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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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CLIA Compliance

On July 1, 1997 the Health Care Financing Administration (HCFA) began its active enforcement of the Clinical Laboratory Improvement Amendments (CLIA) for physician office laboratories (POLs). The HCFA has advised its Medicare carriers that they may begin to deny payment to specific POLs for laboratory service performed by those POLs. Before denying claims for POLs, the Health Services Quality Bureau will contact labs which appear to be out of compliance with CLIA requirements and work with them to understand those CLIA requirements or correct data in the HCFA systems.

To assist POLs in understanding what tests they may bill, the carriers also have lists of the tests which are covered by the CLIA certification for waived tests and Provider Performed Microscopy Procedures (PPMP). POLs may contact the carriers for a list.

Beginning October 1, 1997 all clinical diagnostic laboratories must include their CLIA numbers on all claims (paper and electronic) for laboratory services which they perform in their labs. If the number is not included on the HCFA-1500, the claims will be paid but the laboratory will receive a remittance advice stating that beginning January 1, 1998 clinical diagnostic lab claims will be rejected without the CLIA number. The period between October 1, 1997 and January 1, 1998 is a grace period to allow independent labs and physician office labs time to implement billing changes to comply with the CLIA number requirement.

All clinical diagnostic laboratory claims received on or after January 1, 1998 will require the CLIA number to receive payment. Otherwise, the claim will be rejected as an unprocessable claim.

The January 1, 1998 compliance action will also include denial of lab services if the lab was not certified for the test which it performed or the lab performed tests outside of the effective dates of its CLIA certificate. The Medicare carriers will send remittance advice notices and EOMBs noting that the provider was not approved to perform that service on that date. The EOMB will state that the beneficiary may not be billed for the denied service.

Carriers have notified their appropriate state agencies of the HCFA plans for CLIA compliance. The state agencies will work with labs to assist them in attaining compliance.

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What s New

CLIA Compliance: Beginning October 1, 1997, all clinical diagnostic and physician office laboratories must include their CLIA number on all claims. For paper claims, this information must be entered in Item 23 of the HCFA-1500 claim form (see page 11). Electronic claim filers must enter this information in the FA0 record, field 34, positions 164-178, of the National Standard Format (see page 42).

Medicare Registration Applications: The Health Care Financing Administration has issued three new enrollment applications: the HCFA 855 - General Enrollment; the HCFA 855C - Change of Enrollment Information and the HCFA 855G - Individual Group Member Enrollment. A brief description of all three forms can be found on page 51. In addition, copies of the HCFA 855C and 855G can be found on pages 53-65.

Documentation Guidelines for Evaluation and Management Services: These guidelines have been developed jointly by the American Medical Association (AMA) and the Health Care Financing Administration (HCFA). The goal of this document is to provide physicians and claim reviewers with advice about preparing or reviewing documentation for Evaluation and Management services. These guidelines are available on the HCFA Web page at www.hcfa.gov/medicare/mcarpti.htm, and through county medical societies or specialty associations. This documentation may also be obtained by calling our B Line BBS (see page 73). In addition, Medicare Part B of Florida will will be offering classes on this subject throughout the state. Watch for this information in future editions of the Update!

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Information on Non-coverage Policy

I would like to call your attention to a new Florida Medicare local medical review policy, Non-coverage Policy , published in this issue of the Medicare B Update! (page 31).

During the past year it has been our experience that Medicare Part B of Florida is sometimes billed for services which are never covered by the Medicare program. When payment is denied for these services, providers and patients are usually surprised and disappointed that Medicare will not pay their bills. As outlined in the policy, these denials are based on either national coverage policies or local medical review policy exclusions we have developed.

As far as we know, this is the first time a carrier has developed a policy which clearly states to the medical community which services are not covered and how to request coverage if it is believed a service is appropriate for coverage. While this list of non-covered services is not complete, most of the items appear as policy statements in other publications. We thought it would be useful to have these consolidated in one place.

It is important to note that the establishment of a CPT code or FDA approval for an item does not in itself make the procedure medically reasonable and necessary and therefore covered by Medicare. New services, procedures, drugs or technology must be evaluated and approved before they are considered covered services under the Medicare program. If a company, provider or other individual wishes to have a procedure, test or drug covered by Medicare, they must write to the carrier to request coverage and include supporting documentation. Ideally, the supporting documentation would include at least two valid studies from peer reviewed medical literature indicating that the service, test or procedure is medically necessary and reasonable.

This policy in no way restricts what services may be provided for a beneficiary. Our policies are coverage policies, not treatment policies. Our position is that treatment plans are best decided by patients in consultation with their physician.

Additional services will be added to the non-coverage policy and others will be removed as appropriate, and these changes will be published as they occur. Should you have any questions or concerns about this policy, please feel free to share them with us.

Sincerely,

Sidney Sewell, M.D.

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Advance Notice Requirement

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.

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 in 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 he 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. The signature of the provider of service is not required.

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.

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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 in FYI section), or download the text version from our on-line service, the B LINE BBS (see this issue 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 HCFA 855-C must be completed in the event of relocation. See page 53 for a copy of this form.

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HCFA-1500 Completion Requirements

As we approach the year 2000, HCFA is embarking on the millenium initiative. This not only includes changes to claims processing, it also includes changes to claims reporting reqirements. The following changes have been made to the HCFA-1500 instructions to accomodate the new millennium. Most of the changes are instructional and involve items on the HCFA-1500 form that require a date. Medicare carriers will be able to accept eight-digit dates as of October 1, 1997. All providers of service and/or suppliers must be in compliance with these instructions as of October 1, 1998.

For example, October 1, 1997 would be entered as: 10011997 (MMDDCCYY).

In addition to the millinium changes, these instructions include the following additions:

A new place of service code and definition (POS code 60, Mass Immunization Center)

Claim reporting instructions for Care Plan Oversight

Clarifications to reporting requirements in items 11 and 19;

Claim reporting instructions for National Emphysema Treatment trial claims; and

Claim reporting instructions for Clinical Laboratory Improvement Act certification number for laboratory services billed by a physician office laboratory

All non-millennium changes are effective for claims received October 1, 1997 and after.

Note: Providers are asked to ignore all claim filing instructions regarding PAYERID and NPI. The implementation dates for these initiatives have not yet been established. Providers will be notified of the effective dates for NPI and PAYERID in future editions of the Medicare B Update!

Information denoted with a bar indicates items which have been revised since the October 1, 1996 HCFA-1500 claim completion requirements were issued.

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The HCFA-1500 answers the needs of many health insurers. It is the basic form prescribed by HCFA for the Medicare program for claims from physicians and suppliers, except for ambulance services. It has also been adopted by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) and has received the approval of the American Medical Association (AMA) Council on Medical Services.

Use these instructions for completing this form. The HCFA-1500 has space for physicians and suppliers to provide information on other health insurance. Use this information to determine whether the Medicare patient has other coverage which must be billed prior to Medicare payment, or whether there is a Medigap policy under which payments are made to a participating physician or supplier.

Items 1-13 - Patient and Insured Information

Item 1

Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.

Item 1a

Enter the patient s Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer.

Item 2

Enter the patient s last name, first name, and middle initial, if any, as shown on the patient s Medicare card.

Item 3

Enter the patient s eight-digit birth date (MMDDCCYY) and sex.

Item 4

If there is insurance primary to Medicare, either through the patient s or spouse s employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

Item 5

Enter the patient s mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.

Item 6

Check the appropriate box for patient s relationship to insured when item 4 is completed.

Item 7

Enter the insured s address and telephone number. When the address is the same as the patient s, enter the word SAME. Complete this item only when items 4 & 11 are completed.

Item 8

Check the appropriate box for the patient s marital status and whether employed or a student.

Item 9

Enter the last name, first name, and middle initial of the enrollee in a Medigap policy, if it is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank. This field may be used in the future for supplemental insurance plans.

NOTE: ONLY PARTICIPATING PHYSICIANS AND SUPPLIERS ARE TO COMPLETE ITEM 9 AND ITS SUBDIVISIONS, AND ONLY WHEN THE BENEFICIARY WISHES TO ASSIGN HIS/HER BENEFITS UNDER A MEDIGAP POLICY TO THE PARTICIPATING PHYSICIAN OR SUPPLIER.

Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for all Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer.

Medigap. A Medigap policy meets the statutory definition of a Medicare supplemental policy contained in 1882(g)(1) of Title XVIII of the Social Security Act and the definition contained in the NAIC Model Regulation which is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the gaps in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the

applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as specified disease or hospital indemnity coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.

Item 9a

Enter the policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP.

NOTE: Item 9d must be completed if you enter a policy and/or group number in Item 9a.

Item 9b

Enter the Medigap insured s eight-digit birth date (MMDDCCYY) and sex.

Item 9c

Leave blank if a Medigap PayerID is entered in item 9d. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two letter postal code, and zip code copied from the Medigap insured s Medigap identification card. For example:

1257 Anywhere Street

Baltimore, MD 21204

is shown as 1257 Anywhere St MD 21204.

Item 9d

Enter the nine-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, then enter the Medigap insurance program or plan name.

If you are a participating provider of service or supplier and the beneficiary wants Medicare payment data forwarded to a Medigap insurer under a mandated Medigap transfer, all of the information in items 9, 9a, 9b, and 9d must be complete and accurate. Otherwise, the Medicare carrier cannot forward the claim information to the Medigap insurer.

Items 10a thru 10c

Check YES or NO to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Enter the State postal code. Any item checked YES indicates there may be other insurance primary to Medicare. Identify primary insurance information in item 11.

Item 10d

Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient s Medicaid number preceded by MCD.

Item 11

THIS ITEM MUST BE COMPLETED. BY COMPLETING THIS ITEM, THE PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO DETERMINE WHETHER MEDICARE IS THE PRIMARY OR SECONDARY PAYER.

If there is insurance primary to Medicare, enter the insured s policy or group number and proceed to items 11a - 11c.

NOTE: Enter the appropriate information in item 11c if insurance primary to Medicare is indicated in item 11.

If there is no insurance primary to Medicare, enter the word NONE and proceed to item 12.

If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g. - insured retired), enter the word NONE and proceed to item 11b.

Insurance Primary to Medicare. Circumstances under which Medicare payment may be secondary to other insurance include:

Group Health Plan Coverage:

Working Aged;

Disability (Large Group Health Plan); and

End Stage Renal Disease.

No Fault and/or Other Liability:

Work-Related Illness/Injury:

Workers Compensation;

Black Lung; and

Veterans Benefits.

NOTE: For a paper claim to be considered for Medicare Secondary Payer benefits, a copy of the primary payer s explanation of benefits (EOB) notice must be forwarded along with the claim form.

Item 11a

Enter the insured s eight-digit birth date (MMDDCCYY) and sex if different from item 3.

Item 11b

Enter employer s name, if applicable. If there is a change in the insured s insurance status, e.g., retired, enter the eight-digit retirement date (MMDDCCYY) preceded by the word RETIRED.

Item 11c

Enter the nine-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the complete primary payer s program or plan name. If the primary payer s EOB does not contain the claims processing address, record the primary payer s claims processing address directly on the EOB.

Item 11d

Leave blank. Not required by Medicare.

Item 12

The patient or authorized representative must sign and enter the eight-digit date (MMDDCCYY) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with 3047.1 -3047.3. If the patient is physically or mentally unable to sign, a representative specified in 3008 may

sign on the patient s behalf. In this event, the statement s signature line must indicate the patient s name followed by by the representative s name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless patient or the patient s representative revokes this arrangement.

The patient s signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier, when the provider of service or supplier accepts assignment on the claim.

Signature by Mark (X). When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

Item 13

The signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item, or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service/supplier s office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

Items 14-33 - Provider of Service or Supplier Information

Item 14

Enter eight-digit date (MMDDCCYY) of current illness, injury, or pregnancy. For chiropractic services, enter the eight-digit date (MMDDCCYY) of the initiation of the course of treatment and enter the eight-digit X-ray date (MMDDCCYY) in item 19.

Item 15

Leave blank. Not required by Medicare.

Item 16

Enter the eight-digit dates (MMDDCCYY) patient is employed and unable to work in current occupation. An entry in this field may indicate employment related insurance coverage.

Item 17

Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

Referring Physician: A physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering Physician: A physician who orders non-physician services for the patient such as diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.

The ordering/referring requirement became effective January 1, 1992, and is required by 1833(q) of the Social Security Act. All claims for Medicare covered services and items that are the result of a physician s order or referral must include the ordering/referring physician s name and National Provider Identifier (NPI). This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following:

Diagnostic laboratory services;

Diagnostic radiology services;

Consultative services; and

Durable medical equipment.

Claims for other ordered/referred services not included in the preceding list must also show the ordering/referring physician s name and NPI. For example, a surgeon must complete items 17 and 17a when a physician refers the patient. When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests), the performing physician s name and assigned NPI must appear in items 17 and 17a.

All physicians who order or refer Medicare beneficiaries or services must obtain an NPI even though they may never bill Medicare directly. A physician who has not been assigned an NPI must contact the Medicare carrier.

When a physician extender or other limited licensed practitioner refers a patient for consultative service, the name and NPI of the physician supervising the limited licensed practitioner must appear in items 17 and 17a.

When a patient is referred to a physician who also orders and performs a diagnostic service, a separate claim form is required for the diagnostic service.

Enter the original ordering/referring physician s name and NPI in items 17 and 17a of the first claim form.

Enter the ordering (performing) physician s name and NPI in items 17 and 17a of the second claim form.

Surrogate NPIs: If the ordering/referring physician has not been assigned an NPI, one of the surrogate NPIs listed below must be used in item 17a. The surrogate NPI used depends on the circumstances and is used only until the physician is assigned an NPI. Enter the physician s name in item 17 and the surrogate NPI in item 17a. All surrogate NPIs, with the exception of retired physicians (RET00000), are temporary and may be used only until an NPI is assigned. You must monitor claims with surrogate NPIs.

The term physician , when used within the meaning of 1861(r) of the Social Security Act, and used in connection with performing any function or action, refers to:

(1) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;

(2) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions, and who is acting within the scope of his/her license when performing such functions;

(3) A doctor of podiatric medicine for purposes of subsections (k), (m), (p)(1), and (s) and 1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;

(4) A doctor of optometry, but only with respect to the provision of items or services described in 1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or

(5) A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of 1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist). For the purposes of 1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the

country in which the inpatient hospital services (referred to in 1862(a)(4) of the Act) are furnished

Item 17a

Enter the HCFA assigned NPI of the referring/ordering physician listed in item 17. Enter only the 7-digit base number and the 1-digit check digit.

When a claim involves multiple referring and/or ordering physicians, a separate HCFA-1500 must be used for each ordering/referring physician.

Use the following surrogate NPIs for physicians who have not been assigned individual NPIs. Claims received with surrogate numbers will be tracked and possibly audited.

Residents who are issued an NPI in conjunction with activities outside of their residency status must use that NPI. For interns and residents without NPIs, use the eight (8) character surrogate NPI RES00000;

Retired physicians who were not issued an NPI may use the surrogate RET00000;

Physicians serving in the Department of Veterans Affairs or the U.S. Armed Services may use VAD00000;

Physicians serving in the Public Health or Indian Health Services may use PHS00000;

The law extends coverage and direct payment in non-Metropolitan Statistical Areas to practitioners who are State licensed to order medical services or refer patients to Medicare providers without the approval or collaboration of a supervising physician. Use the surrogate NPI NPP00000" on claims involving services ordered/referred by nurse practitioners, clinical nurse specialists, or any non-physician practitioner who is State licensed to order clinical diagnostic tests; and

When the ordering/referring physician has not been assigned an NPI and does not meet the criteria for using one of the surrogate NPIs, the biller may use the surrogate NPI OTH00000" until an individual NPI is assigned.

Item 18

Enter the eight-digit date (MMDDCCYY) when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19

Enter the eight-digit date (MMDDCCYY) patient was last seen and the NPI of his/her attending physician when an independent physical or occupational therapist, or physician providing routine
foot care submits claims. For physical and occupational therapists, entering this information certifies that the required physician certification (or recertification) is being kept on file. (See 2206.1.)

Enter the eight-digit X-ray date (MMDDCCYY) for chiropractor services. By entering an X-ray date, and the initiation date for course of chiropractic treatment in item 14, you are certifying that all the relevant information requirements (including level of subluxation) of the MCM, 2251 and 4118 are on file along with the appropriate X-ray and all are available for carrier review.

Enter the drug s name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a concise description of an unlisted procedure code or a NOC code if one can be given within the confines of this box. Otherwise an attachment must be submitted with the claim.

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and mod represents all modifiers applicable to the referenced line item.

Enter the statement Homebound when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See 2051.1 and 2070.1H respectively, for the definition of homebound and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, Patient refuses to assign benefits when the beneficiary absolutely refuses to assign benefits to a participating provider. In this case, no payment may be made on the claim.

Enter the statement, Testing for hearing aid when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.

When dental examinations are billed, enter the specific surgery for which the exam is being performed.

Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.

Enter the eight-digit assumed and/or relinquished date (MMDDCCYY) for a global surgery claim when providers share post-operative care.

Enter the statement, Attending physician, not hospice employee when a physician renders services to a hospice patient but the hospice providing the patient s care (in which the patient resides) does not employ the attending physician.

Item 20

Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the yes block is checked. A yes check indicates that an entity other than the entity billing for the service performed the diagnostic test. A no check indicates that no purchased tests are included on the claim. When yes is annotated, item 32 must be completed. When billing for multiple purchased diagnostic tests, each test must be submitted on a separate claim form.

Item 21

Enter the patient s diagnosis/condition. All physician specialties must use an ICD-9-CM code number and code to the highest level of specificity. Enter up to 4 codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for non-physician specialties must be submitted on an attachment.

Item 22

Leave blank. Not required by Medicare.

Item 23

Enter the Professional Review Organization (PRO) prior authorization number for those procedures requiring PRO prior approval.

Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-Approved clinical trial.

For physicians performing care plan oversight services, enter the 6-digit Medicare provider number of the home health agency (HHA) or hospice when CPT code 99375 or 99376 or HCPCS code G0064, G0065, or G0066 is billed.

Enter the 10-digit CLIA (Clinical Laboratory Improvement Act) certification number for laboratory services billed by a physician office laboratory.

Enter Demonstration ID number 30" for all National Emphysema Treatment trial claims.

Item 24a

Enter the eight-digit date (MMDDCCYY) for each procedure, service, or supply. When from and to dates are shown for a series of identical services, enter the number of days or units in column G.

Item 24b

Enter the appropriate place of service code(s) from the list provided in 2010.3. Identify the location, using a place of service code, for each item used or service performed.

NOTE: When a service is rendered to a hospital inpatient, use the inpatient hospital code.

Item 24c

Medicare providers are not required to complete this item.

Item 24d

Enter the procedures, services or supplies using the HCFA Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.

Enter the specific procedure code without a narrative description. However, when reporting an unlisted procedure code or a NOC code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment must be submitted with the claim.

Item 24e

Enter the diagnosis code reference number as shown in item 21, to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service; either a 1, or a 2, or a 3, or a 4.

If a situation arises where two or more diagnoses are required for a procedure code (e.g., Pap Smears), you must reference only one of the diagnoses in item 21.

Item 24f

Enter the charge for each listed service.

Item 24g

Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages or allergy testing procedures). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in item 24g. Convert hours into minutes and enter the total minutes required for this procedure.

Suppliers must furnish the units of oxygen contents except for concentrators and initial rental claims for gas and liquid oxygen systems. Rounding of oxygen contents is as follows:

For stationary gas system rentals, suppliers must indicate oxygen contents in unit multiples of 50 cubic feet in item 24g, rounded to the nearest increment of 50. For example, if 73 cubic feet of oxygen were delivered during the rental month, the unit entry 01" indicating the nearest 50 cubic foot increment is entered in item 24g.

For stationary liquid systems, units of contents must be specified in multiples of 10 pounds of liquid contents delivered, rounded to the nearest 10 pound increment. For example, if 63 pounds of liquid oxygen were delivered during the applicable rental month billed, the unit entry 06" is entered in item 24g.

For units of portable contents only (i.e., no stationary gas or liquid system used) round to the nearest five feet or one liquid pound, respectively.

Item 24h

Leave blank. Not required by Medicare.

Item 24i

Leave blank. Not required by Medicare.

Items 24j and 24k

Enter the NPI of the performing provider of service/supplier if they are a member of a group practice.

NOTE: Enter the first two digits of the NPI in Item 24j. Enter the remaining six digits of the NPI in Item 24k, including the two-digit location identifier.

When several different providers of service or suppliers within a group are billing on the same HCFA-1500, show the individual NPI in the corresponding line item.

Item 25

Enter your provider of service or supplier Federal Tax I.D. (Employer Identification Number) or Social Security Number. The participating provider of service or supplier Federal Tax I.D. Number is required for a mandated Medigap transfer.

Item 26

Enter the patient s account number assigned by the provider of service s or supplier s accounting system. This field is optional to assist you in patient identification. As a service, any account numbers entered here will be returned to you.

Item 27

Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If MEDIGAP is indicated in block 9 and MEDIGAP payment authorization is given in item 13, the provider of service or supplier must also be a Medicare participating provider of service or supplier and must accept assignment of Medicare benefits for all covered charges for all patients.

The following providers of service/suppliers and claims can only be paid on an assignment basis:

Clinical diagnostic laboratory services;

Physician services to individuals dually entitled to Medicare and Medicaid;

Participating physician/supplier services,

Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;

Ambulatory surgical center services for covered ASC procedures; and

Home dialysis supplies and equipment paid under Method II.

Item 28

Enter total charges for the services (i.e., total of all charges in item 24f).

Item 29

Enter the total amount the patient paid on the covered services only.

Item 30

Leave blank. Not required by Medicare.

Item 31

Enter the signature of provider of service or supplier, or his representative, and the eight-digit date (MMDDCCYY) the form was signed.

Item 32

Enter the name and address of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient s home or physician s office. When the name and address of the facility where the services were furnished is the same as the billers name and address shown in item 33, enter the word SAME. Providers of service (namely physicians) must identify the supplier s name, address, and NPI when billing for purchased diagnostic tests. When more than one supplier is used, a separate HCFA-1500 should be used to bill for each supplier.

This item is completed whether the supplier personnel performs the work at the physician s office or at another location.

If a QB or QU modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA), the physical location where the service was rendered must be entered if other than home. However, if the address shown in item 33 is in a HPSA and is the same as where the services were rendered, enter the word SAME.

If the supplier is a certified mammography screening center, enter the 6 digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician s office. If an independent laboratory is billing, enter the place where the test was performed and the NPI, including the 2-digit location identifier.

Item 33

Enter the provider of service/supplier s billing name, address, zip code, and telephone number.

Enter the NPI, including the 2-digit location identifier, for the performing provider of service/supplier who is not a member of a group practice.

Enter the Group NPI, including the 2-digit location identifier, for the performing provider of service/supplier who is a member of a group practice.

****

POS Definitions

00-10

(Unassigned)

11 Office

Location, other than a hospital, Skilled Nursing Facility (SNF), Military Treatment Facility, Community Health Center, State or Local Public Health Clinic or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.

12 Patient s Home

Location, other than a hospital or other facility, where the patient receives care in a private residence.

13-20 (Unassigned)

21 Inpatient Hospital

A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

22 Outpatient Hospital

A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to

sick or injured persons who do not require hospitalization or institutionalization.

23 Emergency Room - Hospital

A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24 Ambulatory Surgical Center

A free-standing facility, other than a physician s office, where surgical and diagnostic services are provided on an ambulatory basis.

25 Birthing Center

A facility, other than a hospital s maternity facilities or a physician s office, which provides a setting for labor, delivery and immediate post-partum care as well as immediate care of new born infants.

26 Military Treatment Facility

A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

27-30 (Unassigned)

31 Skilled Nursing Facility

A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32 Nursing Facility

A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

33 Custodial Care Facility

A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

34 Hospice

A facility, other than a patient s home, in which palliative and supportive care for terminally ill patients and their families are provided.

35-40 (Unassigned)

41 Ambulance-Land

A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

42 Ambulance Air or Water

An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

43-49 (Unassigned)

50 Federally Qualified Health Center

A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

51 Inpatient Psychiatric Facility

A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52 Psychiatric Facility Partial Hospitalization

A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

53 Community Mental Health Center (CMHC)

A facility that provides the following services:

Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC s mental health services area who have been discharged from inpatient treatment at a mental health facility;

24 hour a day emergency care services;

Day treatment, other partial hospitalization services, or psychosocial rehabilitation services;

Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and

Consultation and education services.

54 Intermediate Care Facility/Mentally Retarded

A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.

55 Residential Substance Abuse Treatment Facility

A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56 Psychiatric Residential Treatment Center

A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

57-59 (Unassigned)

60 Mass Immunization Center

A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting. (See 4408.8.)

61 Comprehensive Inpatient Rehabilitation Facility

A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62 Comprehensive Outpatient Rehabilitation Facility

A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

63-64 (Unassigned)

65 End Stage Renal Disease Treatment Facility

A facility other than a hospital, which provides dialysis treatment, maintenance and/or training to patients or care givers on an ambulatory or home-care basis.

66-70 (Unassigned)

71 State or Local Public Health Clinic

A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.

72 Rural Health Clinic

A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

73-80 (Unassigned)

81 Independent Laboratory

A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician s office.

82-98 (Unassigned)

99 Other Unlisted Facility

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General Information

Claims for Concurrent Care

Concurrent care is one of the most misunderstood concepts under the Medicare program. Concurrent care is defined as care rendered

by more than one physician to the same patient on the same day. The following article is intended to assist providers in:

understanding what concurrent care is;

determining what happens to a claim once concurrent care has been identified; and

ensuring that claims are processed correctly.

When two or more physicians render inpatient Evaluation and Management (E/M) visits for the same patient on the same day, it is considered concurrent care. Concurrent care is a situation, not a procedure code or modifier. While Medicare generally limits payment to one E/M service for the same date of service, there are exceptions when more than one evaluation and management service furnished by different physicians may be covered for the same date of service. In these instances, the services of each physician must be medically necessary for the patient s care. The patient s condition must require the specialized ability of two or more physicians.

How Does Medicare Identify Concurrent Care?

The Medicare Part B processing system is programmed to identify E/M services where concurrent care is suspected. The system is alerted when a physician s claim is received for hospital care on the same date of service as another physician s service. The procedure codes subject to concurrent care guidelines are:

01996 Daily management of epidural or subarachnoid drug administration

94656-94657 Ventilation assist and management

99217-99239 Hospital inpatient services

99295-99297 Neonatal intensive care

What Happens Once Concurrent Care is Identified?

If concurrent care is identified during claim processing, Medicare Part B must determine the following:

If the patient s condition warrants the services of more than one physician;

If the services provided by each physician are reasonable and necessary;

If the physicians are of different specialties; and

If the physicians are treating the patient for different diagnoses/conditions.

If physicians of different specialties are treating the patient for different conditions, the claim will process routinely. If the physicians are of the same or similar specialty and are both treating the patient for the same condition, one of the services in question will be denied for concurrent care unless documentation supporting the medical necessity of the E/M service is provided.

Examples of How Concurrent Care Guidelines are Applied

Covered Services

A patient is being treated by Dr. Nicholas, a cardiologist, for myocardial infarction. Dr. Michaels, a nephrologist, is treating the patient for renal failure. Since the physicians are of different specialties and the patient is being treated for different conditions, both visits would be allowed.

Sometimes, it may become necessary for two physicians to co-manage an acutely ill patient. In this case, both physician s visits may be covered provided to required documentation supports the medical necessity of the visit.

Situations Requiring Medical Review

A patient is being treated by an internist for uncontrolled hypertension. The patient is also being seen by a family practitioner for heart disease. Because the physicians have similar specialties, and the conditions being treated are similar, this situation would require medical review to determine whether the second claim would be allowed.

Situations Which Warrant a Concurrent Care Denial

Dr. Tyler, an internist, admits his regular patient with symptoms indicative of a heart attack. After a work-up, the diagnosis is confirmed as an esophageal hiatal hernia and gastric reflux. Dr. Costas, a gastroenterologist, is called in to assume care of the patient. Dr. Tyler stays on the case as a courtesy, but is not actively treating a medical condition requiring hospitalization. In this case, one of the physician s visits will be denied payment due to concurrent care.

How You Can Help?

To ensure your claims are processed appropriately, here are some suggestions:

Only submit the ICD-9-CM diagnosis(es) for which the patient is being treated. Submission of all diagnoses from the hospital face sheet is not recommended unless you are treating the patient for all of the diagnoses listed. The primary diagnosis for which the patient is being treated should be reported in item 24e of the HCFA-1500 or the equivalent EMC field.

If you suspect that your claim may be identified for a concurrent care denial, the following documentation must be submitted with your claim:

doctor s orders;

progress notes;

history and physical; and

discharge summary.

Before submitting documentation to Medicare Part B of Florida, be sure that all handwritten documentation and signatures are legible.

What to Do if You Believe That Your Claims Were Improperly Denied

If your claim has been denied for concurrent care and you disagree, you may request a review by writing to:

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

Note: All review requests must include the documentation listed above for the service dates in question.

Check Your Specialty Code

To ensure that your specialty is correctly recorded on our files, refer to your latest disclosure statement. For your convenience, a list of specialty codes follows:

01 General Practice

02 General Surgery

03 Allergy/Immunology

04 Otolaryngology

05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Therapy
13	Neurology
14	Neurosurgery
16	Obstetrics, Gynecology
18	Ophthalmology
19	Oral Surgery, Dentists
20	Orthopedic Surgery
22	Pathology
24	Plastic and Reconstructive Surgery
25	Physical Medicine
26	Psychiatry
28	Colorectal Surgery
29	Pulmonary
30	Radiology (Diagnostic)
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatrics
38	Geriatric
39	Nephrology
40	Hand Surgery

41	Optometry
42	Certified Nurse Midwife
43	CRNA, Anesthesia Assistant
44	Infectious Disease
46	Endocrinology
48	Podiatry
50	Nurse Practitioner
62	Psychology
64	Audiology
65	Physical Therapy
66	Rheumatology
67	Occupational Therapy
68	Clinical Psychology
69	Independent Clinical Lab
70	PA Groups
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
80	Clinical Social Worker
81	Critical Care
82	Hematology
83	Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology

93 Emergency Physician

94 Interventional Radiology

95 IPL

98 Gynecological Oncology

If your specialty is listed incorrectly on the disclosure statement, you may request a change by writing to:

Medicare Registration
P.O. Box 44021
Jacksonville, FL 32231-4021

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Correct Coding Modifiers

Procedure code modifier 59 (Distinct procedural service) 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 modifier 59 should never be used when one of the following Correct Coding modifiers would be more appropriate:

E1-E4 eyelids

F1-F9 fingers

FA left hand thumb

TA left foot great toe

T1 T9 toes

LT left side of body

RT right side of body

25 significant, separately identifiable evaluation and management service by the same physician on the day of a procedure

78 return trip to the operating room for a related procedure during a post-operative period

58* staged or related procedure or service by the same physician during the post-operative period

79 unrelated procedure by the same physician during a post-operative period

LC left circunflex coronary artery

LD left anterior descending coronary artery

RC. right coronary artery

* Based on clarification received from the Health Care Financing Administration, procedure code modifier 58 has been added to the list of correct coding modifiers.

The national CCI policy has been extended to define code pairs for which Correct Coding modifiers will not be allowed. The use of the CCI modifiers listed above will not bypass the CCI edits when such code pairs are billed to Medicare Part B. Under no circumstances will payment be made for the component service. In addition, denied component services will not be overturned at the appeals level.

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Ordering a National Correct Coding Policy Manual

The National Technical Information Service (NTIS) in the Department of Commerce has developed a correct coding manual to promote correct coding nationwide and to assist physicians in correctly coding their services for reimbursement.

To order HCFA s National Correct Coding Policy Manual for Part B Medicare Carriers by mail, please call the National Technical Information Service (NTIS) sales desk at (703) 487-4650.

If requesting a paper copy of the manual for each quarter of 1997, use order # PB97-957602LOV ($65.00 plus 4.00 handling fee). A subscription for 1997 may be purchased for $260.00.

If you are requesting the CD-ROM version, use order # PB97-594071LOV ($88.00 plus $4.00 handling fee).

If you are requesting the ASCII version (raw data), use order # PB97-594081LOV ($140.00 plus $4.00 handling fee).

Individual Chapters of the Correct Coding Manual

A one-time individual chapter of the correct coding manual may be purchased at $40.00 plus handling for each chapter or a one year subscription (updated quarterly) for one chapter may be purchased

for $160.00. Listed below are the individual chapters that are available for purchase.

CHAP: 2
Anesthesia Services(00000-09999) PB97-990202LOV

CHAP: 3 Surgery: Integumentary System (10000-19999) PB97-990302LOV

CHAP: 4 Surgery: Musculoskeletal System (20000-29999) PB97-990402LOV

CHAP: 5 Surgery: Respiratory, Cardiovascular, Hemic, and Lymphatic System (30000-39999) PB97-990502LOV

CHAP: 6 Surgery: Digestive System (40000-49999) PB97-990602LOV

CHAP: 7 Surgery: Urinary, Male & Female Genital, Maternity Care, and Delivery System (50000-59999) PB97-990702LOV

CHAP: 8 Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, Auditory System (60000-69999) PB97-990802LOV

CHAP: 9 Radiology Services (70000-79999) PB97-990902LOV

CHAP: 10 Pathology and Laboratory Services (80000-89999) PB97-991002LOV

CHAP: 11 Medicine, Evaluation, and Management Services (90000-99999) PB97-991102LOV

Questions and Answers Regarding the Correct Coding Initiative Manual

Q If I already own a previous edition of the Correct Coding Initiative Manual, what is the benefit of owning the most recent edition?

A The benefit is that only by using the most recent manual can you be sure of receiving full and appropriate reimbursement for the medical services you provide. A completely new manual is produced quarterly because code changes from version to version are so extensive that pen and ink changes would not be feasible.

Q How often will the manual be updated in 1997?

A A new manual will be issued quarterly. Each edition will represent the latest codes available as authorized by the Health Care Financing Administration. The table below shows which edition you should use to ensure full and appropriate compensation.

If filing claims in 1997 from....July 1 to Sept. 30

Then...you should use the third edition, Version 3.2 (to be released 6/1/97)

If filing claims in 1997 from... Oct. 1 to Dec. 31
Then... you should use the fourth edition, Version 3.3 (tentatively available 9/1/97)

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HCPCS Codes

A4263: Lacrimal Punctum Plugs in Office Setting

Separate payment for procedure code A4263 (permanent, long-term, non-dissolvable lacrimal duct implant, each) will be made only when it is provided in an office setting with procedure code 68761 (Closure of lacrimal punctum; by plug, each). As a reminder, procedure code A4263 is subject to the limiting charge requirements when it is provided in this situation and submitted on a nonassigned basis.

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Third Quarter Revisions to the 1997 Fee Schedule for DMEPOS

Fees have been established for the following codes

Code	Fees
L8600	$394.34
L8610	$426.64
L8612	$412.27
L8613	$193.59
L8630	$196.34
L8641	$203.05
L8642	$187.20
L8658	$181.68
L8670	$220.38

These revisions are effective for claims processed October 20, 1997, and after.

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A4300: Implantable Vascular Access Devices Covered in Office Settings

Separate payment will be made for procedure code A4300 (Implantable vascular access devices) only when it is provided in an office setting with procedure code 36533 (Insertion of implantable venous access port, with or without subcutaneous reservoir). As a reminder, procedure code A4300 is subject to the limiting charge requirements when it is provided in this situation and submitted on a nonassigned basis.

Additionally, effective for services furnished on or after January 1, 1996, an ambulatory surgical center (ASC) may be paid for the acquisition cost of either an implantable access catheter (procedure code A4300) or an implantable access total system (procedure code A4301) in addition to the ASC facility fee for procedure code 36533. For more information on coverage for implantable access devices furnished by an ASC, refer to page 17 of the November/December 1996 Medicare B Update!

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A4550: Surgical Trays with Office Surgical Procedures

Separate payment is made for surgical trays (procedure code A4550) when they are provided in an office setting with certain surgical procedures. The following is a complete list of surgical procedures for which separate payment is made for procedure code A4550.

19101, 19120, 19125, 19126, 20200, 20205, 20220, 20225, 20240, 25111, 28290, 28292, 28293, 28294, 28296, 28297, 28298, 28299, 32000, 37609, 38500, 43200, 43202, 43220, 43226, 43234, 43235, 43239, 43245, 43247, 43249, 43250, 43251, 43458, 45378, 45379, 45380, 45382, 45383, 45384, 45385, 49080, 49081, 52005, 52007, 52010, 52204, 52214, 52224, 52234, 52235, 52240, 52250, 52260, 52270, 52275, 52276, 52277, 52283, 52290, 52300, 52301, 52305, 52310, 52315, 57520, 57522, 58120, 62270, 85095, 85102, 96440, 96445, 96450

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E0782, E0783: Implantable Infusion Pumps

Implantable infusion pumps for the delivery of insulin to treat diabetes is not covered. Section 60-14B.2 of the Coverage Issues Manual states:

Implanted infusion pumps for the infusion of insulin to treat diabetes is not covered. The data does not demonstrate that the pump provides effective administration of insulin.

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J3005: Billing Metastron (Strontium-89)

Metastron (Strontium-89) is covered as a supply used in conjunction with radiation therapy. A new procedure code will be assigned to Metastron (Strontium-89), but until then providers should bill for Metastron (Strontium-89) using procedure code J3005 (Injection, Strontium-89 Chloride, per 10 ml).

Radionuclides Subject to Limiting Charges

The July/August 1997 Medicare B Update! included the allowances for the following radionuclides reported with Level III codes. Level III codes describe procedures not included in Level I (numeric codes - CPT) or Level II (alpha-numeric - HCFA-assigned) and begin with an alpha prefix of W-Z (e.g., W4131). Most Level III , or locally assigned, codes have been deleted as part of the standardization of the Medicare program. Due to an oversight, the nonparticipating fee schedule amounts and the limiting charges were not published.

Procedure Code: W4125
Description: Tc-99m Technetium, Pertechnetate, up to 30 mCi
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4128
Description: I-131 Iodohippurate Sodium, per uCi (HIPPURAN)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4130
Description: Tc-99m Technetium, Mebrofenin, up to 10 mCi (CHOLETEC)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4131
Description: Tc-99m Technetium, Mertiatide, up to 20 mCi (MAG 3, TECHNESCAN MAG3)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4132
Description: Tc-99m Technetium, Labeled Red Blood Cells (RBCs), up to 30 mCi (LABELED RBCs)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4133
Description: Co-57 Cobalt Cyanocobalamin, Phase 1 -OR- 2 (SCHILLING TEST KIT, COBATOPE-57, RUBRATOPE-57)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4134
Description: Tc-99m Technetium, Pyrophosphate, up to 30 mCi (PYP, PHOSPHOTEC, PYROLITE, SODIUM PYROPHOSPHATE)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4136
Description: Xe-133, Xenon, per 10 mCi
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4139
Description: Tc-99m Technetium Pentetate, up to 30 mCi (PENTETATE DTPA, AN-DTPA, TECHNEPLEX, DTPA, TECHNESCAN DTPA)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4140
Description: I-123 Sodium Iodide capsule, per 100 uCi (SODIUM IODINE capsules)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4141
Description: I-131 Sodium Iodide capsule (diagnostic), up to 100 uCi (IODOTOPE, Diagnostic)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4142
Description: I-131 Sodium Iodide capsule (therapeutic), up to 6 MCi (IODOTOPE, Therapeutic)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4143
Description: I-131 Sodium Iodide capsule (therapeutic), each additional mCi (IODOTOPE, Therapeutic)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4144
Description: Ga-67, Gallium Citrate, per mCi (NEOSCAN)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4147
Description: I-131 Sodium Iodide solution (therapeutic), up to 6 MCi (IODOTOPE, Therapeutic solution)

Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4149
Description: Tc-99m Technetium, Gluceptate, up to 30 mCi (GLUCO, GLUCOSCAN)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4150
Description: Tc-99m Technetium, Macroaggregated Albumin, up to 10 mCi (PULMONITE, MAA)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4151
Description: Tc-99m Technetium, Medronate, up to 30 mCi (AN-MDP, OSTEOLITE, MDP, TECHNESCAN MDP)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4153
Description: Tc-99m Technetium, Sulfur Colloid, up to 10 mCi (AN-SULFUR COLLOID, SC, TESULOID)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4156
Description: Tc-99m Technetium, Disofenin, up to 10 mCi (HEPATOLITE, HIDA)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

Procedure Code: W4158
Description: Tc-99m Technetium, Exametazine, up to 30 mCi (CERETEC, HMPAO)
Max Med B Par Allowance:
Max Med B Nonpar Allowance:
Max Limiting Charge:

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Anesthesia/Surgery

Visual Field Interpretation

On June 2, 1997, opthamalogists in the state of Florida were mailed a special notice on the documentation required for upper eyelid and brow surgical procedures. These surgeries include blepharoplasty (procedure codes 15822-15823), repair of brow

ptosis (procedure code 67900), and blepharoptosis (procedure code 67901-67908).

Since the publication of that notice, many providers have raised the question, What constitutes a visual field test interpretation?

A visual field interpretation would be the physician s written narrative on the findings/results of the visual field test. The actual visual field tests results are not required; however, the physician s written interpretation of the test results for each eye must be submitted. The following is an example of a written narrative on the findings/results of the visual field test:

There was a loss of 30 percent or 12 degrees of the upper field of vision which was restored with lids elevated.

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Coding New Techniques for Breast Biopsy

In the past few years, breast biopsy techniques have changed with the emergence of stereotactic instruments. This technology makes it possible to biopsy small, nonpalpable lesions for definitive diagnosis. There has been considerable variation on the part of the physicians and Medicare carriers as to appropriate coding for these breast biopsy procedures.

At present, physicians have been reporting procedures performed with these devices with CPT codes 19100, 19101, or 19120. However, Medicare Part B of Florida, like most carriers, has instructed physicians that they should not bill code 19101 (Biopsy of breast; incisional) because CPT directs the coding of stereotactic breast biopsies only with code 19100 (Biopsy of breast; needle core). (See the cross reference under code 76095 on page 271 of CPT 1997.) Moreover, an article in the April 1996 CPT Assistant reinforced this coding policy.

The CPT Editorial Panel has revised the cross-reference under 76095 on page 271 of CPT 1997 to state: For procedure, see 19100, 19101, 88170. This change will be made in the CPT 1998 book. The Health Care Financing Administration (HCFA) and Medicare Part B of Florida agree with this revision and will implement this new coding policy now rather than wait for the publication of the CPT 1998 book.

Therefore, effective immediately, the Medicare Part B of Florida will allow code 19101 for the reporting of image-guided biopsies of nonpalpable breast lesions. Physicians should continue to report needle core biopsies of palpable lesions using needles such as Tru-Cut with CPT code 19100. By making this change, the carrier will implement a consistent coding policy that recognizes the additional physician work and supply costs associated with stereotactic breast biopsies.

Finally, as a reminder, when multiple tissue samples are removed from one lesion, only one biopsy code (19100 or 19101) should be billed. The reimbursement for each 19100 or 19101 includes all biopsies done on the identified lesion. If two separate lesions are identified in the same breast and a biopsy is made of each, then 19100 or 19101 may be billed once for the first lesion and 19100-51 or 19101-51 for the second. If a lesion is found in both breasts, then 19100-50 or 19101-50 should be billed to indicate a bilateral procedure was performed. The image guided portion of the procedure (stereotactic or ultrasound) should be reported using code 76095 (stereotactic localization for breast biopsy) or 76942 (ultrasonic guidance for biopsy).

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20974: Ultrasonic Osteogenic Stimulators

Ultrasonic osteogenic stimulators are not covered under Medicare because there is insufficient evidence to support the medical necessity of using these devices. Section 35-48B of the Coverage Issues Manual states:

An ultrasonic osteogenic stimulator is a non-invasive device that emits low intensity, pulsed ultrasound. The ultrasound signal is applied to the skin surface at the fracture location via ultrasound, conductive, coupling gel in order to accelerate the healing time of the fracture. The device is intended for use with cast immobilization.

There is insufficient evidence to support the medical necessity of using an ultrasonic osteogenic stimulator. Therefore, the device is not covered, because it is not considered reasonable or necessary.

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30520 and 30620: Correction to Documentation Requirements

The March/April Medicare B Update! article Procedures Which May be Considered Either Cosmetic or Reconstructive (p. 39) discussed documentation guidelines for procedures that may be considered cosmetic or reconstructive.

The documentation requirements published for procedure codes 30520 and 30620 were incorrect. The following table outlines the correct documentation requirements:

Code Descriptor: 30520

Documentation Required: Septoplasty or submucous resection, with or without cartilage scoring, contouring, or replacement with graft History and physicalOperative report

Code Descriptor: 30620
Documentation Required: Septal or other intranasal dermatoplasty (does not include obtaining graft) History and physicalOperative report

Advance Notice

Applies to medical necessity (see page 4).

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Matrix Bioelectric Treatment System Not Appropriate to Bill As Electrical Stimulation

Information has been received stating that providers are being encouraged to use electrical neurostimulators such as the Matrix Bioelectric Treatment System as a pain control treatment method. The providers are then being advised to report services resulting from the use of these electrical neurostimulators using various procedure codes, including those that describe nerve blocks (procedure codes 64400-64530).

Providers who receive marketing material from companies that manufacture electrical neurostimulators should be aware that Medicare Part B only allows for coverage of electrical stimulation to assess a patient s suitability for TENS or PENS, and these services are reported using procedure codes 64550-64595. These procedure codes are not appropriate to use to bill for electrical stimulation treatment services provided as a non-invasive method of pain control.

Finally, some marketing material also describes physical therapy modalities that should be billed as an addendum to the electrical neurostimulator treatment. Physical therapy and evaluation may be paid only if all of the physical therapy requirements are met.

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62350-62351, 62360-62362: Clarification: Revising or Repositioning Catheters

Guidelines regarding the implantation, revision, and repositioning of intrathecal or epidural catheters have been clarified. If a procedure entails a revision or repositioning of intrathecal or epidural catheters some time after the initial implantation is performed, it may be covered as catheters can become inoperative and require repositioning.

Providers should report procedure codes 62350 or 62351 separately if there is a need to revise or reposition the intrathecal or epidural catheter associated with the pump or reservoir.

Procedure codes 62350 (Implantation, revision or repositioning of intrathecal or epidural catheter, for implantable reservoir or implantible infusion pump) and 62351 (with laminectomy) may be billed separately from the following reservoir/pump implantation procedure codes:

62360 Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir;

62361 non-programmable pump;

62362 programmable pump, including preparation of pump, with or without programming.

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Diagnostic Tests

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 MPFSDB 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 reevaluated 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 the latest revisions to the MPFSDB.

Procedure Code 64744

The bilateral indicator for procedure code 64744 (Avulsion of the greater occipital nerve) has been updated, meaning that this procedure may be performed bilaterally. This change will be effective for services furnished January 1, 1997, and after.

Procedure Code 73725

The status code for procedure codes 73725, 73725-TC, and 73725-26 (Magnetic Resonance Angiography, lower extremity, with or without contrast material(s) has changed from noncovered to restricted coverage. A comprehensive article on Medicare s coverage guidelines for procedure codes 73725, 73725-TC and 73725-26 can

be found in the article below. This change will be effective for services furnished May 1, 1997, and after.

Code: 73725
Par Fees LOC 1 & 2: 454.34
Par Fees LOC 3:502.65
Par Fees LOC 4: 538.59
Nonpar Fees LOC 1 & 2: 431.63
Nonpar Fees LOC 3: 477.52
Nonpar Fees LOC 4: 511.66
Limiting Charge LOC 1 & 2: 496.37
Limiting Charge LOC 3: 549.15
Limiting Charge LOC 4: 588.41

Code: 73725-TC
Par Fees LOC 1 & 2: 373.36
Par Fees LOC 3: 416.82
Par Fees LOC 4: 448.61
Nonpar Fees LOC 1 & 2: 354.69
Nonpar Fees LOC 3: 395.98
Nonpar Fees LOC 4: 426.18
Limiting Charge LOC 1 & 2: 407.90
Limiting Charge LOC 3: 455.38
Limiting Charge LOC 4: 490.11

Code: 73725-26
Par Fees LOC 1 & 2: 81.07
Par Fees LOC 3: 85.83
Par Fees LOC 4: 89.98
Nonpar Fees LOC 1 & 2: 77.02
Nonpar Fees LOC 3: 81.54
Nonpar Fees LOC 4: 85.48
Limiting Charge LOC 1 & 2: 88.57
Limiting Charge LOC 3: 93.77
Limiting Charge LOC 4: 98.30

Procedure Codes 77600, 77605, 77610, 77615, 77620

Effective for services performed on or after October 1, 1997, the status code for procedure codes 77600-77620 (Hyperthermia) has changed from active to restricted coverage. These changes also apply to the technical (TC) and professional (26) components of these procedures.

Procedure Code 80050

Effective for services performed on or after October 1, 1997, procedure code 80050 (General health panel) will be considered a screening test and therefore is noncovered.

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70541, 73725: Magnetic Resonance Angiography

Magnetic Resonance Angiography (MRA) is an application of magnetic resonance (MR) imaging that provides visualization of

blood flow, as well as images of normal and diseased blood vessels. MRA techniques are typically noninvasive because they do not require the use of contrast media. While contrast media may sometimes be used to enhance the images obtained in MRA, the use of these agents is not necessary. As a result, MRA is an attractive imaging alternative for patients who cannot tolerate contrast media.

Although MRA may be performed on various anatiomical regions, presently available scientific data and studies reveal that the most clinically useful application of MRA is in evaluation of blood flow and vessels in the head and neck. In addition, effective for services performed May 1, 1997, and after, MRA is also covered when used for the evaluation of the peripheral vessels of the lower extremities. Studies have proven that MRA is most effective when evaluating large vessels, such as the carotids.

Medical policy was developed defining the circumstances under which Medicare Part B of Florida will consider Magnetic Resonance Imaging to be medically reasonable and necessary.

HCPCS Codes

70541 Magnetic resonance angiography, head and/or neck, with or without contrast materials

73725* Magnetic resonance angiography, lower extremity, with or without contrast materials

* Effective for services performed on or after May 1, 1997, procedure code 73725 is a covered service provided the conditions listed below are met. This change will be implemented for claims processed on or after October 1, 1997.

Indications and Limitations of Coverage

This is a covered procedure only for the evaluation of the carotid vessels in the head and neck and the peripheral vessels of the lower extremities. It is covered only when all of the following conditions are met:

The MRA is performed when conventional catheter angiography is inappropriate because contrast media is contraindicated for the patient.

The MRA is performed on patients with vascular conditions of the head and neck, such as carotid stenosis, for which surgery is anticipated and may be found to be appropriate based on the MRA test results; or

The MRA is performed to determine the presence and extent of peripheral vascular disease in lower extremities.

Medicare will cover either MRA or Contrast Angiography to evaluate peripheral vessels of the lower extremities. However, both MRA and CA may be useful in certain cases:

A CA was unable to identify a viable run-off vessel for bypass, and exploratory surgery is not believed to be a reasonable course of action.

The patient had an MRA and the results are inconclusive.

Coding Guidelines

Bill for magnetic resonance angiography, head and/or neck using CPT code 70541. Bill for magnetic resonance angiography, lower extremity using CPT code 73725. The appropriate ICD-9 code indicating the condition for which the test was ordered must accompany the claim.

Reasons for Denial

Magnetic Resonance Imaging performed for conditions other than those listed in the indications and limitations of coverage will be denied.

HCFA considers the following codes to be investigational and, therefore, not covered:

MRA of the chest (71555);

MRA of the spine (72159);

MRA of the upper extremity (73225); and

MRA of the abdomen (74185).

Medicare does not cover MRA as a screening procedure.

Advance Notice Requirement

Applies to medical necessity requirements (see page 4).

Documentation Requirements

The medical record must indicate the medical necessity for this procedure. All of the previously stated conditions must be fulfilled for MRA to be a covered benefit. Specifically, the study should be done on carotid vessels of the head and neck and on peripheral vessels of the lower extremities, and only on those patients for whom surgery is anticipated and who are felt to be inappropriate candidates for conventional catheter angiography. Documentation of fulfillment of these requirements must be available for review as necessary.

If the provider of the MRA studies is other than the ordering/referring physician, the provider of the services must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician s order for the studies. When ordering magnetic resonance angiography from another provider, the ordering/referring physician must state the reason for the MRA in the order for the tests.

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76092: Diagnosis Coding for Screening Mammography

Effective for claims received on or after October 1, 1997, ICD-9 diagnosis code V76.1 (Special screening for malignant neoplasm; breast) will be replaced by ICD-9 diagnosis codes V76.11 (Screening mammogram for high risk patient) and V76.12 (Other screening mammography). ICD-9 codes V76.11 and V76.12 are to be reported as the principal diagnosis on screening mammography claims. To allow providers to adjust their billing practices, all three diagnosis codes will be accepted for a 90 day grace period from October 1, 1997 through December 31, 1997.

Beginning January 1, 1998, ICD-9 diagnosis code V76.1 will become an invalid ICD-9 code. After this date, all claims submitted with ICD-9 diagnosis code V76.1 will be returned as unprocessable.

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84484: New Troponin Policy

Previously, regardless of the variety or mixture of varieties provided, only one unit of Troponin (procedure code 84484) could be billed. This policy was based upon the presumption that the beneficiary would be hospitalized by the time additional units would be required. Now, because of new acute coronary syndrome protocols, more than one unit of Troponin may be allowed if medically necessary. Documentation of the medical necessity for additional units of Troponin must be provided before payment can be made.

The new Troponin policy is effective January 1, 1997.

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Medicine

98940-98942: Chiropractic Services

Chiropractic manipulation is covered by Medicare Part B when it is medically reasonable and necessary for the patient s condition/illness. The procedure codes that relate to chiropractic manipulation are:

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

98941 spinal, three to four regions

98942 spinal, five regions

To ensure that claims are paid only for medically necessary services, chiropractic manipulation is covered only when it is performed for the following diagnoses:

346.00-346.91, 350.1-350.9 , 352.0-352.9, 353.0-353.4, 355.0, 355.1, 356.0, 356.1, 356.4, 356.8, 715.00 , 715.08, 715.10, 715.18, 715.20, 715.28, 715.30, 715.38, 715.80, 715.88, 715.90, 716.10, 716.90, 720.0, 720.1, 720.2, 720.81, 720.9, 721.0-721.91*, 722.0, 722.10-722.11, 722.2, 722.30-722.32, 722.4, 722.51-722.52, 722.70, 722.71, 722.72, 722.73, 722.80, 722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0-723.9, 724.00, 724.01, 724.02, 724.09, 724.1, 724.2, 724.3, 724.4, 724.6, 724.71-724.79, 724.8, 726.5, 726.90, 728.10, 728.11, 728.12, 728.2, 728.3, 728.4, 728.5, 728.81, 728.85, 729.0, 729.1, 729.2, 733.00, 733.01, 733.02, 733.03, 733.09, 737.0, 737.10, 737.12, 737.20, 737.21, 737.22, 737.30, 737.31, 737.32, 737.34, 737.8, 738.2, 738.4, 738.6, 756.11, 756.12, 756.13, 756.14, 756.15, 756.16, 756.17, 756.2, 784.0, 846.0, 847.0, 847.1, 847.2, 847.3, 847.4, 848.3, 848.41, 848.42, 848.5, 905.1, 905.6, 907.3, 953.0-953.5, 954.0, 954.1, 956.0

* Diagnosis codes marked with an asterisk (*) were inadvertently omitted from the previous ICD-9-CM specificity update. As with all codes, they should be billed to the highest level of specificity.

Advance Notice Requirement

Applies to diagnosis (see page 4).

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92506-92508: Billing Guidelines Clarified

Medicare Part B of Florida s reimbursement for the following otorhinolaryngologic services is based on a per service basis as opposed to an hourly basis.

92506 Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status

92507 Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual

92508 group, two or more individuals

Therefore, the number 1" must be entered in Item 24g of the HCFA-1500 or the equivalent EMC field for each service reported.

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99321-99333: Nurse Practitioner Services

Medicare Part B covers services by nurse practitioners (NPs) in rural and metropolitan areas. However, coverage is limited to nursing facilities in a metropolitan area.

For services in either metropolitan or rural areas, the team concept applies to all NP services in any nursing facility.

Domicilliaries, rest homes, custodial care facilities, Adult Congregate Living Facilities, etc., are not considered nursing facilities; therefore, the team concept does not apply.

Use the following table to determine proper modifiers to use with NP services.

Area: Metro
Place of Service: Nursing Facility (SNF, ICF, ECF, NH)
Modifier: AL-Metro area, team visit

Area: Rural
Place of Service: Nursing Facility (SNF, ICF, ECF, NH)
Modifier: AK - Rural area, team visit

Area: Metro
Place of Service: Any other than Nursing Facility (SNF, ICF, ECF, NH)
Modifier: Not covered under NP guidelines

Area: Rural
Place of Service: Any other than Nursing Facility (SNF, ICF, ECF, NH)
Modifier: AV - Rural area, non-team visit

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This section of the Medicare B Update! features new and revised medical policies developed as a result of either the Local Medical Review (LMR) or Focused Medical Review (FMR) initiatives. Both the LMR and FMR 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.

Effective Dates

The policies contained in section are effective for claims processed October 20, 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 73 of the September/October 1997 Medicare B Update!

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A0322, A0328, A0330: ICD-9 Specificity Updates for Emergency Transports

The following diagnoses for which medical necessity will be presumed for emergency transports were inadvertently not coded to the correct level of specificity:

Under Severe Seizure or Convulsive Activity, ICD-9 codes 345.30, 345.31 and 780.3 should read: 345.3 and 780.3.

Under Cardiac problems causing chest pain or rhythm disturbances, the ICD-9 code range 426-427.9 should read 426.0-427.9

Under Anaphylactic Shock, the ICD-9 code 995.6 should read 995.60-995.69.

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A9270: Noncoverage Policy

The purpose of this policy is to create a working list of medical services and procedures that are never covered by the Medicare program. Such services and procedures are always denied either because:

a national decision to noncover the service/procedure exists, or

the service/procedure is included on the list of local medical review policy exclusions contained in this policy.

This local medical review policy is iterative and will be updated as national and local coverage decisions change.

Indications and Limitations of Coverage and/or Medical Necessity

A service or procedure on the national noncoverage list may be noncovered for a variety of reasons. It may be noncovered based on a specific exclusion contained in the Medicare law; for example, acupuncture; it may be viewed as not yet proven safe and effective and, therefore, not medically reasonable and necessary; or it may be a procedure that is always considered cosmetic in nature and is denied on that basis. The precise basis for a national decision to noncover a procedure may be found in references cited in this policy.

A service or procedure on the local list is always denied on the basis that we do not believe it is medically reasonable and necessary. Our list of local medical review policy exclusions contains procedures that, for example, are:

experimental

not yet proven safe and effective

not yet approved by the FDA

It is important to note that the fact that a new service or procedure has been issued a CPT code or is FDA approved does not, in itself, make the procedure medically reasonable and necessary. It is our policy that new services, procedures, drugs, or technology must be evaluated and approved either nationally or by our local medical review policy process before they are considered Medicare covered services.

HCPCS Codes

Local Noncoverage Decisions

Laboratory Procedures

86910 Blood typing, for paternity testing, per individual; ABO, Rh, and MN

86911 each additional antigen system

82523* Collagen cross links, any method

89250 Culture and fertilization of oocyte(s)

88349 Electron microscopy: scanning

84999* Lymphocyte mitogen response assays used to monitor the treatment of cancer

88000-88099 Necropsy (autopsy)

Drugs and Biologicals

J3520 Edetate disodium, per 150 mg (chemical endarterectomy)

J0270 Injection, Alprostadil, per 1.25 mcg

A9270 Muse

J3530 Nasal vaccine inhalation

Procedures

01990 Physiological support for harvesting of organs from brain-dead patients

01995 Regional I.V. administration of local anesthetic agent (upper or lower extremity)

11975 Insertion, implantable contraceptive capsules

11977 Removal with reinsertion, implantable contraceptive capsules

15820-15821 Blepharoplasty, lower lid

15824-15829 Rhytidectomy

15831-15839 Excision, excessive skin and subcutaneous tissue (including lipectomy)

15876-15879 Suction assisted lipectomy

17380 Electrolysis epilation, each 1/2 hour

35452* Transluminal balloon angioplasty (PTA) in treatment of obstructive lesions of aortic arch

55899* Transurethral Needle Ablation (TUNA)

58750* Tubo-tubal anastomosis

58970 Follicle puncture for oocyte retrieval, any method

58974 Embryo transfer, intrauterine

58976 Gamete, zygote, or embryo intrafallopian transfer, any method

59012 Cordocentesis (intrauterine), any method

76499* MRI for use in measuring the blood flow, spectroscopy imaging of cortical bone and calcification, and procedures involving resolution of bone or calcification

92548* Computerized dynamic posturography

93650 Intracardiac catheter ablation of arrhythmogenic focus or tract(s), including intracardiac mapping, with or without temporary pacemaker placement

93799* Metaidobenzylquanidine (MIBG) imaging

95999* Biothesiometry

97799 Low vision rehabilitation

99360 Stand-by anesthesia

A9270* Cellular Therapy

A9270 High Voltage Pulsed Current (HVPC) Therapy

A9270* Light reflecting rheography

A9270* Pelvic floor stimulator

A9270 Politzer Procedure

95999* Surface electromyography

27599* Tidal knee irrigation

M0540 Signal-averaging EKG

National Noncoverage Decisions

Devices

59899* Artificial hearts and related devices (CIM 65-15)

E0782* Implantable infusion pumps for the delivery of insulin to treat diabetes (CIM 60-14)

A9270* Intrapulmonary percussive ventilator for home use (CIM 60-21)

20974* Ultrasonic osteogenic stimulators (CIM 35-48)

Laboratory Procedures

86999* Cytotoxic leukocyte tests for food allergies (CIM 50-2)

88399* Human tumor stem cell drug sensitivity assays (CIM 50-41)

Drugs and Biologicals

J3570* Laetrile (Amygdalin, Vit B17) (CIM 45-10)

A4260* Levonorgestral (contraceptive) implants system, including implants and supplies (Statute 1862 [a][1][a])

J7140-J7180 Oral Medication (MCM 2049)

J8499 Oral Medication (MCM 2049)

J8499* Sublingually administered antigens (CIM 45-28)

Procedures

A9270* Acupuncture (CIM 35-8)

93784-93790* Ambulatory blood pressure monitoring (CIM 50-42)

59899* Ambulatory home monitoring of uterine contractions (MCM 2005.1)

90908 Biofeedback (psychiatric only)

53899* Bladder Stimulator (CIM 65-11)

A9270 Carbon Dioxide Therapy (CIM 35-29)

A9270* Cardiac output monitoring by electrical bioimpedance (CIM 50-54)

A9270* Cardiointegram (CIG) as an alternative to stress test or thallium stress test (CIM 50-47)

A9270* Carotid body resection to relieve pulmonary symptoms, including asthma (CIM 35-7)

A9270* Carotid sinus nerve stimulator for treatment of paroxysmal supraventricular tachycardia (CIM 65-4)

95075* Challenge injection food testing for diagnosis of RA, depression, respiratory disorders (CIM 50-22)

A9270* Chelation Therapy (EDTA) for treatment of arteriosclerosis (CIM 35-64)

69949* Cochleostomy with neurovascular transplant for Meniere s Disease (CIM 35-50)

A9270* Colonic irrigation (CIM 35-1)

A9270 Cosmetic surgery (MCM 2329)

A9270* Cryosurgery of the prostate (CIM 35-96)

A9270* Diathermy or ultrasound treatments performed for respiratory conditions or diseases (CIM 35-41)

48550* Donor pancreatectomy (CIM 35-82)

78351* Dual Photon Absorptiometry (CIM 50-44)

A9270* Ear/carbon therapy (CIM 35-29)

A9270* Electrical aversion therapy for treatment of alcoholism (CIM 35-23.1)

A9270* Electrical continence (CIM 65-2)

95999* EEG monitoring during open heart surgery and in immediate post-op period (CIM 35-57.1)

A9270* Electrosleep therapy (CIM 35-18)

A9270* Electrostimulation in the treatment of wounds (CIM 35-98)

A9270 Electrotherapy for the treatment of facial nerve paralysis (Bell s Palsy) (CIM 35-72)

A9270* External Counterpulsation (ECP) (CIM 35-74)

A9270 Eye exam, routine (MCM 2320)

A9270* Fabric wrapping of abdominal aneurysms (CIM 35-34)

90846 Family medical psychotherapy (without patient present) (CIM 35-14)

A9270* Gastric balloon for treatment of obesity (CIM 35-86)

M0100* Gastric freezing (CIM 35-65)

A9270* Hair analyis (CIM 50-24)

V5010 Hearing exam for the purpose of a hearing aid (MCM 2320)

A9270* Hemodialysis for treatment of schizophrenia (CIM 35-51)

90875-90876 Individual psychophysiological therapy incorporating biofeedback (CIM 35-27)

55970-55980* Intersex surgery (CIM 35-61)

44131* Intestinal by-pass surgery (CIM 35-40)

A9270* Intravenous histamine therapy (CIM 35-19)

A9270* Investigational IOLS in FDA Core Study or Modified Core Study (MCM 2020.25)

32999* Lung volume reduction surgery (CIM 35-93)

A9170 Noncovered service by chiropractor (MCM 2026.26)

A9160 Noncovered service by podiatrist (MCM 2020.4)

A9270 Osteopathic cranial manipulation (MCM 2020.2)

A9270 Osteopathic pulmonary manipulation (MCM 2020.2)

48160* Pancreatectomy, total, with transplantation (CIM 35-82)

A9270* Partial ventriculectomy (also known as ventricular reduction, ventricular remodeling, or heart volume reduction surgery) (CIM 35-95)

96910 Photo Chemotherapy, PCT treatment (CIM 35-66)

93797 Physician services for outpatient cardiac rehab without continuous ECG monitoring (per session) (CIM 35-25)

A9270* Platelet-derived wound healing formula (Procuren) (CIM 45-26)

A9270* Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (CIM 35-13)

75978 PTA, venous, supervision/interaction only (CIM 50-32)

15775-15776 Punch graft for hair transplant (MCM 2329)

65760-65767,65771* Refractive keratoplasty to correct refractive error (CIM 35-54)

32491 Removal of lung, other than total pneumonectomy; excision-plication of emphysematous lung(s) (bullous or non-bullous), for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure (prior to 1/1/97 HCPCS code G0061) (CIM 35-93)

95199 Repository antigen (MCM 2005.2)

90760 Routine physical exam (MCM 2320)

A9270 Speech therapy by pathologist/speech therapist (MCM 2206.2)

64999* Stereotactic cingulotomy as a means of psychosurgery

A9270* Sweat test as predictor of efficacy of sympathectomy in PVD (CIM 50-3)

11920-11922 Tattooing (MCM 2329)

A9270* Thermogenic therapy (CIM 35-6)

A9270* Tinnitus masking (CIM 35-63)

90899* Transcendental meditation (CIM 35-92)

A9270* Transfer factor for treatment of multiple sclerosis

A9270* Transilluminator light scanning or diaphanography (CIM 50-46)

A9270* Transmyocardial Revascularization (TMR) (CIM 35-94)

48554* Transplantation of pancreatic allograft (CIM 35-82)

A9270* Transvenous (catheter) pulmonary embolectomy (CIM 35-55)

A9270* Treatment of decubitus ulcers by ultraviolet light, low intensity direct current, topical application of oxygen and topical dressings with balsam of Peru in castor oil (CIM 35-31)

A9270 Treatment of motor function disorders with electrical nerve stimulation (CIM 35-20)

A9270* Ultrafiltration independent of conventional dialysis (CIM 55-3)

A9270* Vertebral Axial Decompression (VAX-D) (CIM 35-97)

A9270 Vitamin B injections to strengthen tendons, ligaments of the foot (CIM 45-4)

These lists of noncovered services are not all- inclusive.

*Services which are noncovered due to their being investigational/experimental.

Reasons for Denial

See criteria for noncoverage.

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 efficacy.

Documentation Requirements

National noncovered services will not be covered by the local carrier under any circumstances. In order for noncovered services to be evaluated for coverage, the following documentation must be submitted to the local carrier:

Peer reviewed articles from appropriate medical journals;

Statements from authorities within the field;

FDA approval;

Appropriate CPT/HCPC code.

Rationale for Creating Policy

This policy is created to establish the parameters by which Medicare Part B of Florida will consider services to be noncovered, and to ensure that reimbursement is made only for those services which are medically reasonable and necessary.

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G0062, G0063: Bone Mineral Density Studies

Osteoporosis has classically been defined as skeletal fragility due to low bone mass, which results in fractures associated with minimal trauma. To quantify this concept, osteoporosis has been defined as bone mass more than 2.5 standard deviations below the mean of young normals. Osteoporosis is a major health problem, and it has been estimated that 70% of fractures in women age 45 and older are the types associated with osteoporosis. Multiple risk factors have been identified that increase the risk for developing osteoporosis (heredity, estrogen deficiency, alcoholism, race and sex being the most prominent).

Bone mineral density studies are performed to establish the diagnosis of osteoporosis and to assess the individual s risk for subsequent fracture. Bone densitometry includes the use of single photon absorptiometry (SPA), dual photon absorptiometry (DPA), dual energy radiographic absorptiometry (DEXA), portable dual energy radiographic absorptiometry (p-DEXA), quantitative computed tomography (QCT), and bone ultrasound densitometry (BUD). Low radiation dose, availability and ease of use have made DEXA the most widely used technique for measuring bone density in clinical trials and epidemiological studies.

Bone density can be measured at the wrist, spine, hip or calcaneus. The medical literature is divided on the accuracy of predicting osteoporosis of the spine or hip by measuring peripheral sites (wrist, calcaneus). It does appear, however, that measurement of bone density of the bone involved gives a better measurement of osteoporosis than does measurement of another bone not known to be involved. Medicare does not pay for screening, hence, Medicare will only pay for measurement of the bone involved.

Precise calibration of the equipment is required for accuracy and to reduce variation of test results and risk of misclassification of the degree of bone density. Lack of standardization in bone mineral measurement remains an issue, and tests are best done on the same suitably precise instrument to insure accuracy. For these reasons, tests done on mobile or portable instruments are

non-covered because of lack of sufficient data to determine accuracy and precision. It is important to use results obtained with the same scanner when comparing a patient to a control population, as systematic differences among scanners have been found.

A stationary bone densitometer is a device that is permanently located in an office.

A mobile densitomer is one that is transported by vehicle from site to site.

A portable densitometer is one that can be picked up and moved from one site to another.

It has been noted both nationally and locally that p-DEXA has been billed as the more expensive DEXA due to the lack of an appropriate code. As of 1997, HCPCS alpha codes have been developed for both the peripheral and central DEXA studies (G0062 and G0063). The previous code for DEXA (76075) is no longer valid, effective for services rendered January 1, 1997, and after. These HCPCS alpha code changes were published in the December 1996 Medicare B Update! Special Issue: 1997 HCFA Common Procedure Coding System and Medicare Physician Fee Schedule Database Update.

In addition, procedure code 76075 has been selected as a Focused Medical Review (FMR) aberrant code for 1997. Analysis of January-June 1996 claims data revealed that this procedure was being billed with diagnoses that did not substantiate medical necessity and services were being billed at unusually frequent intervals.

Local Medical Review Policy has been developed to ensure that Medicare Part B is paying for services that are medically necessary and reasonable. The policy defines the services and the circumstances under which Medicare Part B will consider the tests to be medically necessary and reasonable, it provides guidelines for medical review, and it includes a diagnosis to procedure code edit.

Indications and Limitations of Coverage and/or Medical Necessity

G0062: Peripheral skeletal bone mineral density studies (e.g., radius, wrist, heel)

In general, it appears that a peripheral bone denisty study is useful in screening for osteoporosis; however, Medicare is prevented by statute from paying for screening for osteoporosis.

A peripheral bone density study is covered for the patient with a Colles fracture or other distal radius or ulnar fracture when the study is done because of suspicion that osteoporosis is a component of the cause of the fracture. If the diagnosis of osteoporosis is already established, this would not be covered.

You would not expect to see this test performed for Colles or other fracture more than once.

ICD-9 Codes That Support Medical Necessity

813.40-813.44

813.50-813.54

G0063: Central skeletal bone mineral density studies (e.g., spine, pelvis)

A central bone density study is covered for the following indications:

A patient with a recent fracture of the spine, long bone, hip or pelvis, when the fracture is suspected to be associated with osteoporosis; code with the appropriate ICD-9 code for the fracture.

Radiographic Osteopenia: For this indication, the test is covered to verify and quantify osteoporosis and to determine if the patient is to be treated with medication to increase bone density.

A patient with documented osteoporosis on therapy with drugs known to increase bone mineral density when the test is done to determine response to therapy; ICD-9 code 733.00 for unspecified osteoporosis, ICD-9 code 733.01 for postmenopausal osteoporosis, ICD-9 code 733.02 for idiopathic osteoporosis.

A patient with known hyperparathyroidism when the test result is being used to determine if the patient requires a parathyroidectomy. Use ICD-9 code 252.0 for hyperparathyroidism.

A patient on long-term corticosteroid therapy (greater than 3 months, on the equivalent dose of 30 mg cortisone [or 7.5 mg prednisone] or greater per day). For this indication, the test is covered only if the result is used to determine if the patient is to be treated with drugs to increase bone density. Use ICD-9 code 733.09 for drug-induced osteoporosis and E932.0 for adrenal cortical steroids.

A patient on long-term (greater than 1 month) heparin therapy. For this indication, the test is covered only when the result is used to determine if the patient is to be treated with drugs to increase bone density. Use ICD-9 code 733.09 for drug-induced osteoporosis and E934.2 for heparin.

A patient on long-term (greater than 3 months) phenytoin therapy. For this indication, the test is covered only when the result is being used to determine if the phenytoin is to be discontinued and or to determine if the patient is to be treated with drugs to increase bone density. Use ICD-9 code 733.09 for drug-induced osteoporosis and E936.1 for phenytoin.

A patient on excessive doses of thyroid replacement. For this indication, the test is covered only if the patient has a subnormal TSH level while on thyroid replacement. For this indication, the test is covered only when the results is being used to determine if the patient is to be treated with drugs to increase bone density. Use ICD-9 codes 244.0-244.9 for hypothyroidism and E932.7 for the excessive thyroid medication.

For asymptomatic women with estrogen deficiency, bone mineral density studies would be considered screening in the absence of signs and symptoms.

Medicare does not cover routine screening procedures or protocols, including the routine screening for osteoporosis through the use of bone mineral density studies. It is expected that these procedures should only be rendered when medically reasonable and necessary for the patient s condition. Therefore, a patients therapy should be individualized; testing or retesting for each patient should not be performed automatically. This test should not be repeated more often than medically necessary.

A bone densitometry study (G0063) code should be billed only once regardless of the number of sites being tested or included in the study (i.e., if the spine and hip are performed as part of the same study only one G0063 can be billed).

ICD-9 Codes That Support Medical Necessity

244.0-244.9, 252.0, 733.00, 733.01, 733.02, 733.09, 733.11-733.16, 805.2, 806.4, 808.0-808.9, 820.0-820.9, E923.7, E932.0, E934.2, E936.1

Coding Guidelines

CPT codes 76070, 76075, and 78350 are no longer recognized for Medicare payment and have been assigned a G (not valid for Medicare payment purposes) status indicator. The G status applies to all three components of the services: global, TC, and -26. The following new interim HCPCS codes have been established for the reporting of peripheral and central skeletal BMD.

G0062 Peripheral skeletal bone mineral density studies (e.g., radius, wrist, heel)

G0063 Central skeletal bone mineral density studies (e.g., spine, pelvis)

With the exception of dual photon absorptiometry (CPT code 78351), physicians and other providers must report all peripheral or skeletal BMD studies under the interim codes. Dual photon absorptiometry remains a noncovered service under Medicare and may not be reported under HCPCS codes G0062 or G0063.

More specifically, G0062 is used to report single photon absorptiometry studies, dual energy absorptiometry studies (CPT code 76075) or computerized tomography on a peripheral skeletal bone, BMD (CPT code 76070). Photodensitometry (a noninvasive radiological procedure that attempts to assess bone mass by measuring the optical density of extremity radiographs with a photodensitometer) is reported using code G0062.

Code G0063 is used to report single photon absorptiometry studies, dual energy absorptiometry studies, or computerized tomography on a central skeletal bone.

Reasons for Denial

Medicare is prevented by statute from paying for screening for osteoporosis (e.g., bone densitometry would be noncovered (a) if done because the patient is or has been a tobacco user, (b) the individual is or has been a consumer of alcoholic products, (c) if the individual is 65 and over but does not have any of the conditions described under COVERAGE).

Medical data is lacking that demonstrates that routine bone densitometry testing results in benefit to individuals in the following categories, and therefore testing would be considered medically unnecessary:

Perimenopausal women who are otherwise asymptomatic and who decide to take estrogen replacement for other reasons;

Patients with end-stage renal disease;

Elderly individuals who are otherwise well, and who do not have the conditions mentioned under indications for coverage;

Patients who have been partially or completely immobilized and are likely to remain partially or completely immobilized from a chronic disease process.

Bone Ultrasound Densitometry (no CPT or HCPCS code) is considered screening until more data is available to determine its appropriateness.

Bone density studies of any type including DEXA scans are not covered under the portable x-ray benefit. The benefit allows for x-ray films of the skeleton, chest or abdomen. Although bone density studies are radiology procedures, they are not x-ray films. Also, to be a benefit of portable x-ray services the equipment must be portable to provide services in the home. Bone density studies done by portable units are considered investigational until more data is available to determine its accuracy, precision and benefit in predicting bone density.

Peripheral DEXA or p-DEXA except in the case of distal ulna/radius or Colles fractures is considered screening.

Photodensitometry, a noninvasive radiological procedure that attempts to assess a bone mass by measuring the optical density of extremity radiographs with a photodensitometer, is considered investigational until more information is available to determine its effectiveness and benefit.

Bone density studies done by mobile units are considered investigational until more data is available to determine the accuracy, precision and benefit in predicting bone density.

The value of bone density studies to improve the outcomes of patients with end-stage renal

disease is considered investigational.

Bone mineral density studies for patients with a history of depression is considered investigational.

Any ICD-9-CM diagnosis not listed in the indications for coverage category.

CPT 78351 (Dual Photon Absorptiometry) is noncovered by Medicare (Coverage Issues Manual 50-44).

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Documentation Requirements

Medical record documentation maintained by the treating physician must clearly document the medical necessity for the ordering of the services. The documentation may be included in any of the following:

history and physical

office/process notes

test results with written interpretation x-ray/radiology with written interpretation.

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93930, 93931: Coverage for Duplex Scan of Upper Extremity Arteries or Arterial By-Pass Grafts

As a result of 1994 Focused Medical Review, medical policy was developed for duplex scanning of upper extremity arteries or arterial by-pass grafts (procedure codes 93930-93931) in 1995. This procedure is considered medically reasonable and necessary when it is performed for one of the following indications:

The patient has otherwise unexplained diminished or absent pulses of one or both upper extremities.

The patient has sustained an embolus or has thrombosis of an upper extremity artery.

The patient has sustained upper extremity trauma and arterial compromise is suspected.

The patient has an upper extremity or subclavian artery aneurysm.

The patient has subclavian steal syndrome.

Diagnosis Requirements

Medicare Part B of Florida will provide coverage for this procedure when it is performed for the following conditions/diagnoses:

353.0, 435.2, 442.0, 442.82, 443.0, 444.21, 447.0, 747.60, 747.63, 747.69, 901.1, 903.00-903.9, 927.00-927.21, 927.8, 998.2

Coding Guidelines

Bill duplex scan of upper extemity arteries using CPT code 93930. For unilateral or limited study, use CPT code 93931.

For duplex scan of hemodialysis access, bill with CPT code 93900.

Reasons for Denial

Medicare Part B of Florida does not provide coverage for duplex scanning of upper extremity arteries when it is done as a screening procedure.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity for this procedure. The results of duplex scanning of upper extremity arteries must be included 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) were published. Since that publication, an additional covered diagnosis has been added: 185 (Malignant neoplasm of prostate).

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

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93990:Duplex Scan Of Hemodialysis Access

Duplex scanning is an ultrasonic scanning procedure with display of both two-dimensional structure and motion with time and Doppler ultrasonic signal documentation with spectrum analysis and/or color flow velocity mapping or imaging. This technique allows sampling of a particular imaged blood vessel with analysis of the blood flow velocity.

Evaluation of endogenous arteriovenous fistulae and synthetic polytetrafluoroethylene (PTFE) grafts, which are the two principal means of creating permanent vascular access for hemodialysis, can be achieved by duplex scanning.

Limited coverage has been established for duplex scanning of hemodialysis access sites in patients with end stage renal disease (ESRD). These procedures are medically necessary only in

the presence of signs and symptoms of possible failure of the access site, and when the results of the procedures may impact the clinical course of the patient.

Appropriate indications for duplex scan of hemodialysis access site would include clear documentation in the dialysis record of signs of chronic (i.e., 3 successive dialysis sessions) abnormal function, including:

Clinical Indicators

difficult canulation by multiple personnel;

thrombus aspiration by multiple personnel;

prolonged bleeding after needle withdrawl;

pain in graft arm;

persistent swelling in graft arm;

elevated venous pressure greater than 200 mm Hg on a 300 cc/min. pump;

elevated recirculation time of 15% or greater;

low urea reduction rate of less than 60%; or

shunt collapse, suggesting poor arterial flow

Physical Findings By Examination of Graft

bruit is discontinuous, systolic only, harsh, high pitched

thrill is at stenotic sites, possibly multiple, discontinuous, systolic only

pulse is water-hammer

Diagnosis Requirements

Medicare Part B of Florida will consider Duplex Scan of Hemodialysis Access to be medically necessary when performed for the following condition/diagnosis:

996.73 Complications due to renal dialysis device, implant, and graft

Coding Guidelines

Bill for these services using CPT code 93990. Provide the appropriate ICD-9 code to describe the medical condition being treated.

The use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be a part of the physical examination of the vascular system and is not separately reported.

Reasons for Denial

Routine evaluation for hemodialysis access failure, in the absence of signs and symptoms of failure, is considered screening and is not a covered service.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Documentation Requirements

Medical record documentation maintained by the physician must clearly indicate the medical necessity of the services being billed. The results of the study must be included in the medical record.

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94010: Clarification for Billing of Spirometries

On page 45 of the January/February 1997 Medicare B Update!, the indications and limitations of coverage for spirometries was published. After receiving numerous inquiries regarding the billing of spirometries (i.e., procedure code 94010 as opposed to procedure code 94060), it was determined that clarification was needed. It is Medicare s position that procedure code 94060 be utilized during the initial diagnostic evaluation of a patient. Once it has been determined that a patient is sensitive to bronchodilators, repeat bronchospasm evaluation is usually not medically necessary, unless one of the following circumstances exist: (1) a patient is exhibiting an acute exacerbation and a bronchospasm evaluation is being performed to determine if the patient will respond to bronchodilators; (2) the initial bronchospasm evaluation was negative for bronchodilator sensivity and the patient presents with new symptoms which suggest the patient has a disease process which may respond to bronchodilators; or (3) the initial bronchospasm evaluation was not diagnostic due to lack of patient effort. Repeat spirometries performed to evaluate patients response to newly established treatments, monitor the course of asthma/COPD, or evaluate patients continuing with symptomatology after initiation of treatment should be utilizing procedure code 94010.

In addition, it is not expected that a pulse oximetry (procedure code 94760 or 94761) for oxygen saturation would routinely be performed with a spirometry. Pulse oximetry is considered medically necessary when the patient has a condition resulting in hypoxemia and there is a need to assess the status of a chronic respiratory condition, supplemental oxygen and/or a therapeutic regimen (i.e., acute symptoms).

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Complex Decongestive Physiotherapy

The lymphatic system has two primary immunologic functions: activating the inflammatory response and controlling infections. In addition, the lymphatic system drains protein-containing fluid from the tissue and conducts it in a unidirectional flow to the circulatory system. When there is a blockage in this drainage, the result is the swelling of a body part, often an extremity. This is referred to as lymphedema, an abnormal accumulation of lymph fluid.

Lymphedema is categorized as primary or secondary. Primary lymphedema is defined as impaired lymphatic flow due to lymph vessel aplasia, hypoplasia, or hyperplasia. This type is an inherited deficiency in the lymphatic channels of unknown origin. Secondary lymphedema is caused by known precipitating factors. The most common causes in the United States are surgical removal of the lymph nodes (i.e., in connection with a mastectomy), fibrosis secondary to radiation, and traumatic injury to the lymphatic system. Filariasis is the leading cause of lymphedema throughout much of the tropical world.

Currently, lymphedema can be treated by many methods such as: Compressive garments, wrapping, elevation, surgery, pneumatic compression devices or Complex Decongestive Physiotherapy (CDP). This policy addresses only the CDP method.

Complex Decongestive Physiotherapy has been referred to by several terms including: non-invasive complex lymphedema therapy (CLT), early conservative lymphedema management, complicated physiotherapeutics, manual lymphedema treatment (MLT), multi-modal lymphedema therapy, and palliative lymphedema therapy. For purposes of consistency, the term CDP will be used.

Each CDP session normally consists of four phases:

Skin care including cleansing, lubrication, debriding and administration of antimicrobial therapy;

Manual lymph drainage involving a gentle massage technique that is carried out in a predetermined manner aimed at redirecting lymph and edema fluid towards adjacent, functioning lymph systems;

Multi-layered compression wrapping (bandages) to prevent any reaccumulation of excavated edema fluid and prevents the ultrafiltration of additional fluid into the interstitial space; and

Individualized exercises with the bandage to enhance lymphatic flow from peripheral to central drainage components. These exercises are aimed at augmenting muscular contraction, enhancing joint mobility, strengthening the limb, and reducing the muscle atrophy that frequently occurs secondary to lymphedema.

Indications and Limitations of Coverage and/or Medical Necessity

As mentioned earlier CDP consists of skin care, manual lymph drainage, compression wrapping, and exercises. Although there is no means for Medicare to allow payment of the total treatment via one treatment code, payment will be allowed for the physical therapy services associated with the treatment. Other services such as skin care and the supplies associated with the compression wrapping are included in the physical therapy services performed during each session.

The goal of this therapy is not to achieve maximum volume reduction, but to ultimately transfer the responsibility of the care from the clinic, hospital, or doctor, to home care by the patient, patient family or patient caregiver. Unless the patient is able to continue therapy at home, there is only temporary benefit from the treatment. The endpoint of treatment is not when the edema resolves or stabilizes, but when the patient and/or their cohort are able to continue the treatments at home. Patients who do not have the capacity or support system to accomplish these skills in a reasonable time are not good candidates for Complex Decongestive Physiotherapy.

It is expected that physical therapy education sessions would usually last for 1 to 2 weeks, with the patient attending 3-5 times per week, depending on the progress of the therapy. After that time, there should have been enough teaching and instruction that the care could be continued by the patient or patient caregiver in the home setting. The maximum benefits of treatment are not expected unless the patient continues treatment at home.

The physical therapy billed in conjunction with the manual lymph drainage therapy will be subject to all national and local policies for physical therapy.

The coverage of the physical therapy would only be allowed if the following conditions have been met:

There is a physician-documented diagnosis of lymphedema; and the physician specifically orders CDP;

The patient is symptomatic for lymphedema, with limitation of function related to self care, mobility and/or safety;

The patient or patient caregiver has the ability to understand and comply with home care continuation of treatment regimen.; and

The services are being performed by a health care professional who has received specialized training in this form of treatment.

Currently, Medicare covers services for lymphedema by the lymphedema pump. Some providers are proposing CDP as an alternative to pumps. A patient requiring both modes of treatment should be rare. In addition, it is not expected that PT and OT would be performed concurrently; (i.e., both PT and OT providing the therapeutic exercise portion of the session)

The physical therapy services for CDP must be provided either by or under the direct personal supervision of the physician or independently practicing therapist.

To ensure that payment is made only for medically necessary services, CDP is covered only when it is performed for the following diagnosis:

457.0

Postmastectomy lymphedema syndrome

457.1

Other lymphedema

757.0

Congenital lymphedema

Since a separate CPT code does not exist for CDP, only the following procedure codes should be utilized when CDP is being performed:

97110 - Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

97124 - Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)

97535 - Self care/home management training (e.g., activities of daily living [ADL] and compensatory training, meal preparation,

safety procedures, and instructions in use of adaptive equipment) direct one-on-one contact by provider, each 15 minutes

Q0103 - Physical therapy evaluation, initial

Q0104 - Physical therapy reevaluation, periodic

Q0109 - Occupational evaluation, initial

Q0110 - Occupational reevaluation, periodic

Coding Guidelines

It is expected that procedure code 97124 will be utilized when the manual lymph drainage is performed, procedure code 97535 for the instruction of bandaging, exercises and self care, and procedure code 97110 when performing the individual exercises.

When an initial evaluation or periodic reevaluation is performed, separate reimbursement may be made. For these evaluations, physical and occupational therapists should use codes Q0103, Q0104, Q0109, and Q0110, and physicians should use the applicable Evaluation and Management codes.

It is not appropriate to automatically bill with an evaluation and management service each time a patient goes for the physical therapy treatment. An evaluation and management code should not be used unless all of the components of the visit have been met.

Documentation Requirements

The medical record documentation maintained by the provider must clearly document the medical necessity of the services being performed.

The documentation for the initial evaluation and treatment must include the following:

A physician-documented diagnosis of lymphedema and a specific order for CDP;

A statement as to the ability of the patient/patient caregiver to follow through with the continuation of treatment on a long term home treatment plan;

History and physical including: the cause of the lymphedema and any prior treatment, measurements of body part/extremity prior to treatment, specific areas of indurated tissue, hardness of edema, condition of nails and skin, infected sites, scars, distal pulses, pain, discomfort and the effects the lymphedema has on the patient s Activities of Daily Living (i.e., symptomatic for

lymphedema, with limitation of function related to self care, mobility and/or safety);

Treatment plan identifying specific short and long term goals; the type, amount, frequency and duration of the services; and

The services/modalities performed including a response to treatment.

The documentation for any subsequent treatment must include:

A report showing the progress of the therapy including periodic measurements of the applicable extremity(ies);

The response of the patient /patient caregiver to the education and their understanding and ability to take on some of the responsibilities of the treatment; and

The services/modalities performed including a response to treatment.

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99183: Coverage for Hyperbaric Oxygen Therapy

In July 1997, the Coverage Issues Manual was revised to clarify the conditions in which HBO is covered. Therefore, a revision in the policy was made. HBO (procedure code 99183) is covered by Medicare Part B for the following conditions. For each of the 14 covered conditions, the following diagnosis should be utilized:

1. Acute carbon monoxide intoxication - Diagnosis 986

2. Decompression illness - Diagnosis 993.3

3. Gas embolism - Diagnosis 958.0, 993.9, or 999.1

4. Gas gangrene - Diagnosis 040.0

5. Acute traumatic peripheral ischemia - Diagnosis 903.01, 904.0 or 904.41

6. Crush injuries and suturing of severed limbs - Diagnosis 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, or 996.90-996.99

7. Progressive necrotizing infections (necrotizing fasciitis, meleney ulcer) - Diagnosis 686.0 or 728.86

8. Acute peripheral arterial insufficiency - Diagnosis 733.40-733.49, 444.21, or 444.22

9. Preparation and preservation of compromised skin grafts - Diagnosis 996.52

10. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management - Diagnosis 730.10-730.19

11. Osteoradionecrosis as an adjunct to conventional treatment - Diagnosis 526.89 or 909.2

12. Soft tissue radionecrosis as an adjunct to conventional treatment - Diagnosis 990

13. Cyanide poisoning - Diagnosis 987.7 or 989.0

14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment. - Diagnosis 039.0-039.9

For acute traumatic peripheral ischemic, crush injuries and suturing of severed limbs, Hyperbaric Oxygen Therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures, when loss of function, limb, or life is threatened.

The principal treatment for progressive necrotizing infections is surgical debridement and systemic antibiotics. HBO is recommended as an adjunct only in those settings where mortality and morbidity are expected to be high despite aggressive standard treatment. One of the necrotizing infections, Meleney s ulcer is a polymicrobial (mixed aerobic-anaerobic organisms) ulcer which slowly progresses affecting the total thickness of the skin. Also called a bacterial synergistic gangrene, the Meleney ulcer is associated with the formation of burrowing cutaneous fissures and sinus tracts that emerge at distant skin sites. This ulcer presents as a wide area of pale red cellulitis that subsequently ulcerates and gradually enlarges to form a large ulcerative plaque, typically with a central area of granulation tissue encircled by gangrenous or necrotic tissue.

Another type of progression necrotizing infection is necrotizing fasciitis. This condition is a relatively rare infection. It is usually a result of a group A streptococcal infection beginning with severe or extensive cellulitis that spreads to involve the superficial and deep fascia, producing thrombosis of the subcutaneous vessels and gangrene of the underlying tissues. A cutaneous lesion usually serves as a portal of entry for the infection, but sometimes no such lesion is found.

HBO therapy should not be a replacement for other standard successful therapeutic measures; however, it is the treatment of choice and standard of care for decompression sickness and arterial gas embolism. Traumatic or spontaneous pneumothorax constitute contraindications to adjunctive HBO therapy only if untreated and pregnancy is considered a contraindication to HBO

except in the case of carbon monoxide poisoning where it is specifically indicated.

Topical application of oxygen (Topox) is noncovered.

Arterial insufficiency ulcers may be treated by HBO therapy if they are persistent after reconstructive surgery has restored large vessel function. HBO therapy for venous stasis ulcers is recommended only if venous surgery, local wound care by elevation, counter pressure support and skin grafting fails.

Note: Prior to the initiation of HBO therapy, it is expected in most cases that the diagnosis will be established by the referring or treating physician.

Indications of effective treatment outcomes for HBO include:

There is improvement or healing of wounds.

There is improvement of tissue perfusion.

There is new epithelial tissue growth and granulation

Tissue PO2 of at least 30 mmHg of oxygen is necessary for oxidative function to occur.

The mechanical reduction in the bubble size of air emboli alleviates decompression sickness

To ensure that payment is being only for medically reasonable and necessary services, HBO is covered for the following diagnoses:

039.0-039.9, 040.0, 444.21-444.22, 526.89, 686.0, 728.86, 730.10-730.19, 733.40- 733.49 , 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

The following diagnoses are considered a program exclusion, and therefore, no program payment will be made:

Cutaneous, decubitus (707.0), and stasis ulcers (454.0, 454.2)

Chronic peripheral vascular insufficiency (443.0-443.9)

Anaerobic septicemia and infection other than clostridial

Skin burns (thermal)

Senility (797)

Myocardial infarction (410.00-412)

Cardiogenic shock (785.51)

Sickle cell crisis (282.62)

Acute thermal and chemical pulmonary damage, i.e., smoke inhalation with pulmonary insufficiency

Acute or chronic cerebral vascular insufficiency

Hepatic necrosis (570)

Aerobic septicemia

Nonvascular causes of chronic brain syndrome (Pick s disease [331.1], Alzheimer s disease [331.0], Korsakoff s disease [294.0])

Tetanus (037)

Systemic aerobic infection

Organ transplantation (V42.0-V42.9)

Coding Guidelines

Evaluation and management services and/or procedures (e.g., wound debridement) provided in a hyperbaric oxygen treatment facility in conjunction with a hyperbaric oxygen therapy session may be reported separately.

This code reflects a per session descriptor, therefore, regardless of the time HBO therapy is performed (i.e., 1 hour, 2 hours) during each session, only 1" in the number billed should be submitted.

Documentation Requirements

Documentation for all services should be maintained on file, (e.g., progress notes and treatment record) to substantiate medical necessity for HBO treatment.

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What s New for EMC?

CLIA Number Requirements for Electronic Claims

The Health Care Financing Administration has mandated that effective for claims processed on or after January 1, 1998, claims for clinical diagnostic and physician office laboratory services must contain the 10-digit Clinical Laboratory Improvement Amendments (CLIA) number in the FA0 record, field 34, positions 164-178, of the National Standard Format. Physicians will be given a grace period from October 1, 1997 through December 31, 1997. During this time frame, providers will receive

an informational message on their remittance advice notices indicating the upcoming need for the CLIA number. Beginning January 1, 1998, physician claims billed electronically with either no CLIA number or a CLIA number formatted incorrectly will be rejected with the message: INV/MISS CLIA1. This requirement does not apply to independent clinical laboratories. Providers may start submitting this information as soon as the capability is developed in their software.

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General EMC Information

Rejects, Denials, and Duplicate Transmissions: What s the Difference?

Do you ever feel frustrated when you call Medicare and are transferred numerous times before you get the right person to assist you with your problems? If so, the following information should help you understand who to call and what to do when you receive a reject, denial, or duplicate transmission letter.

The term reject applies to electronically submitted claims that fail one or more edits and are not accepted into the Medicare B system. The rejected claims print on an EMC Error Report the day after transmission which is then returned by mail to the submitter along with a letter explaining the errors and instructions on how to correct and re-submit the claims. For questions on the EMC Error Report, please contact the Marketing Department at (904) 791-6878.

The term denial refers to claims processed in the Medicare B system but no payment was made. These claims are returned on a Medicare Remittance Notice (MRN) showing lack of payment and an explanation for the denial. For questions regarding MRNs, please contact the Provider Customer Service Department at 904-634-4994.

The term duplicate transmission applies to batches of claims that have been electronically submitted more than once. If an entire batch (a batch may consist of one or more claims) rejects or denies, you will need to alter the batch to avoid a duplicate transmission by adding or deleting a claim, or by splitting the batch. For questions regarding duplicate transmissions please contact Michelle Hackett or Rhonda Lord at (904) 354-5977.

For more information on the different types of duplicates, please refer to the articles Duplicate Problems-Understanding the 4 Types of Duplicate Checks and Notification for EMC Senders and Avoiding Duplicate EMC Transmissions starting on page 68 of the March/April 1997 Medicare B Update.

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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 (MFB) is aggressively dealing with these issues. Please report the following activities, or any fraudulent and abusive practices, to the Medicare Fraud Branch by phone, fax, or by mail at:

Medicare Part B Provider Lines (904) 634-4994
Mediicare Part A Provider Lines (904) 355-8899
MFB Fax Line (904) 791-6716

Medicare Fraud Branch
P.O. Box 45087
Jacksonville, FL 32231-0048

Please include as much detail as possible, including at least one beneficiary name who has been victimized, or at least the provider s name, address and code(s) at issue. You may remain anonymous and the information will not be shared beyond law enforcement entities. All reports are held in the strictest confidence.

National Medicare Fraud Alert

This section is a compilation of the most recent National Medicare Fraud Alerts, which are produced as a result of the findings of various Medicare carrier fraud units, state and federal agencies. These alerts are distributed in full by the Medicare Fraud Information Specialist to various state, federal, provider and beneficiary associations and agencies. They are highlighted in this section to further reach Florida providers and beneficiaries. Please report anyone attempting to involve you in any of these schemes and use caution when asked to approve services such as these for your patients.

False DME Claims: Multiple companies have been identified as submitting false claims for the following items:

Body Jackets w/ attachments (L0430, L1240, L1260, L1280);

Knee Orthoses (L1845, L1845 LT/RT);

Prosthetic Shrinker (knee socks for amputees L8460 LT/RT);

Diabetic Shoes (A5500ZX, A5502ZX);

Low Pressure Positioning Equalization Pad (E0192 NU);

Appliance Cleaner (A5131 ZX);

Lymphedema Pumps (E0652, E0671); and

Surgical Dressings (K0197, K0210, K0216, K0218, K0243, K0248, K0264, K0265).

IPLs Billing False Claims For Respiratory Studies: Investigations are underway on IPL s that are allegedly submitting false claims for respiratory studies. The following list of pulmonary studies are being performed as a battery of pulmonary examinations which are either not indicated or medically necessary:

94060- Bronchospasm Evaluation;

94200- Maximum Breathing Capacity;

94375- Respiratory Flow Volume Loop;

94620- Pulmonary Stress Testing;

94664- Aerosol or Vapor Inhalations;

94762- Pulse Oximetry, Overnight Monitoring;and

95807- Sleep Studies.

IPL s Performing Diagnostic Exams Already Included in the Capitation Payment: Carrier fraud units have identified multiple IPL s which are marketing ESRD facilities to perform diagnostic flow studies of venous access grafts and other non-invasive vascular studies for ESRD beneficiaries. The common procedure codes identified are procedure codes 93925, 93926, 93931, and 93990. Be aware that routine flow evaluations are included in the monthly capitations paid to dialysis facilities and are not separately billable unless medically warranted as additional studies.

Cost Report Fraud Involving Medicare Bad Debts: An OIG Special Agent from the western United States identified a scheme related to cost report fraud involving Medicare bad debts arising from improper waiver of the deductible. The provider also generated false records to substantiate them to Medicare auditors. The

facility routinely failed to collect Medicare deductibles from patients, and actually used this waiver as an incentive to induce patients to use their clinic. The uncollected deductibles were then claimed as bad debts on the clinic s Part A cost report.

Doctors Billing Incorrect CPT Code For Psychotherapy Services: An OIG Suboffice has uncovered a scheme where doctors have been billing using procedure code 90855 (Interactive individual medical psychotherapy) when procedure code 90862 (Pharmacologic management with no more than minimal psychotherapy) should have been billed. Be advised that procedure code 90855 cannot be used in lieu of 90862, or to maximize reimbursement. Physicians are required to bill using the procedure code that most appropriately describes the service(s) rendered.

Criminal/Civil Actions in Florida

An oxygen and medical equipment dealer agreed to pay the federal government $612,500 to settle a civil lawsuit involving Medicare claims related to oxygen services. The monies were related to claims for oxygen services paid from 1987-1989, which were services which did not meet medical necessity requirements or were related to qualifying tests performed by the actual provider of the oxygen services.

A Miami laboratory owner was sentenced on Friday, May 16, 1997, after pleading guilty to 38 counts of money laundering, mail fraud, conspiracy, and filing false claims. He received a sentence of 30 months imprisonment followed by three years supervised release, ordered to make restitution in the amount of $500,000 to the Medicare trust fund, and must pay a special assessment of $900.

A Miami owner of a medical clinic was sentenced on Friday, May 16, 1997, after pleading guilty to 38 counts of money laundering, mail fraud, and filing false claims. She was sentenced to four months imprisonment, 2 years supervised release, ordered to make restitution in the amount of $50,000 to the Medicare trust fund, and must pay a special assessment of $500.

During May and June 1997, 15 new Medicare numbers were flagged by the Medicare Fraud Branch. The grand total of beneficiaries flagged by the MFB stands at 387. Savings associated with this activity are:

April- 14,204 services were denied-representing a total billed amount of $1,654,828,.01.

May- 8,583 services were denied- representing a total billed amount of $1,077,842.99.

Ten people, including two doctors, were arrested in Dade County by federal agents on June 19, 1997, on charges of defrauding Medicare of more than $6 million. The two doctors, Jose Valiente and Gerald Amado, both of Miami, were accused of signing charts for Medicare patients they had never seen.

A multi-state provider of psychiatric services, Andrew Shankman, and his chief therapist, Mary Jane Pedrick, were found guilty on all counts of charges that they bilked the government out of millions of dollars, single counts of conspiracy, 59 counts of mail fraud, and 30 counts of wire fraud for submitting false claims to the government.

In The News/FYI

Health care fraud has Become one of the IRS Top Priorities: Health care fraud has become one of the highest priorities of the IRS Criminal Investigative Division(CID) because of the impact of fraud on the taxpaying population. The IRS CID has 3,200 special agents and another 1,300 support staff members. Although the CID does not have specific agents working on health care fraud, five percent of its investigative time is devoted to these issues. The agency is there to follow the money that resulted from the fraud and is there to recommend prosecutions for tax charges and money laundering charges.

HCFA to Add 12 More States to Anti-Fraud Efforts: DHHS announced that a new and expanded phase of Operation Restore Trust (ORT) will include an additional 12 states and the use of ORT techniques in all 50 states. The ORT demonstration in five states resulted in $187.5 million in Medicare and Medicaid savings from restitutions, fines, settlements, and other identified overpayments. The following new states will be added over the course of the next two years: Arizona, Colorado, Georgia, Lousiana, Massachusetts, Michigan, New Jersey, Ohio, Pennsylvania, Tennessee, Virginia, and Washington.

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Updates to the Medigap Insurer Listing

The following updates to the Medigap Insurer List have been performed. Please make the necessary corrections in your April 1996 Medicare B Update Special Issue: Medigap Crossover Insurer Listing.

Medigap Insurer Address Change

Number Insurer Name/Address
40062 BCBS OF NEW JERSEYPO BOX 1184NEWARK NJ 07102
Number to Use: MAIN NUMBER

40021 BCBS OF NEW JERSEY3 PENN PLAZA EASTNEWARK NJ 07102
Number to Use: X-REF TO 40062

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	Insurer Name
19206	COMERICA BANK & TRUST
19318	MIAMI DADE HEALTH PLAN
19456	SOUTHERN GENERAL
19612	MAYO CLINIC HEALTH INS
19657	AIR PRODUCTS HEALTH PLAN
19940	SENTRY LIFE INS COMPANY
20099	GEORGIA FED BANK
23213	HEALTH ALLIANCE MEDICAL
30013	PLUMBERS MEDICAL FUND
31051	IBA HLTH & LIFE ASSURANCE
42051	LABOR WELFARE FUND
42231	THE ELDER PLAN CARD
54010	DESERET MUTUAL

Principal Financial Group Principal Mutual Life

Principal Mutual Life designated their Omaha Nebraska Claim Center as the sole claim paying office for Principal Mutual Life s Medigap crossover claims. All Medigap crossovers from Medicare carriers are sent to their Omaha Claim office, instead of other claim offices.

Medigap insurer numbers were formerly developed to include many of Principal Mutual Life s locations. At Principal Mutual Life s request, many Medigap numbers (active and exempt) are no longer needed.

A number of changes have been made to the Medigap insurer numbers assigned to Principal Mutual Life Principal Financial Group . The updates are outlined in the following sections. Please make the necessary corrections in your Update.

Active Medigap Insurer Numbers For Principal Mutual Life

Number	Name/Address	Number to Use
37015	PRINCIPAL MUTUAL LIFE330 N 117TH STREETOMAHA NE 68154	Main Number
19012	PRINCIPAL FINANCIAL GRP330 N 117TH STREET	Cross-Ref to 37015

45115 PRINCIPAL MUTUAL LIFE1105 SCHROCK RD 530COLUMBUS OH 43229 Cross-Ref to 37015

53099 PRINCIPAL MUTUAL LIFE 7330 SAN PEDRO S-700SAN ANTONIO TX 78216 Cross-Ref to 37015

New Medigap Insurer Number

Number Name/Address Number to Use
16115 PRINCIPAL MUTUAL LIFEPO BOX 39710COLORADO SPGS CO 80902 Cross-Ref to 37015

Medigap Insurer Number Changed to Active

Please change the Y to an N in your Update.

Number Name/Address Number to Use
19402 PRINCIPAL MUTUAL LIFE9428 BAYMEADOWS ROAD JACKSONVILLE FL 32216 Cross-Ref to 37015

EXCEPTION NOTE: Principal Mutual Life s Medigap policy numbers start with the following: N81493, N81494, N81496-N81498, N82112, N82332, N83125, N83350, N83373, N83500, N83634, N83980, N84020, N84740, N84775, N85418, N85561, N86558-N86581, N86583-N86585, N86587-N86589, N86591-N86598, N87748, N88118, N88121-N88156.

Deleted Medigap Insurer Numbers For Principal Mutual Life

The following Medigap insurer numbers have been changed to a DELETE/EXEMPT status and noted in our insurer files as NOT IN USE. We will not cross over claims if these numbers are used.

Please use the ACTIVE Medigap insurer numbers for sucessful crossover.

Medigap Insurer Numbers formerly an ACTIVE status (N). Please change the N to a Y in your Update.

Number Name
13011 PRINCIPAL MUTUAL
25007 PRINCIPAL MUTUAL LIFE INS
33020 PRINCIPAL MUTUAL LIFE INS
59026 PRINCIPAL MUTUAL LIFE INS
02093 PRINCIPAL MUTUAL LIFE

Medigap Insurer Numbers Formerly an EXEMPT Status (Y)

Number Name
19759 PRINCIPAL FINANCE GROUP
17020 PRINCIPAL FINANCIAL
19039 PRINCIPAL FINANCIAL
47004 PRINCIPAL FINANCIAL

25018 PRINCIPAL FINANCIAL GROUP
19249 PRINCIPAL FINANCIAL GRP
20011 PRINCIPAL FINANCIAL GRP
19505 PRINCIPAL HEALTH CARE
35032 PRINCIPAL HEALTH CARE
90213 PRINCIPAL HEALTH CARE
19628 PRINCIPAL HLTH CARE FL
15089 PRINCIPAL MUTUAL
17021 PRINCIPAL MUTUAL
19941 PRINCIPAL MUTUAL
23021 PRINCIPAL MUTUAL
23044 PRINCIPAL MUTUAL
23108 PRINCIPAL MUTUAL
25001 PRINCIPAL MUTUAL
25040 PRINCIPAL MUTUAL
42115 PRINCIPAL MUTUAL
48094 PRINCIPAL MUTUAL
57004 PRINCIPAL MUTUAL
19057 PRINCIPAL MUTUAL LIFE
25042 PRINCIPAL MUTUAL LIFE
26010 PRINCIPAL MUTUAL LIFE
35024 PRINCIPAL MUTUAL LIFE
42089 PRINCIPAL MUTUAL LIFE
53060 PRINCIPAL MUTUAL LIFE
90198 PRINCIPAL MUTUAL LIFE

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Latest ICD-9-CM Update Effective October 1, 1997

The latest update to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis coding structure will take effect October 1, 1997. For claims processed on or after this date, Medicare Part B of Florida will recognize both the existing and new versions of ICD-9-CM to allow physicians sufficient time to obtain and begin to use the new codes. For claims processed on or after January 1, 1998, detail lines which include missing or invalid ICD-9-CM diagnosis codes will either be returned by Medicare Part B of Florida as unprocessable (assigned) or developed for a complete diagnosis code (unassigned). To avoid payment delays related to the use of invalid or incomplete ICD-9-CM diagnosis codes, providers must utilize the most recent ICD-9-CM coding materials and code each condition to its highest level of specificity. As a reminder to paper claim billers, the one-digit reference code number (1-4) corresponding to the ICD-9-CM diagnosis code(s) listed in item 21 must be entered in item 24e for each service.

How to Obtain ICD-9-CM Materials

Medicode Publications offers a variety of hard copy and electronic versions of the latest ICD-9-CM coding structure. A softbound standard version of Volumes 1 and 2 sells for $51.95, and the spiral bound deluxe or compact (6 x 9) editions sell for $66.95. Various versions of ICD-9-CM, CPT, and HCPCS software

are also available for purchase; ask your Medicode representative about their special offers on these products. For further information, contact Medicode at 1-800-999-4600.

St. Anthony s Publishing also offers 1998 ICD-9-CM materials; the softbound version sells for $69.95, and a binder version which includes quarterly updates sells for $149.00. For further information, contact St. Anthony s at 1-800-632-0123.

The American Medical Association also offers 1998 ICD-9-CM materials; the cost for the AMA ICD-9-CM code book is $52.95 for AMA members and $65.95 for non-members. For further information, call the AMA at 1-800-621-8335.

ICD-9-CM materials may also be available from medical publishing and consulting firms in your area.

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Update to the ESRD MSP Provision of OBRA 1993

Page 67 of the September/October 1996 Medicare B Update! featured an article stating the Health Care Financing Administration s position on when a retirement plan is primary or secondary for claims for beneficiaries who have End Stage Renal Disease. The article stated HCFA s intent to ensure sufficient time is allowed for interested parties to become aware of the legislative changes and HCFA s position. As a result of litigation involving this issue, an extension period was granted through December 31, 1996, for the filing of claims for services furnished between August 10, 1993, through September 30, 1994.

Because this litigation is still pending, HCFA has again extended the time period for filing claims from December 31, 1996, to December 31, 1997, for services provided between August 10, 1993, and April 24, 1995. This extension does not apply to claims for services provided after April 24, 1995.

For additional information on ESRD MSP provision of OBRA 1993, refer to the July/August 1995, March/April 1996, and the September/October 1996 issues of the Medicare B Update!

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Send ESRD Lab Services from Diagnostic Facilities to Medicare A

Effective September 1, 1997, CLIA-certified independent Diagnostic Facilities (DFs) must submit claims for separately billable End Stage Renal Disease (ESRD) laboratory services to the Medicare Part A intermediary on the HCFA-1450 form under bill type 72X. DFs may not bill for any lab tests that are not within the scope or complexity level of their CLIA approval.

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Overpayment Interest Rates

Medicare Part B assesses interest on overpaid amounts which were 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 assessed to overpaid funds:

Period	Rate
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 - April 23, 1997	13.625%
April 24, 1997 - July 24, 1997	13.50%
July 25, 1997 to present	13.75%

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Changes in HPSA Designation

Medicare Part B of Florida has learned that Calhoun, Gilchrist, Holmes and Walton counties are no longer classified as geographic Health Professional Shortage Areas (HPSAs). The designation for Hendry county has been revised and only census tracts 9603 and 9604 of Labelle qualify for the incentive payment. These changes are effective for service dates October 1, 1997, and after.

If you have any questions regarding this information, please contact our Provider Customer Service department at (904) 634-4994.

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Schedule for Beneficiary Benefit Notices

A select group of Medicare carriers, which includes Medicare Part B of Florida, changed the look of beneficiary statements January 1, 1997. The Explanation of Medicare Benefits (EOMB) was replaced with the Medicare Summary Notice (MSN).

Effective October 1, 1997, the MSN mailing schedule will change for beneficiary notices where payment is made to a party other than the beneficiary, or in cases where no payment has been issued. Under the new mailing system, beneficiaries will receive MSNs every 30 days.

Due to this change, beneficiaries may receive an office statement prior to receiving a MSN specifying Medicare s payment and their liability. If your patients have questions regarding the late receipt of their MSN, please inform them that they will receive it within 30 days of the claim payment date.

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Provider Identification Numbers

Effective immediately, Medicare Part B of Florida s Medicare Registration department will, in some situations, assign alpha-numeric provider identification numbers (i.e., EXXXX, KXXXX, EXXXXZ).

Reminder applications for a new Medicare provider number should be submitted to the following address:

Medicare Registration
P.O. Box 44021
Jacksonville, FL 33231-4021

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Extension of the ESRD Coordination Period

Currently, Medicare benefits are secondary to benefits payable under an employer group health plan (EGHP) in the case of individuals entitled to benefits solely on the basis of ESRD during a period of up to 18 months. Medicare is secondary during this period even though the employer policy or plan contains a provision stating that its benefits are secondary to Medicare s, or otherwise excludes or limits its payments to Medicare beneficiaries. This is referred to as the ESRD coordination period.

Under this provision, the EGHP must be billed first for services provided to an Medicare ESRD beneficiary. If the EGHP does not pay for covered services in full, Medicare may pay secondary benefits in accordance with 3335.7B. This provision applies to all Medicare covered items and services (not just treatment of ESRD) furnished to beneficiaries who are in the coordination period. These instructions do not apply to beneficiaries entitled to Medicare because of age 65 or disability.

Section 4631(b) of the Balanced Budget Act of 1997 extends the ESRD coordination period to 30 months for any qualified individual who would reach the 18-month mark on or after September 1, 1997. Claims for primary payment that are submitted for applicable individuals during the 30-month coordination period will be denied payment.

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page 1

Medicare Part BFinancial Services Department

The Medicare Part B Financial Services department assists providers and beneficiaries with the following issues:

Overpayments: Manages the notification and collection of overpayments which are due to Medicare Part B.

Checks: Assists providers and beneficiaries with researching Medicare Part B checks which may have been lost, stolen or mutilated. This includes providing copies of endorsed checks and reissuing duplicate checks when necessary.

Forgeries: Researches cases where a Medicare Part B check may have been endorsed and cashed by an unauthorized party.

Garnishments/Tax Levies: Manages the recoupment of Medicare Part B payments which are the result of garnishments and/or tax levies.

Bankruptcies: Manages the coordination of Medicare Part B overpayments for parties who have filed a petition for bankruptcy.

Written Inquiries: Assists beneficiaries and providers with questions related to refund requests and various other functions of the Financial Services department through written responses.

Undeliverables: Researches provider and beneficiary addresses to ensure that all returned checks are successfully delivered to the appropriate recipient. Providers who relocate must notify the Medicare Registration department by using the HCFA 855C. The form should be mailed to:

Medicare Registration
P.O. Box 44021
Jacksonville, FL 32231-4021

For further information, providers can call the Medicare Registration department at (904) 791-6689. Other financial information is available by calling the Provider Customer Service department at (904) 634-4994.

Medicare Part B Financial Services Provider Request Form

The Financial Services department has created a form which will ensure inquiries and refunds are handled appropriately. This form is located on page 49 of this Update! This form may be

photocopied, or additional copies may be requested by calling our Provider Customer Service department.

The following pages provide in-depth information about the notification and collection of overpayments which are owed to Medicare Part B.

What is an Overpayment?

Overpayments are Medicare funds that a provider or a beneficiary has received in excess of amounts due and payable under the Medicare statute and regulations. Once it has been determined that an overpayment has been made, the amount of the overpayment is a debt owed to the United States government. The following are some examples of overpayments:

Payment based on a charge that exceeds the fee schedule or reasonable charge (e.g., services which are processed with an incorrect procedure code; thus, the Medicare approved amount is incorrect).

Duplicate processing of the same charges/claims (e.g., duplicate billing).

Payment made to incorrect payee.

Payment for non-covered items/services or medically unnecessary services.

Incorrect application of the deductible or co-insurance.

Payment for items/services provided during a period of patient non-entitlement.

Claims processed with Medicare Part B as the primary payer when Medicare Part B should have been the secondary payer.

Overpayments are referred to the Medicare Part B Financial Services department and are identified in many ways:

Providers and beneficiaries determine that the overpayments are made. In these instances, they should notify Medicare Part B of the overpayments by writing to the Financial Services department.

An overpayment can be identified through the review or hearing process.

Overpayments can also be the result of an investigation of customer complaints or a random sample of a provider s billing practices.

Federal agencies (e.g., Health Care Financing Administration, Office of Inspector General, etc.) conduct audits of providers claims which may result in the identification of overpayments.

Regardless of how overpayments are detected, they are referred to the Financial Services department for collection. All overpayment refund requests are made by letter and clearly state how the overpayment occurred, who is liable and what is necessary to satisfy the obligation to repay the debt.

Overpayments Detected by Providers and Beneficiaries

Providers and beneficiaries occasionally determine overpayments exist before refunds are requested by Medicare Part B. In these instances, refunds may be made without written overpayment requests.

If a provider finds that an overpayment exists on all claims associated with their Medicare check, the original check and all Provider Remittance Notices associated with the check should be returned to the Financial Services department with an explanation for returning the check. If an overpayment exists on only one or some of the claims, the provider should cash the Medicare check and issue a separate check to Medicare for the overpaid amount. The refund should include an explanation of the overpaid amount and a copy of the Provider Remittance Notice or a detailed listing explaining the claims in which the overpayment applies.

Beneficiaries may follow these same instructions for their overpayments. However, it is unusual for overpayments to exist on multiple claims for beneficiaries. Therefore, the original Medicare check and a copy of the Medicare Summary Notice should be returned to the Financial Services department.

How to Refund Overpayments

Overpayments must be refunded to Medicare Part B within 30 days from the date of the overpayment request. If a refund is not made within 30 days, a second overpayment request will be sent and the balance due (either full or partial) will be satisfied by withholding future claim payments.

The second overpayment request does not imply that the debtor has another 30-day period to refund the amount due and it does not prevent the withholding of future claim payments after the 30-day period has elapsed. Additionally, overpayments due from providers are subject to the assessment of interest on the balance due after the 30-day period.

To ensure timely and accurate posting of overpayments, refunds should be made by check payable to Medicare Part B and should be sent with a copy of the refund request. If a copy of the refund request cannot be included with the check, the following information should be given:

Medicare provider number or patient s Medicare health insurance claim number (depending upon to whom the refund request was made.)

Date of service(s) involved.

A brief explanation of why a refund is being made.

A copy of the Medicare Summary Notice or Provider Remittance Notice to which the overpayment applies.

All refunds should be sent to the Financial Services department.

Disagreements with Overpayment Requests

In some cases, a provider or beneficiary may disagree with the overpayment request (e.g., they do not believe an overpayment exists). In these instances, they should follow the steps for requesting an appeal as outlined in the overpayment letter. Listed below are the general appeal rights:

If the amount of the refund request is $100 or more, you should request a hearing if you do not agree with the overpayment letter. The address for requesting a hearing is:

Medicare Hearings
P.O. Box 45156
Jacksonville, FL 32232-5156

You can combine other refund request you have received, or claims that have previously been reviewed to meet the $100 limit for requesting a hearing.

If the amount of the refund request is under $100, you should request a review if you do not agree with the overpayment letter. The address for requesting a review is:

Medicare Part B

Financial Services
P.O. Box 44141
Jacksonville, FL 32231

Review requests for overpayments resulting from claims paid in error as primary when Medicare should have been the secondary payer should be sent to the following address:

Medicare Secondary Payer
P.O. Box 44078
Jacksonville, FL 32231-4078

How to Track Offset Claims

Overpayment request letters contain an accounts receivable number known as a Financial Control Number (FCN). The FCN is used to account for and track monies refunded and/or offset (withheld) from paid claims. If refunds due are satisfied through the offset of paid claims, the FCN will appear on the Provider Remittance Notice or the Medicare Summary Notice on which the offset was applied. The FCN can then be used to cross-reference the offset claim to the overpayment request letter.

We are required to accrue interest on provider overpayments that are not refunded within 30 days from the date on the refund request letter. When money is offset (withheld) from your paid claims, it is applied to the accrued interest first and then to the principal.

Extended Repayment Schedules for Overpayments

The Health Care Financing Administration (HCFA) has established repayment options for providers who find it difficult to repay debts to the Medicare program. For debts in excess of $1000, Medicare Part B may approve repayment schedules up to a period of 12 months.

Requests for extended repayment schedules must be documented in writing to Medicare Part B. The documentation should include:

A detailed explanation of the problems preventing a lump sum repayment.

A statement of how much the provider can pay for each installment and the number of months.

A Financial Statement of Debtor form (HCFA-379). All blocks on the HCFA-379 must be completed or must indicate"N/A (not applicable).

Requests for extended repayment schedules should be sent to the Financial Services department.

Within 10 to 15 days of the request, Medicare Part B will document to the provider an approval or renegotiate the payment amount. Once the extended repayment schedule is established,

Medicare Part B will provide an amortization schedule based on the approved amount (which will begin with the balance and any accrued interest). An explanation of when the payments are due with the appropriate instructions for repayment will also be provided.

Repayment Schedules for Longer Than 12 Months

Requests for extended repayment schedules for longer than 12 months are referred to HCFA for approval.

The requests must include extensive and specific financial documentation from the provider to support the request. HCFA will make a decision to grant, modify or reject the extended repayment schedule based on the financial documentation submitted with the request.

The documentation required to support a request for an extended repayment schedule for more than 12 months varies. This depends on the debtor s legal identity (as explained below) at the time the overpayment case was established. The forms for the documentation are provided upon request by the Financial Services department or the Provider Customer Service department.

Sole Proprietors: For sole proprietors (i.e., an individual physician who is not part of a group or individual owner), the following documentation must be completed and submitted to the Financial Services department:

A Financial Statement of Debtor form (HCFA-379). All blocks on the HCFA-379 must be completed or must indicate N/A (not applicable).

A copy of the provider s most recent federal income tax return.

Entities: For entities (i.e., partnership, group or corporation), the following documentation must be completed and submitted to the Financial Services department:

A copy of the federal income tax return for the most recent tax year for both the partnership, group or corporation and the individual debtor or principal owner of the group or corporation.

A Financial Statement of Debtor form (HCFA-379).

The most current balance sheet and the balance sheet for the last complete fiscal year.

The most current income statement and the income statement for the last complete fiscal year.

A statement of source and application of funds for the period covered by the submitted income statements.

Cash flow statements for the periods covered by the submitted balance sheets. If the date of request for an extended repayment schedule is more than three months after the date of the most recent balance sheet, a cash flow statement for all months between that date and the date of the request is required.

A projected cash flow statement covering the remainder of the fiscal year. If fewer than six months remain in the fiscal year, a projected cash flow statement for the following year is required.

A list of restricted cash funds, by amount, as of the date of the request and the purpose of each.

A list of investments, by type (stock, bond, etc.,), amount and current market value as of the date of the request.

A list of notes and mortgages payable by amount as reflected in the balance sheet and their due dates.

If requesting an extended repayment period of 12 months or more, the debtor must include at least two letters from separate financial institutions denying the debtor s loan request for the amount of the overpayment. A copy of the loan application(s) is also required.

The financial statements should be completed by the debtor s accountant. The balance sheets and income statements should include the following statements:

Misrepresentation or falsification of any information contained in this balance sheet or income statement may be punishable by fine and/or imprisonment under federal law.

Certification by Officer/Owner of Debtor(s):

I hereby certify that I have examined the balance sheet and income statement prepared by

and that to the best of my knowledge and belief, it is true, correct and the complete statement from the books and records of debtor.

Signed

Officer or Owner of Debtor(s)

Title

Date

Once all documentation is submitted for requests for extended repayment schedules for longer than 12 months, Medicare Part B reviews the documentation and sends their recommendations to HCFA. The requested repayment schedule is either approved by HCFA or Medicare Part B is advised of the suggested repayment schedule. When the repayment schedule is established, Medicare Part B notifies the debtor of the results and sends an amortization schedule based on the approved amount. An explanation of when the payments are due with the appropriate instructions for repayment will also be provided.

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(end of file)