only be considered medically necessary to perform one serum gammaglobulin test, i.e. IgA or IgG, to determine the effectiveness of therapy. Periodically, two or more of the gammaglobulin tests may be performed on the same day when the patient has myeloma for purposes of monitoring therapy and/or propensity to infection.

IgDs have questionable clinical significance except in the rare instance of IgD myeloma. It would be expected that this test only be performed to assist with diagnosis of that condition and, therefore, would only be rarely performed. Routinely performing a serum IgD level when performing the other tests would generally not be medically necessary or reasonable.

*Generally, in Hodgkin's Disease, B cell function is intact. Therefore, serum immunoglobulins are normal and generally not

performed for diagnostic purposes when this condition is suspected.

Coding Guidelines

Because the procedure code describes IgA, IgD, IgG, and IgM, each, i.e. as separate tests, there should be no more than the number four' indicated in the number billed' field. In addition, it would not be expected that each of the four tests be performed more than once in a single day except in cases where the patient is receiving plasmapheresis therapy.

Documentation Requirements

The physician should clearly document the rationale for each test ordered/performed in the patient's progress note/office note, and the results of the test(s), as well as any impact the results have on the patient's treatment or plan of care.

Services which exceed the established parameters will be reviewed on a prepayment basis.

In addition, it would not be expected to routinely see claims for all four tests, i.e. IgA, IgD, IgG, and IgM because of the unknown clinical significance of IgD except in rare cases of IgD myeloma. If the physician is not performing the IgD to determine whether the patient has IgD myeloma, the tests could be denied as not medically necessary or reasonable. Also, when monitoring therapy for either IgG or IgA myeloma, it would only be considered medically necessary and reasonable to perform a single test. Periodically, more than one Ig may be performed to monitor therapy of the myeloma and/or to determine the patient's propensity to infection.

Reasons for Denial

Serum gammaglobulins performed in the absence of those instances listed under the "Indications and Limitations" section of this policy will be denied as not medically necessary or reasonable. Also, tests performed at unusually frequent intervals and in which the outcome would not affect the patient's treatment or care or are not done for purposes of monitoring therapy, advancement of disease, or propensity for infection may be denied after prepayment medical review.

It should be obvious from the patient's medical record that the ordering of gammaglobulin testing is clearly indicated by the patient's signs, symptoms and disease state. If the medical record does not clearly include the above, then denial of payment for gammaglobulin determinations will occur.

Advance Notice Requirement

Applies to utilization screen (see page 4).

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92004-92014: Coverage for General Ophthalmological Services

The 1995 Medicare claims data indicate that procedure codes 92004, 92012, and 92014 have been billed substantially more in Florida than at the national level. As a result, local medical review policy has been developed for procedure codes 92002-92014 to focus on the definition of the services and the circumstances for which Medicare Part B of Florida will consider the service to be medically necessary and therefore, covered.

An ophthalmological examination includes many components and is further divided into intermediate and comprehensive ophthalmological services.

An intermediate eye examination (procedure codes 92002 and 92012) pertains to the evaluation of a new or existing condition complicated by a new diagnostic or management problem not necessarily relating to the primary diagnosis. The intermediate eye exam includes a history, general medical observation, external ocular and adnexal examination and other diagnostic procedures as indicated. It may include the use of mydriasis.

A comprehensive eye examination (procedure codes 92004 and 92014) requires a general evaluation of the complete visual system including a history, general medical observation, external and ophthalmoscopic examination, gross visual fields, basic sensorimotor examination. It often includes, as indicated, biomicroscopy, examination with cycloplegia or mydriasis and tonometry. This service always includes initiation of diagnostic and treatment programs as indicated

Ophthalmoscopic examinations are covered by Medicare Part B in patients with the following conditions:

previously diagnosed ocular disease.

patients presenting with ocular or periocular symptoms such as ocular pain, tearing discharge, swelling, decreased vision not related to refractive disorders, etc. (decreased vision related to refractive disorders are noncovered)

patients with neurologic abnormalities which could affect the eye, periocular regions or visual system (i.e., blepharospasm, stroke) or patients requiring ophthalmologic evaluation for local or systemic problems affecting the eye, periocular regions, or visual system (i.e., Sarcoid, Systemic Lupus, Diabetes, brain tumor, headache).

patients with traumatic injury to ocular region, periocular region or skull.

Since general ophthalmoscopic examinations are not covered for refractive disorders, the diagnoses range 367.0-367.9 (Disorders of refraction and accommodation) is considered noncovered.

Documentation Requirements

Hospital, outpatient, ASC or office records should contain an appropriate history and physical exam for the level of service billed.

Normally, the documentation for a comprehensive exam includes the following components:

Visual Acuity (does not include determination of refractive error) - typically, this will include a description noted by a large capital "V" in two or three designations without correction (SC- meaning without any eyeglasses), with correction (CC- meaning with eyeglasses on), or BC (best-corrected - meaning with the best obtainable eyeglass prescription in place). A designation of "N" is a visual acuity test at near, while the traditional visual acuity test is performed at the equivalent of a distance of 20'.

Gross visual field testing by confrontation - the standard confrontation approach is normally described by the term "full to finger counting" or FTFC.

Ocular motility test including primary gaze alignment - this is a sensory motor exam of the eye which may be documented with comments such as straight, ortho (also means straight), E', ET (this reflects esophoria or esotropia which is an in-turning of the eye in a latent or in a manifest form). In addition, the terms X or XT (represents exodeviation, exotropia, or exophoria which is an outward deviation) or full D & V (represents full ductions and versions) may be documented.

Inspection of bulbar and palpebral conjunctivae - documentation such as "eyes white and quiet" or 2+ injection, etc. may be some of the terms used.

Examination of ocular adnexae including lids , lacimal glands, lacrimal drainage, orbits and preauricular lymph nodes - comments regarding the ocular adnexa and lids such as absence or presence of ptosis, lagophthalmos, blepharitis, lid margin scaling, aberrant lashes, stagnation of tear flow, etc. should be documented.

Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size (e.g. anisocoria) and morphology - The documentation of this examination most frequently describes PERLA which reflects pupils equal to light and accommodation.

Anterior segment - This is performed by a slit lamp examination (biomicroscopy) and involves: inspection of the corneas including epithelium, stroma, endothelium, tear film; inspection of the anterior chambers including depth, cells, flare; and inspection of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus. Comments regarding the cornea might be "clear", or demonstrate an inflammatory process of any of the epithelial, stromal, or endothelial layers. The anterior chamber will have a comment with regard to its depth and the status of its inflammatory state, and the lens, will have comments regarding clarity with respect to cataract changes, be they cortical, nuclear, or posterior subcapsular.

Measurement of intraocular pressures - this is the glaucoma test and is traditionally recorded with a capital "T" and numbers listed to the side in a vertical arrangement. The right eye is always listed above the left eye. This recording is in millimeters of mercury and, typically, the instrument chosen for the exam is noted. A small "a" reflects Goldmann applanation, an "s" which is rarely seen is the Schiotz indentation tonometer, and an "NCT" is one of the air driven noncontact tonometers.

Ophthalmoscopic examination with or without dilation - this is an examination of the optic discs including size, C/D ratio, appearance and nerve fiber layer; and the posterior segments including retina and vessels. This examination may be performed by the direct method which assesses the optic nerve head, macula, vessels and retina or the indirect method which includes all of the above plus the peripheral retina.

The documentation for an intermediate exam will include a minimum of one or two sections of the comprehensive exam depending on the symptoms which drove the examination.

Advance Notice Requirement

Applies to medical necessity guidelines (see page 4).

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92585: Brainstem Auditory Evoked Responses (BAER)

As part of the Focused Medical Review process, procedure code 92585 (Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system) has been identified as an aberrancy for Medicare Part B of Florida.

The policy focuses on the definition of the service and the circumstances for which Medicare Part B of Florida will consider the service to be medically reasonable and necessary and, therefore, covered.

Evoked Potential Studies evaluate the integrity of visual, somatosensory, and auditory nerve pathways by measuring the brain's electrical response to stimulation of the sense organs or peripheral nerves.

Brainstem auditory evoked potentials or responses (BAEP or BAER's) are obtained through scalp electrodes placed on the vertex and on each earlobe. Stimuli, consisting of between 1000-2000 clicking noises or tone bursts are delivered first to one ear then the other by high quality earphones at a fixed rate and intensity. In normal subjects, a total of seven short-latency waves can be defined within 10 milliseconds after each stimulus. Each of these waveforms corresponds closely to a specific brainstem relay station as follows: Wave I (Acoustic nerve), Wave II (Cochlear nucleus[Pons]), Wave III (Superior olivary nucleus), Wave IV (Lateral lemniscus), Wave V (Inferior colliculus[midbrain]), Wave VI (Medial geniculate[hypothesis only]), and Wave VII (Auditory radiations [hypothesis only]).

In order for the BAER to be considered medically necessary, the medical record such as office notes and history and physical must document the patient's symptomotology, objective findings and other audiologic function tests and/or diagnostic test performed (i.e., the Weber, Rinne, and schwabach tuning fork tests for differentiation of conductive from sensorineural hearing loss; and vestibular function tests such as finger-to-nose, heel-to-shin, Romberg tests and gait testing to determine if vertigo is peripheral or central). In addition, the medical record must indicate one of the following conditions:

Evaluation of a patient presenting with loss of hearing, disturbed sense of balance, unsteadiness of gait or any other symptoms suggestive of an auditory system lesion especially of the 8th cranial nerve (i.e., acoustic neuroma and other tumors of the cerebellopontine angle)

Evaluation of a patient with symptoms suggestive of Meniere's Disease (recurrent attacks of vertigo associated with fluctuating tinnitus and deafness, and varying degrees of nausea and vomiting)

Diagnosis of intrinsic brainstem lesions including multiple sclerosis, brainstem infarctions when auditory pathways are

involved, brainstem gliomas, or degenerative disorders of the central nervous system

Evaluation of the comatose patient for the confirmation of brain death when conventional EEG is inconclusive

Intraoperative assessment of cranial nerve VIII function in patients undergoing removal of an acoustic neuroma

Evaluation of a patient that presents with dizziness in which all other causes have been ruled out (i.e., arrthymias, ear infection, headache, hypotension, etc.) or the patient continues to exhibit dizziness after treatment has been initiated for potential cause

Evaluation of hearing loss in the child or neonate, since BAER testing does not require verbal responses

Initial assessment of hysterical or factitious hearing loss

Initial evaluation to differentiate sensory (cochlear) from neural (8th nerve) hearing loss

Evaluation of a patient in which a detailed history and physical examination revealed "true vertigo" which may suggest vestibular disease. Patients with symptoms of swaying, light-headedness, or a swimming sensation are usually referred to as giddiness or other types of pseudovertigo. True vertigo is described as a feeling of impulsion, rotation, oscillopsia with associated signs of nausea, vomiting, tinnitus, and deafness, staggering with relief by sitting or lying still.

Advance Notice Requirement

Applies to medical necessity guidelines (see page 4.)

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93000, 93005, 93010 - Addition to EKG Diagnoses List

On page 42 of the October 1996 Special Issue of the Medicare B Update!: New Local Medical and Focused Medical Review Policies, the coverage criteria for Electrocardiograms (procedure codes 93000, 93005, and 93010) were published. Since that time, three additional diagnoses have been added: 789.01 (Abdominal pain, right upper quadrant), 789.02 (Abdominal pain, left upper quadrant), and 789.06 (Abdominal pain, epigastric).

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Applies to utilization screen (see page 4).

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93526-93529 - Cardiac Catheterization

The following ICD-9 diagnoses are covered for combined cardiac catheterization (93526, 93527, 93528, and 93529):

410.00-410.92
412
415.11
415.19
416.0
416.8
420.0
420.90-420.99
422.0
422.90-422.99
424.0-424.3
425.0-425.9
428.0-428.9
429.71
745.4

Although these procedures have specific diagnosis requirements, payment will not automatically be denied when performed for a diagnosis/condition other than those listed. When these procedure are performed for a diagnosis/condition other than those listed, a copy of the patient's history and physical and the heart catheterization report must be submitted with a paper claim.

For a list of indications and limitations of coverage of right and left heart catheterizations please refer to the September/October1995 Medicare B Update (p.32).

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93797, 93798: Cardiac Rehabilitation Programs

The following ICD-9 diagnoses are covered for the Cardiac Rehabilitation Programs policy (procedure codes 93797and 93798):
410.00-410.92
411.0
412
413.9
V45.81

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Applies to utilization screen (see page 4).

For additional information on this policy, please refer to the October 1996 Medicare Part B Special Issue (p.45).

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93965-93971: NonInvasive Evaluation Of Extremity Veins

The following diagnoses/conditions reflect the indications for which procedure codes 93965, 93970, and 93971 are considered medically necessary. Appropriate conditions that would warrant the performance of non-invasive evaluation of extremity veins include:

415.11; 415.19; 451.0; 451.11; 451.19; 451.81; 451.83; 451.89; 454.0; 454.1; 454.2; 454.9; 457.1; 459.1; 459.81; 729.5; 729.81; 757.0; 901.2; 901.3; 902.10; 902.50; 902.87; 903.00; 903.02; 903.1; 903.2; 903.3; 903.5; 903.8; 903.9; 904.2; 904.3; 904.40; 904.42; 904.50; 904.52; 904.54; 904.6; 904.7; 904.8; 904.9.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Applies to utilization screen (see page 4).

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99183: Hyperbaric Oxygen Therapy

The following ICD-9 diagnoses are covered for the Hyperbaric Oxygen Therapy (HBO Therapy) policy (procedure code 99183):

039.0-039.9; 040.0; 444.21-444.22; 526.89; 686.0; 730.10-730.19; 733.40; 903.01; 904.0; 904.41; 909.2; 927.00-927.09; 927.10-927.11; 927.20-927.21; 927.8; 927.9; 928.00-928.01; 928.10-928.11; 928.20-928.21; 928.8-928.9; 958.0; 986; 987.7; 989.0; 990; 993.3; 993.9; 996.52; 996.90-996.99; 999.1.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Applies to utilization parameter (see page 4).

For additional information on this policy, please refer to the October 1996 Medicare Part B Special Issue (p.46).

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96100-96117: Psychological Testing

Medicare claims payment data for Florida indicates that psychological testing (CPT code 96100) has been billed substantially more than those at a national level. As a result, coverage requirements have been developed for psychological testing to ensure that payment is limited to those services which are medically appropriate for the treatment and/or diagnosis of the patient.

Codes included in this policy are:

96100 Psychological testing (includes psycho-diagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS-R, Rorschach, MMPI) with interpretation and report, per hour

96105 Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour

96110 Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report

96111 extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Developmental) with interpretation and report, per hour

96115 Neurobehavorial status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour

96117 Neuropsychological testing battery (e.g., Halstead-Reitan, Luria, WAIS-R) with interpretation and report, per hour

Indications and Limitations of Coverage

Medicare Part B of Florida will consider the above procedure codes medically necessary when they meet the following requirements:

Psychological testing is indicated when the patient has a psychiatric or Central Nervous System (CNS) illness and/or is demonstrating emotional or behavioral symptoms sufficient to suspect an underlying psychiatric or CNS illness.

Assessment of higher cerebral function with medical interpretation, aphasia testing (96105) with interpretation and report per hour is covered provided the history and physical supports the need to ascertain the type, causal factors (s), and the severity of a speech and language disorder. Re-evaluation is covered only if the patient exhibited a change in functional speech or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated speech pathology or for those conditions which are assumed to result in interval changes in language.

Developmental testing; limited (e.g., developmental screening test II, early language milestone screen), with interpretation and report (procedure code 96110) is a noncovered service.

Developmental testing (96111) with interpretation and report, per hour and cognitive testing (96115) with interpretation and report per hour are limited to when an:

abnormality of cognitive functioning is suspected on history and neurological exam, or previous psychological or psychiatric evaluation

history of systemic, developmental, traumatic, toxic or infective etiology indicates a possibility of improvement

treatment plan will be affected by the outcome of testing and clear goals established within specified time of expectations

Re-evaluation is covered where the treatment plan has been in effect and where re-evaluation will affect further treatment plans.

CPT code 96117 describes testing which is intended to describe and diagnose the neurocognitive effects of medical disorders that impinge directly or indirectly on the brain. Examples of problems which might lead to neuropsychological testing are:

detection of neurologic diseases based on quantitative assessment of neurocognitive abilities (e.g., mild head injury, anoxic injuries, AIDS dementia);

differential between psychogenic and neurogenic syndromes (e.g., depression vs. dementia);

delineation of the neurocognitive effects of CNS disorders;

neurocognitive monitoring of recovery or progression of CNS disorders; and

assessment of neurocognitive functions for the formulation of rehabilitation and/or management strategies among individuals with neurologic disorders.

The content of Neuropsychological Testing procedures differs in a large part from that of Psychological Testing (96100) in that Neuropsychological testing consists primarily of individually administered ability tests that comprehensively sample ability domains that are known to be sensitive to the functional integrity of the brain (e.g., abstraction, memory and learning, attention, language, problem solving, sensorimotor functions, constructional praxis, etc.). These procedures are objective and quantitative in nature and require the patient to directly demonstrate their level of competence in a particular cognitive domain. Neuropsychological Testing does not rely on self-report questionnaires such as the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), rating scales such as the Hamilton Depression Rating Scale, or projective techniques such as the Rorschach or Thematic Apperception Test (TAT). These procedures are intended for psychological testing and should be covered under 96100.

Performing Psychological Tests when mental illness is not suspected would be a screening procedure and therefore, not covered by Medicare Part B of Florida.

Each test performed must be medically necessary. Therefore, standardized batteries of tests are not acceptable.

Repeat testing not required for a diagnosis or continued treatment would be considered not medically necessary. Non-specific behaviors which do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing.

Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone (e.g., response to medication) would not require psychological testing, and therefore, would not be considered medically necessary.

Adjustment reactions or dysphoria associated with moving to a nursing facility, do not constitute medical necessity for psychological testing.

Procedure codes 96100-96117 are not covered for Licensed Clinical Social Workers (specialty 80).

Claims submitted for procedures performed at unusually frequent intervals will be reviewed by Medicare to make certain that services were medically reasonable and necessary.

Coding Guidelines

The Folstein Mini-Mental Exam (or similar test) is not separately reimbursable by Medicare Part B of Florida and is included in the clinical interview or evaluation and management service.

CPT codes 96100-96117 should not be reported by the treating psychiatrist for reading a psychologist's report of the psychological testing results. Such reports enter into the medical decision making by the psychiatrist and are, therefore, included in the evaluation and management code for that day.

It should be noted that CPT codes 96100, 96105, 96111, 96115, and 96117 have time applied to these services. If the testing is done over several days, the testing time (including administration, scoring, and interpretation) should be combined and reported all on the last date of service.

Diagnosis Requirements

Procedure codes 96100, 96105, 96111, 96115, and 96117 are covered when they are performed for the diagnoses/conditions of mental disorders (ICD-9 codes 290.0-316). The ICD-9 diagnosis codes must be coded to the highest level of specificity for coverage by Medicare Part B of Florida.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Applies to utilization screen (see page 4).

Medical Record Documentation

The medical record must indicate the presence of mental illness or signs of mental illness for which psychological testing is acceptable as an aid in diagnosis and therapeutic planning. The record must show the date the tests were performed, scoring and interpretation as well as the time involved.

Required documentation in support of medical necessity would include:

History and physical

Office/progress notes

Test results

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What's New for EMC?

Electronic Transmission of Unlisted or Non-Specific Procedure Codes

Good news for providers who want to submit unlisted or non-specific procedure codes electronically that require narrative information (description of services). Some unlisted/non-specific procedure codes can be submitted electronically.

When billing for the unlisted or non-specific procedure codes noted below, the description of service must be submitted electronically in the Narrative record. If your claims submission format is set up (programmed) to submit the narrative record electronically, the description of services will be transmitted along with the claim.

Procedure codes requiring additional documentation such as operative reports, pathology reports or radiology reports will still need to be submitted on paper with the appropriate reports attached. If you are unsure of the need for documentation reports to be attached for processing, call the Provider Customer Service area at (904) 634-4994.

If your system does not offer you the ability to transmit the narrative data fields, please contact your electronic claims software support vendor. If they have not developed the narrative record for your use and they are interested in developing it, advise them the format specifications are available on the Medicare B-Line BBS electronic bulletin board at (904) 791-6991.

For example, procedure code J3490 (in bold in the chart below) is a high-volume code that can be submitted electronically. When submitting electronically, indicate the name of the drug, its strength, and the dosage administered.

The codes that can be submitted electronically are listed below.

Unlisted or Non-Specific Procedure Codes that can be Submitted Electronically

01999;	15999;	17999;	19499;	20999;	21089;	21299;
21499;	21899;	22899;	22999;	23929;	24999;	25999;
26989;	27299;	27599;	27899;	28299;	28899;	29799;
29909;	30999;	31299;	31599;	31899;	32999;	33999;
36299;	37799;	38999;	39499;	39599;	40799;	40899;
41599;	41899;	42299;	42699;	42999;	43499;	43999;
44799;	44899;	45999;	46999;	47399;	47999;	48999;
49999;	53899;	55899;	56399;	58999;	59899;	60699;
64999;	66999;	67299;	67399;	67599;	67999;	68399;

68899; 69399; 69799; 69949; 69979; 76499; 76999;
77299; 77399; 77499; 77799; 78099; 78199; 78299;
78399; 78499; 78599; 78699; 78799; 78999; 79999;
80099; 81099; 84999; 85999; 86849; 86999; 87999;
88099; 88199; 88299; 88399; 89399; 90699; 90749;
90799; 90899; 90999; 91299; 92499; 92599; 93799;
94799; 95199; 95999; 96549; 96999; 97039; 97139;
97799; 99199; 99429; 99499; A0999; A4421; A4641;
A4644; A4645; A4646; A4913; D0999; D2999; D3999;
D4999; D5899; D5999; D6999; D7999; D8999; D9999;
E1399; E1699; J7599; J7699; J7799; J3490; J9999;
L1499; L2999; L3649; L3999; L5999; L7499; L8499;
V2199; V2299; V2399; V2499; V2599; V2629; V2799;
V5299.

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General EMC Information

Understanding the Four Types of Duplicate Checks And Notification

This information will help you understand where duplicate checks take place, how to recognize the type (reports and understanding them), and give you helpful ideas to eliminate them. There are four types of duplicate checks and notification within the electronic environment, which are outlined in this article in the order they occur.

72 Hour Duplicate Check

While your claims transmission/batch is being confirmed/acknowledged, it is also checked to ensure it is not a duplicate of a previous transmission received within the last three days (72 hours). This duplicate check looks for transmissions with identical claim volume totals and transmissions total dollar amounts. If a duplicate transmission is found, you will receive a message on your confirmation/acknowledgment indicating "this is a duplicate of a previous transmission."

If you receive this kind of reject you should check your previous transmissions confirmations/ acknowledgments for the three previous days to see if your transmission/batch was a duplicate.

The majority of the time when this kind of reject is received it is due to a previous transmission/batch being accepted, and you did not receive a confirmation/ acknowledgment, either you or your system attempted to send it again. If you do not receive the confirmation/acknowledgment during the same connection as your claims transmission, and only after attempting to "retrieve/obtain" it during a subsequent connection, you should contact the Help Desk for a verbal confirmation before resubmitting it.

For tips on how to avoid submitting duplicate transmissions/batches, refer to "Avoiding Duplicate EMC Transmissions" article following.

30 Day Duplicate Check

An additional preventative step to reduce unnecessary duplicate transmissions/batches from entering the processing system is the 30 day check. This duplicate check acts in much the same way as the 72 hour duplicate check: it looks for transmissions/batches with identical claim volume totals and transmissions total dollar amounts. It also looks at the first claim in the batch to further identify duplicate transmissions/batches received.

Since this check involves extensive search of data, it is done after the transmission/batch is received. This means you may receive a confirmation/acknowledgment indicating that we received the transmission/batch and accepted it, when it is actually a duplicate transmission/batch within the 30 day block, and rejected. All transmissions/batches failing the 30 day duplicate check are not forwarded to the specified line of business, and reject letters are mailed to sender locations within a week.

When you receive notification that your batch failed the 30 day duplicate check, review your confirmations/transaction acknowledgments and claims transmission summaries to determine which transmission/batch it was a duplicate of, and why you or your system transmitted the duplicate batch. If you are unable to determine why the duplicate batch was transmitted contact your electronic claims submission software support vendor for assistance.

For tips on how to avoid submitting duplicate transmissions/batches, refer to the "Avoiding Duplicate EMC Transmissions" article on page 70.

Duplicate Denials

Claim denials are different from the 72 hour and 30 day duplicate checks which occur prior to the processing system. Claim denials are determined within the claims processing system and are reflected on the Medicare Remittance Notice (MRN). These claims are actually accepted by the processing system within a transmission/batch that was not an exact duplicate (72 hour or 30 day check), but denied on the claim or detail level for services previously paid.

When attempting to determine which claims your denials are duplicates of, the following information should be helpful to resolve when the initial and duplicate claim were submitted.

Identifying Claims Submission Method and Date

Claims are assigned an Internal Control Number (ICN) as they are accepted by the Medicare B processing system. The ICN identifies the method of submission (paper or EMC) and the date they were received (by Julian date). ICNs are indicated on your Medicare Remittance Notice (MRN) and an example of one along with how to determine its method and date of receipt is as follows:

For ICN# 50-6-001-234-56-00
Position: 1-2
Definition: Region; method of claims submission (50-59 = submitted electronically

Position: 3
Definition: Year Received (6 = 1996, 7 = 1997)

Position: 4-6
Definition: Julian Date received; day of the year claim was received (1996 and 1997 enclosed)

Position: 7-9
Description: Batch Number (internal counting method)

Position: 10-11
Description: Sequence Number (internal counting method)

Position: 12-13
Description: Type Claim (internal counting method)(00/original claim, 01-09/split claim, 10-90/review claim)

The portion of the ICN that is significant to you is the region, year and Julian date. This will tell you how and when the claim was received by us. With this you should be able to refer back to the confirmation/acknowledgment along with claims submission summaries to hopefully determine what the source of your duplicate problem is.

High Volume Duplicates Considered Program Abuse

Currently, about six percent of all claims filed to Medicare B of Florida are denied as duplicate claims. And, since the Health Care Financing Administration (HCFA) funds the carrier $1.36 per claim, and Florida processes over 50 million claims annually, this costs the program more than $4.5 million in duplicate claims alone.

With these staggering numbers, Medicare Part B of Florida is certainly taking much more aggressive efforts to work with providers who submit the largest proportions of duplicate claims and are monitoring their progress monthly to ensure rapid progress is being made. Notification letters are mailed to the top 250 abusers monthly. We are also working in partnership with the Medicare Fraud Branch, since this can be considered a form of program abuse, to educate providers about the alternatives to duplicate filing.

As we all work toward eliminating duplicate claim filing, all providers should keep the following in mind:

It is not appropriate to automatically refile claims to Medicare Part B without first obtaining the status of the original claim. Therefore, for those who have automatic refilling of claims capabilities loaded in their software, the capability should be quickly eliminated, or limited to wait at least 45 days from the date the first claim was filed. It is not appropriate to use an automatic refiling system as an alternative to bookkeeping and determining claim status.

Several alternatives to automatically refiling claims include:

Carefully reviewing your Medicare Remittance Notice (MRN) and/or Electronic Remittance Notification (ERN) to reconcile your records.

Contacting the provider customer service telephone lines for the status of specific claims, or, for providers set up to receive Electronic Claim Status (ECS), access your current data that will provide the status of all pending claims (processing has not been completed/not showed up on MRN) 14 days old or older. The status of claims may also be obtained by writing to:Medicare Part B CorrespondenceP. O. Box 2360 Jacksonville, FL 32231

If you received a denial (other than duplicate) on a "Medicare Remittance Notice" (MRN) of one detail line on an original claim, when you correct and re-transmit it, you should only resubmit the denied detail line, not the entire claim. If you submit the entire claim, the details that were paid on the original claim will be denied as duplicates.

If you received an electronic claims reject on an "EMC Error Report" it only lists the detail(s) that caused the reject, when in fact the entire claim rejected. Unlike a duplicate denial when you only need to resubmit the denied detail, the entire claim needs to be resubmitted after correcting it, not just the detail(s) causing the reject. If you do not submit the entire claim the other details without errors will not be processed for payment.

Software Problems

If you determine that for some unknown reason your computer system is inadvertently resubmitting claims without your knowledge, contact your electronic claims submission software support vendor immediately.

We hope this review of duplicates will help you understand any existing problems or concerns you may have and provide you with suggestions to prevent any future problems you may encounter.

For tips on how to avoid submitting duplicate transmissions/batches, refer to "Avoiding Duplicate EMC Transmissions"on page 70.

If you have questions concerning this article, please feel free to contact the Provider Electronic Services (PES) area at (904)791-8767.

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Avoiding Duplicate EMC Transmissions

A duplicate transmission occurs when an EMC sender location submits a batch of claims that were previously submitted and accepted by Blue Cross Blue Shield of Florida. These batches are rejected as duplicates before being routed to Medicare B of Florida for processing.

Several steps are listed below that will help you and your staff avoid transmitting duplicate claim batches:

Keep a log of the date, time, number of claims and total charges for each transmission which should be referenced prior to each transmission.

If you do not receive a confirmation/acknowledgment or if your batch seems to have aborted during transmission within the same connection as your claims transmission, contact the Help Desk at (904)791-9880 for a verbal confirmation prior resubmitting it. You should do this only after attempting to retrieve/obtain your confirmation/acknowledgment during a subsequent connection and are unable to receive it.

If the entire batch rejects on an Medicare B EMC Error Report, after making corrections and before resubmitting them electronically, ensure you don't transmit an exact duplicate batch transmission. You can do this by altering the totals, adding additional claims or by splitting the batch. If you don't alter the batch, it will be subject to the 72-hour and 30-day duplicate check on the front end.

When you are experiencing delays in claims payments, research the status of claims by accessing Medicare B's Express Line/ARU at (904)353-3205 prior to resubmitting a batch. Check a random sample of claims in the batch to see if the claims were received. If the claims are found, then the batch was received and the claims are being processed. If the claims are not found then the batch may not have been received.

If, after you have followed the above tips and it appears that the batch was not received, you can contact the Provider Electronic Services (PES) Reject/EMC Error Report area at (904) 791-6878 to verify if Blue Cross Blue Shield has routed your transmission/batch to Medicare B for processing. Have your sender number and EMC Error Report available when you call.

Software Problems: If you determine that for some unknown reason your computer system is inadvertently resubmitting claims batches without your knowledge, contact your software support vendor immediately.

If you observe the above tips your location should be able to avoid duplicate batch transmission problems. For an in-depth explanation of how the different types of duplicate checks affect EMC senders, refer to the article "Duplicate Problems - Understanding the 4 Types of Duplicate Checks and Notification for EMC Senders."

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Phone Number for the B Line BBS (904) 791-6991

In our January/February 1997 Medicare B Update!, we published an incorrect telephone number for access to the B LINE BBS in an article on ANSI eligibility and response. The correct number for access to the B LINE is (904) 791-6991.

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Mail Box Phone Line Capacity Increases

EDI Services is proud to announce the completion of a significant capacity upgrade for Mail Box telephone lines.

By March 1997, the capacity for all phone lines into the Mail Box system will have increased between 50 percent and 150 percent! Needless to say, this should result in significantly better access and reduced busy signals for all Mail Box users.

EDI Services recognizes that this increase is long overdue and would like to express our appreciation to those users who have been so patient during our expansion efforts. We expect that as of March 1, we will achieve our goal of 98 percent access on the first dial for all Mail Box users. Subsequently, we are asking any Mail Box user experiencing excessive busy signals to call the Customer Support Help Desk at 904-791-9880. As of March 1, the Help Desk will be recording and EDI Services will be evaluating each report of excessive busy signals as part of our continuing effort to supply the best possible service to the Mail Box user community. These reports, in conjunction with the statistical information supplied by our telephone carrier and the Mail Box

system, should allow EDI Services to address current as well as future growth requirements.

Once again, thank you for bearing with us.

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Senders and Vendors: Notify Medicare of Changes

It's important that EMC sender locations notify us of changes related to their electronic software applications. Please review the information below and apply the instructions appropriately.

Address Changes

Any time a provider who sends claims electronically changes physical locations or the mailing address, the Medicare EDI area should be notified. This is the only way that we can ensure your location continues to receive all pertinent information concerning electronic application changes. It is imperative that you complete the "EMC Mailing Address Change Notification" form on page 72 and submit it as soon as you are aware of the address change. This form should also be used to update other location information such as phone numbers, contact, company names, etc.

Refer to page 87 of this issue of the Medicare Part B Update! For the address change form that enables you to update addresses on the Medicare B Provider File, which is used to mail provider checks and the Update!.

Software Support Vendor Change

When an EMC sender changes vendors (software support company), it's important to notify the Medicare EDI area as soon as possible so we can maintain accurate files on your location. Notification is done by submitting a New Electronic Sender Installation/Change of Vendor Form, which was published with completion instructions and requirements on page 57 of the May/June 1996 Medicare B Update!. You are not required to re-test if only your support vendor changed (not the software). If both your software support vendor and software change, you are required to submit a batch of test claims. Notify the Medicare EDI Testing area at (904) 354-5977 when and why the test batch was submitted.

Software, Format or Communication Changes

If a sender location changes its electronic claims submission software format or method of communication from one type to another for any reason, Medicare EDI must be notified immediately. If Medicare EDI is not, you will not be able to transmit your claims. Notification is done by submitting a New Electronic Sender Installation/Change of Vendor Form, which was

published with completion instructions and requirements on page 57 of the May/June 1996 Medicare B Update!. If your software or format changes, you are required to submit a batch of test claims. Notify the Medicare EDI Testing area at (904) 354-5977 when and why it was submitted.

Tax ID Change

If you have changed Tax ID numbers and need your mailbox (means of communication) reconfigured, submit your request by letter (containing old Tax ID#, new Tax ID#, contact name, phone number and fax number) on office letterhead. Send to:

Medicare EDI - 6 Tower
P. O. Box 44071
Jacksonville, FL 32231

You may also fax it to (904) 791-6692. When we change the Tax ID in your mailbox, your password will also change. This will take approximately one week and we will contact you when this is complete.

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Be Aware of Fraud

Billions of taxpayer dollars are lost annually to health care fraud and abuse, money which should be paid to legitimate providers and suppliers for actual services provided to keep our seniors in good health. The Medicare Fraud Branch is aggressively dealing with these issues along with the Health Care Financing Administration (HCFA), the Federal Bureau of Investigation, the Office of the Inspector General, the Medicaid Fraud Control Unit, the Durable Medical Equipment Regional Carrier, and the United States Attorney's Office just to name a few. We have also joined forces with the Florida Medical Association, the Cuban Medical Association, the Florida Chiropractic Association, and many other provider and beneficiary advocacy associations. Outreach education is one of the various methods utilized to reach our physician and supplier communities. Stay abreast of these issues to avoid becoming a victim yourself. Please report suspected fraud and abuse, be a part of the solution rather than the problem. Remember, it is difficult to compete with someone who has more to offer illegitimately and who is actually harming our seniors in this state.

Providers who suspect fraud and abuse may call the Medicare Provider Customer Service lines at (904) 634-4994, or they may write to:

Medicare Fraud Branch
P.O. Box 45087
Jacksonville, Florida 32231-0048

All reports are held in the strictest confidence, and the concerned individual will not be exposed. We at the Fraud Branch are indebted to our providers and suppliers who have identified scams in the community and reported them to us.

Providers please be advised, should any of your patients report that they may have lost or had their Medicare card/number utilized by someone else, please advise them to report this to their local Social Security Office and to the Medicare Fraud Branch.

Medicare Program Safeguards Division Annual Results

April 17, 1995, was a significant date in the history of the Medicare Program in Florida; it was on that date that the Program Safeguards was created. The division's main purpose is to improve the cost effectiveness of the traditional Medicare program for HCFA by influencing the behavior of health care providers and beneficiaries in Florida and aggressively preventing, detecting and recovering inappropriate health care costs.

Some of the activities and major accomplishments of the individual departments within Program Safeguards during 1996 are noted here.

Provider Audit and Reimbursement Department (PARD)

PARD's primary purpose is to determine payment percentages for Medicare Part A providers, reconcile Medicare and Medicaid cost reports, present provider workshops on current Medicare Part A issues and the respective cost report preparation and filing.

During 1996, PARD reviewed and finalized/settled 673 Medicare cost reports and 468 Medicaid cost reports. These audits recovered approximately $76 million in non-reimbursable Medicare costs and reduced Medicaid's liabilities by approximately $66 million. During 1996, multiple workshops were held for various specialties, such as Comprehensive Outpatient Rehabilitation Facilities, Outpatient Physical Therapy providers, Community Mental Health Centers, Hospitals and Skilled Nursing Facilities.

Medicare Registration Department (MRD)

MRD's primary purpose is to ensure that all providers in Florida who request a Medicare provider number meet all HCFA and state requirements. During 1996, MRD has conducted on-site visits at providers' locations/addresses to ensure that state and federal guidelines are met and to validate the information supplied on the provider application form. MRD also maintains and updates all providers registered with this carrier in Florida.

A total of 792 on-site validation visits were performed during 1996, which resulted in a savings of $1.2 million to the Medicare

program in Florida. This came as a result of denying claims submitted from providers who MRD determined to be ineligible for Medicare payment.

Financial Services Department (FSD)

The FSD's primary purpose is to request, collect and manage all refunds from any provider or beneficiary who may have incorrectly received Medicare reimbursement. The FSD also handles all inquiries received as result of a request for a refund and handles the recovery of such refunds, which may include referral to the federal government as "uncollectible".

The Financial Services Department recovered over $37 million dollars last year through their various activities. Approximately 60 percent of the refunds were because of requests initiated by the medical review or the fraud departments.

Medicare Secondary Payer Recovery Department (MSPRD)

MSPRD's primary purpose is to identify all incorrect payments which have been made because of Medicare being incorrectly identified as the primary payer. These situations generally involve beneficiaries who were covered through a group health plan based on employment status, beneficiaries involved in auto accidents, or any other situation in which Medicare was not the primary payor.

Last year, the MSPRD identified and recovered approximately $18 million dollars in mistaken Medicare payments.

Medical Affairs Department

The Medical Affairds Department, which encompasses the Carrier Medical Director and staff, has the primary purpose of coordinating the necessary changes in medical policy with the appropriate medical societies, the HCFA, and all other appropriate state and federal entities.

Medical Utilization Analysis Department (MUAD)

MUAD's primary purpose is to create local medical policy which deals primarily with in-state issues and to ensure compliance with HCFA guidelines. This department also uses a focused medical review process to identify procedure codes which tend to be performed at a higher rate in Florida than nationally. After identifying and researching the issue, local medical policy is developed to explain, correct and/or address the aberrancy.

Approximately $128 million was saved during 1996, as a result of medical policy limitation screens leading to claim reviews for medical necessity, diagnosis requirement audits and claim-by-

claim reviews of certain providers which have been identified as being aberrant.

Utilization Audit Department (UAD)

UAD's primary purpose is to perform the comprehensive medical reviews of claims submitted by providers, which have been identified as being aberrant through statistical analysis. Also, the UAD analyzes the claims submitted by providers who have been placed on review based on previous billing patterns, monitors for assignment violations, and reviews other issues as identified by internal departments or the HCFA.

During 1996, approximately $13.7 million was requested as overpayments based upon comprehensive medical reviews which were preformed, and an additional $1.8 million was saved as a result of the review of specific providers.

Data Analysis Department (DAD)

This department's purpose is to use analytical means to identify providers who require further investigation and possibly referral to proper law enforcement entities. The DAD also assists the Medical Utilization Analysis Department with the identification and analysis of identified aberrant procedures, and working various data requests received from law enforcement agencies.

All of the activities performed within the Program Safeguards Division are directly dependent upon the data and analytical tools/skills of this department.

Carrier Fraud Branch

The Fraud Branch's staff is divided into two specific functional areas: operational and investigative functions. The operations division researches and analyzes beneficiary and provider fraud complaints, and the investigations area handles referral of potentially fraudulent providers to appropriate law enforcement agencies. The investigative staff is also responsible for all follow-up activities, including court testimony, data requests, and so on. The units handle issues from beneficiaries, carrier staff, and HCFA.

During 1996, the operations area responded to approximately 16,000 fraud complaints received from Florida providers, beneficiaries or their families/care givers. The investigations area was responsible for approximately $66.5 million in Medicare savings, generated from overpayment refund requests, placing a hold on the claims submitted by providers who have been referred to the appropriate law enforcement agency, requesting the denial of claims submitted by providers who have been determined to be ineligible to bill the Medicare program, causing the denial of claims submitted which involve lost or stolen Medicare

cards/numbers, and through fines and restitutions ordered against providers as a result of a settlement action or court decision.

National Medicare Fraud Alert

Please report any information about the following activities to the Medicare Fraud Branch at the phone number and address listed in the introduction of the fraud section, or to your Durable Medical Equipment Regional Carrier.

It has been noted that some free-standing and hospital based ESRD facilities are entering into agreements with other entities for the performance of laboratory studies which have already been reimbursed to the facility as included in the monthly capitation.

A home health care agency has been identified submitting claims to Medicare Part A & B for services for deceased beneficiaries. Remember physicians must sign the plan of treatment for beneficiaries related to home health, assure yourself they are still your patient.

Psychologists and psychiatrists have been identified as billing Medicare/Medicaid as if the psychotherapy services were personally provided, when the services were actually provided by social workers and nurses. In addition, services were "upcoded" to maximize reimbursement.

A number of durable medical equipment suppliers have been identified as billing the DMERC's for therapeutic ventilators and justifying the medical necessity with false diagnoses. Before releasing them to suppliers, physicians should always make a copy of all Certificates of Medical Necessity that they sign for their patients.

Visual aid devices are reportedly marketed to visually impaired Medicare beneficiaries as being a covered Medicare service. Additionally, providers are being told that these devices are covered related to an Administrative Law Judge ruling/order. These devices work like overhead projectors by imputing an enlarged image on the TV screen. These devices have been marketed under the names of Telesensor, Aladdin, or Closed Circuit Television Magnification (CCTM). Be advised that these are NOT covered devices under the Medicare program.

Multiple issues have surfaced involving transtelephonic pacemaker monitoring services. A company is reportedly using random physician UPIN's as the referring physician on the claims. This has been causing payment for services for services which are not medically indicated or necessary.

An investigation has uncovered a scheme in which a physician is overutilizing lab studies which are not medically indicated. The physician purchased the lab equipment and is performing the same services on a majority of his patient population, without regard to the medical need for such services. Tests such as strep screens, thyroid panels and amylase levels are involved.

Multiple providers have been identified as performing the same or similar cardiac studies on the same Medicare beneficiaries within short spans of time, all of which are not medically necessary. Echocardiography is billed on one day and a variety of other doppler studies on another day, usually on the day prior to the echo in an effort to reduce the likelihood of the claim being reviewed for medical necessity.

Multiple physician provider types have been identified as billing excessive osteopathic manipulations, excessive physical medicine services, and intermediate level office visit codes on multiple beneficiaries. This scheme involves providing such services multiple times per week, and includes the addition of physical medicine services such as; hot packs, cold packs, electrical stimulation and ultrasound services.

An investigation conducted by an OIG Field Office identified a scheme where DME suppliers were paying kickbacks to podiatrists for Medicare patient referrals, and for the names and numbers of the podiatrists' Medicare beneficiaries. The supplier then submits claims electronically for lymphadema pumps using bogus diagnosis codes. This type of therapy is not a common therapy used by podiatrists.

Several neurologists have been identified as routinely billing for a four extremity electromyogram study while actually conducting nerve conduction studies. These neurologists were also "upcoding" the office visit codes to generate even more revenue.

A number of consulting firms have been identified as offering to maximize billings for radiology, emergency room, and laboratory services by discovering and correcting coding "errors" in return for a percentage of the increased revenues. The carrier realizes that there is little incentive for consultants to correct coding errors which do not increase their consulting fees. However, the consultants at issue in this scheme are initiating and promoting fragmented billings as a method of revenue generation. Providers must be aware of the correct coding rules and should they have concerns related to a practice being recommended, make contact with the carriers provider relations or medical policy staff.

Multiple physicians throughout the United States have been identified as billing for myocardial perfusion imaging tests,

which require the use of nuclear medicine products, as if they were performed from a individual practice setting. This practice is not common because of the cost, regulations, licenser issues and time involved in providing such services. These are generally preformed in a hospital, large clinic, or specialty group practice. The CPT codes at issue in this scheme included 78460 & 78461, which were actually non-rendered services billed to the Medicare program.

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Important Information About Hearings

To offset increasing travel costs, Medicare Part B of Florida Hearing Officers can no longer travel as extensively to conduct in-person hearings. As a result, all in-person hearings will be scheduled in accordance with Medicare guidelines at a "mutually" convenient location. This location will require the appellant and the Hearing Officer to travel approximately the same distance.

As an alternative to the in-person hearing, Medicare Part B of Florida now offers the option of conducting hearings through the use of video teleconferencing technology. The carrier has recently been approved to serve as a pilot for the performance of hearings via teleconference. An appellant will be able to speak with and see the Hearing Officer during a hearing, and provide the same rights to all parties as an in-person hearing.

Video teleconference hearings can be conducted from Blue Cross and Blue Shield branch offices in Miami, Ft. Lauderdale, Tampa, Orlando, and Pensacola. Participation is strictly voluntary; however, since video teleconference hearings do not require extended travel, they can be scheduled and performed more timely than in-person hearings. If you would like more information on the video teleconference hearing program, please contact the Medicare Part B Hearings department at (904) 791-6858.

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Independent Laboratories Try to Protect Against Financial Liability for Denied Laboratory Tests

The March/April 1996 Medicare Part B Update! cover article "Automated Laboratory Profile Changes" advised that providers should target their test ordering to only those tests that are related to specific symptoms or disease conditions. The intent of this policy is to ensure that the Medicare program is only used for problem pertinent testing. Medicare does not usually reimburse for testing related to screening only. If the carrier questions the medical necessity for testing, it would expect that the justification for ordering the test(s) would be evident in the patient's records. There should be some clear connection between the test(s) ordered and the condition or symptom at issue.

The article also advised that the carrier would perform a random audit on automated multichannel tests to verify medical necessity of each test within the profile. At the time of the audit for medical necessity, the carrier would request one or more of the following from the ordering/referring physician:

the diagnosis code

other supportive documentation (such as office records) from the physician which indicates the patient's condition, or,

other physician notes which indicate need for testing.

This does not mean that the carrier now requires diagnosis information to process claims for automated multichannel tests. The carrier does not routinely require diagnosis information from non-physician practitioners (e.g. independent laboratories). A diagnosis may, however, be required if local medical policy or Health Care Financing Administration (HCFA) policy is established and published requiring specific diagnosis criteria be met in order to obtain Medicare reimbursement.

Finally, laboratories were advised of the financial liability for any tests not considered medically necessary during the audit process.

Because of the risk of financial liability, some laboratories now feel it is necessary to require physicians to supply medical necessity information (i.e. diagnosis) at the time of request for laboratory testing. Additionally, some laboratories may request an agreement with physicians in which the physicians would ultimately accept financial responsibility should an overpayment request occur. Understandably, laboratories are making these types of changes to protect themselves from financial risk. But Medicare currently is not mandating the submission of a diagnosis with every multichannel test.

Obtaining Medical Records is Sometimes a Difficult Task

As stated above, Medicare may require independent laboratories to supply office records, progress notes etc. in support of payment for a claim when the medical necessity or frequency is at issue. Obtaining the patients' medical records may be challenging but Medicare considers the billing provider (in this case the laboratory) responsible for the task. Physicians must keep in mind that in most cases, without the patient's medical records, laboratories will not be able to obtain a complete review or hearing. Medicare is asking physicians to cooperate with the laboratories in providing patient records so that a fair and complete evaluation of the test(s) at issue can be achieved.

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Extension to the ESRD MSP Provision

The Health Care Financing Administration (HCFA) has further extended the filing time frame for services to ESRD Beneficiaries submitting initial claims for services provided between August 10, 1993, and September 30, 1994.The normal time limit for these services would have expired on December 31, 1995. The time frame was first extended until June 30, 1996, and again extended until December 31, 1996. Because litigation is still pending, a third extension has been issued to June 30, 1997.

An article published in the July/August 1995 issue of the Medicare B Update! (page 57) discussed the Health Care Financing Administration's position on payment of claims for beneficiaries who have End Stage Renal Disease (ESRD). The article provided the original information advising that the HCFA extended the time frame to allow all interested parties time to become aware of the legislative changes. Please see the following articles for additional information on the OBRA provision:

July/August 1995, pg. 57

March/April 1996, pg. 66

September/October 1996, pg. 67.

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Provider of Service Must Bill Medicare

The carrier has received numerous complaints recently that laboratories are asking physicians to bill Medicare directly for services ordered. For example, the physician would order a complete blood count (CBC) from an independent laboratory. The lab would perform the testing, but would bill the physician directly, not Medicare.

The scenario is inappropriate because the physician did not perform the test, and therefore cannot represent and bill for the CBC as his/her personal service. The provider of the service (in this case, the laboratory) must bill for the test.

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Teaching Physicians: Exception for E/M Services Furnished in Certain Primary Care Centers

The September/October 1996 issue of the Medicare B Update! (page 27) article "New Guidelines for Teaching Physicians" stated that in certain situations, Medicare will pay teaching physician claims for services furnished by residents without the presence of a teaching physician. When a Graduate Medical Education (GME) program is granted the exception, it applies to the following E/M codes.

New Patient	Established Patient
99201	99211
99202	99212
99203	99213

For a complete discussion of Medicare's teaching physician policy, see page 27 of the September/October 1996 Medicare B Update!.

A number of providers have asked who would be an appropriate individual to make the request on behalf of the residency program and what constitutes an acceptable request for the exception. Medicare Part B believes that few people should be making the request for the exception. An example of an appropriate person to request the exception is the Residency Department Chairman, or similar person.

The sample letter on the next page would be acceptable for teaching physician facilities to use when requesting the exception to certain E/M services. Remember that all of the conditions outlined in the letter on the next page must be met for the exception to be granted.

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Overpayment Interest Rates

Medicare Part B assesses interest on overpaid amounts which are not refunded in a timely manner. The interest rate was implemented to help ensure the timely repayment of overpaid funds due to the Medicare program.

The interest rate is based on the higher of the following rates: the Private Consumer Rate (PCR) or the Current Value of Funds (CVF). The following table lists the current interest rates assesed to overpaid funds.

Period	Interest Rate
April 4, 1995 - July 10, 1995	14.125%
July 11, 1995 - October 23, 1995	14.000%
October 24, 1995 - January 29, 1996	13.875%
January 30, 1996 - April 29, 1996	13.75%
April 30, 1996 - July 18, 1996	13.625%
July 19, 1996- October 23, 1996	13.50%
October 24, 1996 - January 22, 1997	13.375%
January 23, 1997 to present	13.625%

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Sample Letter for Teaching Facilities to Request the Exception to Certain E/M Services

Dear Medicare Part B:

The (University name) located at (address of facility) would like to apply for the exception for the low-level E/M services furnished without the presence of a teaching physician. In accordance with the new Health Care Financing Administration/Medicare Teaching Physician regulations, the (University name) attests that all of the following conditions are met for our residency program:

The services are furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's fiscal intermediary. The residency program understands that this requirement is not met when the resident is assigned to a physician's office away from the center or makes home visits. In the case of a nonhospital entity, the carrier should verify with the fiscal intermediary that the entity meets the requirements of a written affiliation agreement between the hospital and the entity.

Any resident furnishing the service without the presence of a teaching physician has completed more than six months of an approved residency program. The residency program understands that it is expected to maintain verification of this information.

The teaching physician in whose name the payment is sought must not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must:

Have no other responsibilities at the time of the service for which payment is being sought;

Assume management responsibility for those beneficiaries seen by the residents;

Ensure that the services furnished are appropriate;

Review with each resident during or immediately after each visit, the beneficiary's medical history, physical examination, diagnosis, and record of tests and therapies;

Document the extent of his or her own participation in the review and direction of the services furnished to each beneficiary.

The parties seen are an identifiable group who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of teaching physicians. The residents must generally follow the same group of patients throughout the course of their residency program, but there is no requirement that the teaching physicians remain the same over any period of time.

The range of services furnished by residents include all of the following:

Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;

Coordination of care furnished by other physicians and providers;

Comprehensive care not limited by organ system or diagnosis.

The services provided by the residency program are performed at(insert name/address of facility).

Sincerely yours,

Signature of Residency Department Chairman or Chairwoman, or other appropriate person

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Getting Your Claims Processed Correctly - The First Time

The Medicare Part B program is working together with the Florida Medical Association and state specialty and county medical societies to inform the medical community how to avoid unnecessary Medicare denials. By following these simple tips, you could avoid the need to refile your claims or request reviews for these common denials. Currently, the Medicare Carrier has identified the following procedures/billing practices which resulted in over 200,000 unnecessary denials during a recent one-month period.

Reason #1: Diagnosis Not Payable for Service Billed

This denial occurs when the ICD-9 diagnosis code billed is not considered "covered" for the procedure rendered. This means the Medicare Carrier will only pay the service for certain ICD-9 diagnosis codes.

The top codes affected during the time frame studied were:

Chest x-rays: (procedure codes 71010 - 71035);

Clinical laboratory codes: 80162 (digoxin), 82270 (occult blood), 82378 (CEA), 82728 (ferritin), 82746 (serum folic acid), 82985 (glycated protein), 83036 (glycated hemoglobin), 83540 (iron), 83550 (iron binding capacity), 84153 (PSA), 84466 (transferrin), 85610-85652 (prothrombin time, non-automated erythrocyte sed rate, automated erythrocyte sed rate), 86149 (CEA - gel diffusion), 86151(CEA - RIA or EIA), 86316 (immunoassay for tumor antigen),86592-86593 (syphilis qualitative or quantitative), 87086-87088 (urine cultures), 88150-88157 (pap smears), 88348 (electron microscopy; diagnostic);

EKG's: (93000-93010).

While some of these denials are appropriate based on current Medicare policy, many are billing errors which can be avoided by:

Referencing the Medicare B Update! ;

Accessing the Medicare Bulletin Board System (BBS)

Purchasing a Procedure/Diagnosis Relationship Report booklet ($15.00 + tax) from the Medicare Carrier;

Calling the Medicare Part B Automated Response Unit at (904) 353-3205; or

Calling the Medicare customer service area at (904) 634-4994

The diagnosis listings obtained from these resources are intended to serve as tools to assist providers by outlining coverage guidelines. They are also designed to limit a provider's financial liability for services subject to diagnosis criteria. In cases where the service is rendered for a condition/illness other than those indicated, an acceptable advance notice of Medicare's denial of payment must be given to the patient if the provider does not want to accept financial responsibility for the service or item. For additional information on the Advance Notice Requirement, see page 4.

Note: In general, services performed for screening purposes are not covered by Medicare Part B. Services billed with screening diagnoses (e.g., V72-V72.7) will be denied payment. The patient may be held financially liable for any denied charges.

The use of these resources solely to maximize payment for services which would otherwise be denied due to a lack of medical necessity will be considered fraudulent activity, and the provider will be subject to civil and/or monetary penalties, exclusion from the Medicare program, or both.

Reason #2: Diagnosis Reference Code Not Indicated.

When an ICD-9 diagnosis code is reported on the claim form, the reference code in block 21 (1, 2, 3 or 4) must be recorded in block 24e, not the ICD-9 diagnosis code. By putting the reference code number on the same line as the service, Medicare will know which condition (ICD-9 diagnosis code) warranted the service. If the actual ICD-9 diagnosis code is reported in block 24e the service will be denied payment.

Note: The diagnosis reference code requirement is applicable whether the claim is filed on paper or electronically.

Example:

Reason #3: Didn't Indicate The UPIN of the Referring/Ordering Physician.

When billing for laboratory services (80002-89399, G0001, G0058-G0060), consultations (99241 - 99275), radiology services (70010-79999) or diagnostic services (90600-90654, 90900-92260, 93000-93350, 93555-94799, 95805-95999) the UPIN of the referring/ordering physician must be indicated - even if that physician is you!

Note: The UPIN directory is the most popular application on the B-Line BBS. This directory includes the UPIN of all registered providers in the state of Florida.

Reason #4: Didn't Indicate if Service was Purchased

The following types of services can be purchased: Radiology and diagnostic services and anatomical pathology. The easiest way to know whether a service can be purchased is to look in the Medicare fee schedule book. If the procedure has a combination of three prices (one for the TC, 26 and no modifier), the service can be purchased. If you did both the test and the interpretation yourself, that means you are billing globally so you must check "NO" in block 20. If you bought the technical component (the actual test) block 20 must be checked "YES" and you must indicate the price you paid or the acquisition cost in block 20. You must also indicate who you purchased the test from in block 32. In either situation, failure to complete block 20 will result in a denial.

Note: If you are billing electronically, there are fields which you are required to complete which are identical to the paper claim requirements.

A comprehensive article on procedure codes subject to the purchased diagnostic test rules can be found on page 35 of the January/February 1997 Medicare B Update!

Example of a chest x-ray provided as a global service:

Example of a chest x-ray provided as a purchased technical service:

Reason #5: Allowance Included in Payment Made for Surgery/Procedure.

When billing for medically necessary evaluation and management services (99201 - 99499: visits, consultations, etc.) within the post-operative period of a surgical procedure, there are several rules that you must remember:

1. If the purpose of the visit was to perform a surgical procedure and it is an established patient, you cannot charge for the visit - only the surgery.

2. If the visit is provided on the same day but is unrelated to the surgery (i.e., a significantly, separately identifiable reason), a 25 modifier must be reported with the visit. In addition, the appropriate ICD-9 diagnosis code must be indicated in block 21, and the reference code must be entered in block 24e.

3. If a decision to perform surgery is made during an encounter, and a major surgical procedure is performed on the same day, (i.e., usually in an emergency situation) a 57 modifier must be reported with the visit/consultation.

4. If the visit is provided on a separate day during the post-operative period of a previous surgery and is unrelated to the surgery (i.e., a separate significantly identifiable reason), you must put a 24 modifier on the visit and indicate the appropriate the ICD-9 diagnosis code (block 21) and the reference code (block 24e) for the ICD-9 diagnosis code.

Note: For a complete description of modifiers 24, 25 and 57, refer to the 1997 CPT-4 book.

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Updates To The Medigap Insurer Listing

In an effort to maintain current Medigap insurer data, ongoing insurer updates are performed. These updates include address corrections, assigning new Medigap Insurer numbers, and change of status (i.e. Exempt). The following updates have been performed. Please make the necessary corrections in your April 1996 Special Issue "Medigap Crossover Insurer Listings".

Number: 42194 Insurer Name: AMALGAMATED LIFE PO BOX 1442 NEW YORK NY 10116
Number: 20020 Insurer Name: BANKERS FIDELITY PO BOX 190240 ATLANTA GA 31119
Number: 42090 Insurer Name: BANKERS TRUST 222 MERCHANDISE MART CHICAGO IL 60654
Number: 15111 Insurer Name: BLUE SHIELD OF CALIFORNIA PO BOX 272560 CHICO CA 95927
Number: 42032 Insurer Name: BLUE SHIELD OF NEW YORK 3 PARK AVE NEW YORK NY 10016
Number: 52008 Insurer Name: BLUE SHIELD OF TENNESSEE PO BOX 98 MEMPHIS TN 38103
Number: 19393 Insurer Name: CELTIC LIFE INSURANCE PO BOX 46337 MADISON WI 53744
Number: 42007 Insurer Name: EMPIRE BCBS OF NY 3 PARK AVE NEW YORK NY 10016
Number: 24036 Insurer Name: FEDERATED MUTUAL INS PO BOX 50487 INDIANAPOLIS IN 46250
Number: 19688 Insurer Name: HEALTH OPTIONS CTRL REG PO BOX 44254 JACKSONVILLE FL 32231
Number: 19207 Insurer Name: HEALTH OPTIONS WEST REG PO BOX 45277 JACKSONVILLE FL 32231
Number: 37018 Insurer Name: IMPERIAL CASUALTY INDEMINITY 1905 HARNEY STREET OMAHA NE 68102
Number: 19811 Insurer Name: JOHN ALDEN PO BOX 829509 SOUTH FLORIDA FL 33082
Number: 59020 Insurer Name: MIDWESTERN NATIONAL INS 2700 MIDWEST DR ONALASKA WI 54650
Number: 58017 Insurer Name: MOUNTAIN STATE BCBS PO BOX 7026 WHEELING WV 26003
Number: 53128 Insurer Name: NATIONAL HEALTH INS CO PO BOX 61999 DALLAS TX 75261
Number: 23151 Insurer Name: UNITED CHAMBERS PO BOX 3048 NAPERVILLE IL 60566
Number: 48121 Insurer Name: UNITED SECURITY ASSURANCE PO BOX 99 SOUDERTON PA 18964

New Medigap Insurer Number

Number: 18056 Insurer Name: CHAMPION HEALTH CARE 7406 FULLERTON ST #200 JACKSONVILLE FL 32256

Medigap Insurer Name/Address Change

Number: 31004 Former Insurer Name: BLUE CROSS MEDEX Change to: BCBS OF MASSACHUSETTS PO BOX 1996 BOSTON MA 02106

Number: 48059 Former Insurer Name: PROVIDERS FIDELITY Change to: LONDON LIFE REINSURANCE PO BOX 1120 BLUE BELL PA 19422

Number: 56001 Former Insurer Name: BCBS OF SW VIRGINIA Change to: TRIGON BLUE CROSS BLUE SHIELD PO BOX 13087 ROANOKE VA 24031

Medigap Insurer Numbers Changed to Exempt

The following Medigap Insurer Numbers have been changed to an Exempt status. We will not cross over Medicare payment data to these Medigap insurer numbers. Please change the N to an Y in your Update.

Number: 19753 Insurer Name: ACCIDENT & HEALTH AGENCY
Number: 56042 Insurer Name: ACT MANAGEMENT CORP
Number: 61070 Insurer Name: AFGE HEALTH INS
Number: 61003 Insurer Name: AFGE HEALTH INS DEPT
Number: 61066 Insurer Name: AFGE HEALTH BENEFIT
Number: 23120 Insurer Name: AMALGAMATED
Number: 19358 Insurer Name: AMALGAMATED LABOR LIFE
Number: 23133 Insurer Name: AMERICAN BEN CORP
Number: 23093 Insurer Name: AMERICAN BENEFIT
Number: 53067 Insurer Name: AMERICAN BENEFIT PLAN
Number: 15100 Insurer Name: AMERICAN BENEFIT PLAN
Number: 33028 Insurer Name: AMERICAN FAMILY INS
Number: 48125 Insurer Name: AMERICAN HEALTH ADM
Number: 19705 Insurer Name: AMERICAN LIFE AND HEALTH
Number: 23152 Insurer Name: AMERICAN PROFESSIONAL INS
Number: 19930 Insurer Name: AMERICAN SECURITY INS CO
Number: 53094 Insurer Name: ARCADIA NAT L LIFE
Number: 20050 Insurer Name: ATLANTA CASUALTY CO
Number: 15015 Insurer Name: BAY PACIFIC
Number: 49004 Insurer Name: BENEFICIAL STANDARD
Number: 26013 Insurer Name: BRENNCO BENEFITS ADMIN
Number: 23170 Insurer Name: CENTRAL ILLINOIS DISTRICT
Number: 59039 Insurer Name: CENTRAL LIFE INSURANCE
Number: 19699 Insurer Name: CENTRAL LIFE INSURANCE
Number: 53056 Insurer Name: CHRISTIAN BROTHERHOOD
Number: 15075 Insurer Name: CONTINETAL INS CO
Number: 42202 Insurer Name: CORPORATE HEALTH SERVICES
Number: 19835 Insurer Name: CRIMMS SELF INS FUND
Number: 24055 Insurer Name: EMPIRE BENE
Number: 27007 Insurer Name: EMPLOYMENT BENEFIT
Number: 19816 Insurer Name: FIRST CHOICE INSURANCE
Number: 23192 Insurer Name: GENERAL BOARD OF PENSION
Number: 42049 Insurer Name: GENERAL BUILDING LABOR
Number: 53012 Insurer Name: GENERAL LIFE ACCIDENT
Number: 40063 Insurer Name: GRAND UNION COMPANY
Number: 15081 Insurer Name: GREAT AMERICAN INS
Number: 53075 Insurer Name: GREAT S LIFE INS CO
Number: 19464 Insurer Name: GULF LIFE MET
Number: 20069 Insurer Name: HARTFORD
Number: 48091 Insurer Name: HARTFORD ACCIDENT
Number: 19240 Insurer Name: HARTFORD INSURANCE
Number: 40042 Insurer Name: HARTFORD LIFE
Number: 23121 Insurer Name: HARTFORD LIFE

Number: 20095 Insurer Name: HEALTH CARE PARTNERS
Number: 19431 Insurer Name: HEALTHWIN
Number: 16003 Insurer Name: HEALTHWIN HMO
Number: 19618 Insurer Name: HEWIT COLEMAN
Number: 42213 Insurer Name: HIP HMO OF GREATER NY
Number: 53120 Insurer Name: INTERNATIONAL CLAIM SVCS
Number: 25013 Insurer Name: ISSI
Number: 45145 Insurer Name: JOHN ALDEN LIFE
Number: 61022 Insurer Name: KAISER FOUNDATION
Number: 19038 Insurer Name: LIFE & CASUALTY
Number: 19186 Insurer Name: LINCOLN NATIONAL
Number: 16019 Insurer Name: LINCOLN NATIONAL
Number: 19386 Insurer Name: MASSACHUSETTS MUTUAL
Number: 56014 Insurer Name: MASSACHUSETTS MUTUAL
Number: 31053 Insurer Name: MEDTAC-CLAIM CENTER
Number: 23117 Insurer Name: MONY
Number: 33045 Insurer Name: MUTUAL BENEFIT
Number: 23183 Insurer Name: N N INVESTORS LIFE
Number: 15071 Insurer Name: NATIONWIDE
Number: 19622 Insurer Name: NATIONWIDE
Number: 17029 Insurer Name: NEW YORK LIFE
Number: 28010 Insurer Name: NEW YORK LIFE
Number: 30033 Insurer Name: NEW YORK LIFE
Number: 42229 Insurer Name: NEW YORK LIFE
Number: 35035 Insurer Name: NEW YORK LIFE
Number: 19761 Insurer Name: NEW YORK LIFE
Number: 61058 Insurer Name: NEW YORK LIFE
Number: 19741 Insurer Name: NEW YORK LIFE INS
Number: 20025 Insurer Name: NEW YORK LIFE INS CO
Number: 15095 Insurer Name: NEW YORK LIFE
Number: 42234 Insurer Name: NEW YORK LIFE INS CO
Number: 42235 Insurer Name: NEW YORK LIFE INSURANCE
Number: 23052 Insurer Name: NEW YORK LIFE INSURANCE
Number: 23140 Insurer Name: NORTH AMERICAN LIFE
Number: 23166 Insurer Name: NORTHERN TRUST CO
Number: 23136 Insurer Name: NORTHEST NATIONAL LIFE
Number: 30073 Insurer Name: NY LIFE INSURANCE
Number: 15056 Insurer Name: PENN GENERAL SERVICES
Number: 19100 Insurer Name: PENN GENERAL SERVICES
Number: 19773 Insurer Name: PENN GENERAL SERVICES
Number: 20063 Insurer Name: PENN GENERAL SVC
Number: 50015 Insurer Name: PEOPLES LIFE INS
Number: 33034 Insurer Name: PHYSICIAN S OF MINNSOTA
Number: 42174 Insurer Name: PREFERRED CARE GOLD
Number: 19801 Insurer Name: PRIMARY CARE HEALTH
Number: 19932 Insurer Name: PROTECTIVE LIFE INS
Number: 45100 Insurer Name: PROVIDENT
Number: 53023 Insurer Name: REPUBLIC NATIONAL LIFE
Number: 56024 Insurer Name: ROYSTER CO/PROVIDENT
Number: 19616 Insurer Name: SECURITY HEALTH AGENCY
Number: 19396 Insurer Name: SENIOR MEDIPLUS
Number: 42195 Insurer Name: SMITHTOWN GCC RISK MGMT
Number: 23035 Insurer Name: SQUAR D CORP PENSION DPT
Number: 19430 Insurer Name: STATE MUTUAL LIFE
Number: 23171 Insurer Name: TOTAL CARE
Number: 56035 Insurer Name: TOTAL PLAN ADMIN
Number: 15074 Insurer Name: TRANSAMERICA

Number: 19365 Insurer Name: USF & G
Number: 19934 Insurer Name: U.S.F.G.
Number: 53118 Insurer Name: UNDERWRITERS ADJ COMPANY
Number: 23115 Insurer Name: UNITED STATES LIFE INS
Number: 15096 Insurer Name: US LIFE INS CO
Number: 53072 Insurer Name: US LIFE INSURANCE
Number: 19245 Insurer Name: VERTICH INS AGENCY
Number: 23097 Insurer Name: WESTERN GENERAL SERVICE

BCBS Rochester New York Insurer #42012

BCBS of Rochester New York policies are primarily complementary which do not qualify as a Medigap crossover. As a result, we will no longer crossover claims to BCBS of Rochester through Medigap Insurer Number 42012.

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Notify Medicare Registration of Changes

Providers should notify the Medicare Registration Department whenever any changes occur which affects information supplied on their original provider application. This includes but is not limited to name, address, phone number, group membership, etc. This department should be apprised of changes as soon as possible. Providers who fail to notify the Medicare Registration Department in a timely manner may subject themselves to temporary cancellation and/or denial of all claims pending. Notification of provider changes should be submitted in writing on the providers letterhead signed by the provider. Providers should also include the provider number which would be affected by the change. A change of address request should be accompanied by the appropriate occupational licenses for the new address.

Physicians who have signed a Reassignment of Benefits form or who are members of groups should notify Medicare Registration when they are no longer employed or affiliated with these groups. However, group providers should also notify our department of any changes. Many physicians do not report when they leave a group practice; in this case, the group is able to use the physician's provider number long after the physician has left the group. Ask yourself this question; would you allow a business to continue to use your credit card for months or years after you severed your relationship?

Physicians have a responsibility to apprise the Medicare Registration Department of any changes. We are asking you to do your part to protect the Medicare Trust Fund.

On-Site Visits

The Medicare Registration Department is conducting on-site visits to selected providers throughout Florida. The visits are conducted at random and are primarily meant for any new provider

applications, but existing providers may also be visited. The main purpose of the visit is to insure that only legitimate providers receive and maintain Medicare provider numbers. Providers may not deny access to Medicare Registration staff. Providers who do so may have their application denied or may experience a delay in the processing of the application until the visit can be made. Existing providers who deny access may have the provider number temporarily canceled.

Applying for Group Membership

All group members must be employees of the entity/organization in which they are requesting membership. Physical therapists, audiologists and occupational therapists must bill independently and may not become group members (see the contracted providers section of this article). If the group has a Medicare Part B provider number and you are requesting membership, follow the guidelines below. Group membership should be requested as soon as employment begins. Medicare Registration does not routinely backdate a group member's eligibility date. Eligibility should begin the date the provider indicates he/she began performing services for this entity (if not more than 30 days before receipt date). If the date is more than 30 days from receipt, the eligibility date will be dated 30 days prior to receipt date. Exceptions to this policy will only be granted with sufficient documentation, such as an employment agreement.

If group member has a Florida Medicare Part B provider number for another location, do the following:

A. Complete page A-1 the HCFA 855 (Medicare Provider/Supplier Enrollment application);

B. Complete an address form which lists all addresses in which you practice;

C. Attach a copy of your current professional license and/or certification;

D. Maintain a copy for your records;

E. Forward original to Medicare Registration; and,

F. If previously sanctioned, provide a copy of reinstatement letter.

If group member has never received a Florida Medicare Part B provider number do the following:

A. Complete a Reassignment of Benefits Information form;

B. Attach a copy of your current professional license/certification;

C. Maintain a copy for your files;

D. Forward original to Medicare Registration; and,

E. If previously sanctioned, provide a copy of reinstatement letter.

Contracted Providers

If you are not an employee of a group or if you work for other entities on a contractual arrangement, you may reassign your benefits only if you meet one or more of the exceptions given in Section 3060 of the Medicare Carriers Manual (MCM). The information provided to Medicare Registration would be the same as a group member. If the entity to whom you are reassigning your benefits to does not have an existing Florida Medicare Part B provider number, and has not completed an application, the entity must complete a HCFA 855. The application should be submitted at the same time the request to reassign is sent.

Qualifications for a Provider Number

Approval is not automatic. Providers must meet the minimum requirements before approval for a provider number.

Minimum Requirements for Approval of a Provider Number

Applicants must complete and submit a HCFA 855 form (Medicare Provider/Supplier Enrollment application).

Providers must obtain and maintain all required federal, state, county, and/or city occupational and professional licenses.

The provider must demonstrate that the practice is open for business, and actively attending patients.

The provider must meet all applicable Medicare requirements for the provider type: (Group, IPL, MD, DO, OD, PHD, LSCW, Mobile X-Ray Supplier, etc.)

Providers who do not meet these requirements will not be issued a provider number.

Providers which are noncovered under the Medicare contract will not receive a Medicare Part B provider number. A few noncovered providers are given below:

Acupuncturist

Blood Bank

Dietitian/Nutritionist

Rehabilitation Center

Neuropath

LPN (Licensed Practical Nurse)

MFT (Marriage Family Therapist)

MHC (Mental Health
Counselor)

RN (Registered Nurse)

SP (School Psychologist)

Hearing aid center/dealer

LMT (Licensed Message Therapist)

SPA (Speech Pathologist)

Optician (Handled by the DME Regional Carrier)

Optical Company (Handled by the DME Regional Carrier)

Speech and Hearing Center without Audiologist

Birthing Centers

Institutions and associations

Any changes or provider applications should be sent to the following address:

Medicare Registration
PO Box 44021

Jacksonville, FL 32231-4021

FEDEX Address:

Medicare Registration
532 Riverside Avenue, 14T
Jacksonville, FL 32202-4918

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Because You Asked

This article is devoted to answering providers' questions about Medicare Part B policies and regulations. "Because You Asked" appears in each issue of the Update! To submit a question, complete and mail the form in the back of this issue.

Q One of my Medicare patients recently brought me a copy of the new Medicare Summary Notice. He was upset by the portion of the notice which says that HCFA is the "Medicare and Medicaid" agency. He felt that the logo implied that he is on Medicaid, which he is not. Can you explain this?

A In designing the Medicare Summary Notice, HCFA has noted that it is the "Medicare and Medicaid Agency." Beneficiaries should be aware that although HCFA administers both the Medicare and Medicaid programs, this does not mean that a beneficiary enrolled in one of these programs is necessarily enrolled in the other. Just as an insurance company may offer different programs to serve the different needs of its customers, HCFA oversees two health care programs which cater to the different needs of its beneficiaries. Although both the Medicare and Medicaid programs appear on the HCFA alpha-representation, there is no association implied other than HCFA's leadership over the two programs.

Q If a surgeon refers a patient to an anesthesiologist for a pre-surgical clearance and the anesthesiologist performs a complete history and physical, may the anesthesiologist be reimbursed for the evaluation and management (E/M) service as well as the anesthesia service performed with the surgery?

A Yes. A physician other than the surgeon may bill and receive payment for a medically necessary pre-operative surgical clearance. The medically necessary pre-operative surgical clearance is a different service than the pre-operative anesthesia service. So, if a surgeon refers a patient to an anesthesiologist for a medically necessary pre-operative surgical clearance, the anesthesiologist may bill the appropriate level E/M procedure code. (Remember, though, that the pre-operative anesthesia services are included in the global payment for anesthesia.) Ifthe anesthesiologist completes the required components of an E/M service, he or she may bill the appropriate E/M code. Documentation in the medical record must support the

level of the E/M code billed and the medical appropriateness of the service.

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end of file