May/June 1997 Medicare Part B Update! Publication
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HCFA
Health Care Financing Administration
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FIRST COAST SERVICE OPTIONS, INC.
A HCFA Contracted Carrier and Intermediary
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Do Not Bill Temporary Lab Panel Codes Until July 1, 1997

Several new panel codes which include clinically relevant groupings of automated multichannel tests were recently approved by the American Medical Association's Current Procedural Terminology board for 1998. HCFA has decided to permit billing of the new lab panels and has developed four new temporary codes to use for services rendered from July 1, 1997, through December 31, 1997.

The new temporary codes are:

G0095 Hepatic Function Panel A

G0096 Basic Metabolic Panel

G0097 Electrolytes Panel

G0098 Comprehensive Metabolic Panel.

Medicare was scheduled to accept the codes on April 1, 1997, and some providers were made aware of the new codes by their medical societies and other professional groups. But the implementation of these codes requires extensive changes to Medicare's processing system. As a result, the effective date for G0095-G0098 has been changed to July 1, 1997.

Claims received containing procedure codes G0095-G0098 for services rendered before July 1, 1997, will be denied payment due to the use of invalid procedure codes. See page 24 for information about policy and reimbursement for procedure codes G0095-G0098.

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What's New

Upcoming Medifest and Specialty Seminars

The next three Medifest seminars have been scheduled as follows:

City	Dates
West Palm Beach	June 17-19
Orlando	August 12-14
Miami	September 16-18

Specialty seminars have been scheduled for the following locations:

City	Dates
Ft. Lauderdale	May 12-13
Miami	May 14-15
West Palm Beach	June 16 and 19
Jacksonville	June 24-26
Orlando	August 11 and 14
Ft. Myers	August 19-20
Miami	September 15 and 18
Tampa	September 23-25

Specialty seminars topics include:

E/M, FMR Dermatology Ambulance Radiology IPL Portable X-Ray Vision Clinical Laboratory/ Pathology Thoracic/Cardiovascular Surgery Gastroenterology Urology Nephrology Mental Health ASC Chiropractic Orthopedics Podiatry Dermatology

For a complete schedule and registration information, see page 5 of this Update!

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Medicine

For Your Information

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A Physician's Focus

Restoring Good Health to the Medicare Program

As the next century approaches, Medicare is facing the specter of financial ill health. However, with a proper diagnosis, a good prognosis is possible. As the Florida Medicare carrier, we work closely with the federal government to help make sure Medicare is getting the "treatment" it needs to restore good health to the program. What is this "treatment"? It's as plain as common sense and as sound as good medicine.

It is founded on making sure Medicare covers only treatments that are medically necessary, so patients can get the care they need while rooting out fraud, waste and abuse. Applying this treatment now helps patients today and protects the program for tomorrow. After practicing family medicine for 30 years, it's now my job to help see that Medicare patients have coverage for the quality care they need and deserve without squandering their lifetime of hard-earned dollars.

The symptoms of the problem are easy to see. Since the inception of the Medicare program in 1966, health care costs have risen dramatically. According to statistics provided by the Health Care Financing Administration (HCFA), the federal agency that manages Medicare, national health care expenditures per person were $247 in 1967; by 1994, these expenses had risen to $3,510 per person. In 1995, total HCFA program outlays were $249 billion, representing 16.4 percent of the total federal budget.

Medicare expenses are growing faster than the deficit. Most experts agree that if such growth continues, the Medicare program will not have the fiscal strength to endure rising health care costs and the flood of new "baby boomer" enrollees beginning in 2010.

These are serious symptoms, but the good news is that they are already being "treated". In Government Programs, we are keeping Medicare focused on good medicine and cutting fraud, waste and abuse. In fiscal year 1996 we saved approximately $475 million through our efforts a return of almost $20 for every dollar spent safeguarding the Medicare program. We also helped educate seniors on protecting their Medicare identification numbers, how to get information on current scams, and how to detect and report suspected fraud.

By continuing these "treatments" of providing access to quality care through Medicare while fighting fraud, waste and abuse, the program's financial ills can be cured. Patients can face the next century confident that the program they rely on to cover their health care needs will itself enjoy rosy good health.

Sincerely,

Sidney R. Sewell, M.D.

Advance Notice Requirement

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

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. 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.

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 on page 88), or download the text version from our on-line service, the B LINE BBS (see page 44 for more information).

Medicare Part B of Florida uses the same mailing address for all correspondence, and cannot designate that each issue of the Update! be sent to a specific person/department within a

provider's office. To ensure continued receipt of all Medicare correspondence, a Change of Address form must be completed in the event of relocation. See page 42 for a copy of this form.

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General Information

Advance Notice Required for Six or More Surgical Procedures

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

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

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

"by report" for the sixth and subsequent procedures.

When filing claims for multiple surgical procedures, the primary procedure should be billed by itself and the subsequent procedures should be billed with procedure code modifier 51. To determine the primary procedure, physicians may refer to their fee schedule books. The procedure with the highest fee schedule allowance (highest relative value unit) would be the primary procedure.

The operative report must be included with the claim when six or more multiple surgical procedures are performed. In addition, when six or more multiple surgical procedures are performed, an 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.

Advance Notice Requirement

Applies to medical necessity guidelines (see page 4).

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ICD-9 Specificity Updates

Effective immediately, the following diagnoses for which these procedures may be covered have been updated to the highest level of specificity (fifth digit).

93312: Transesophageal Echocardiogram

Deleted	Added	Previous Publication
278.0	278.00-278.01	Sept/Oct 1995, (page 31)
415.1	415.11-415.19	

82746: Folic Acid

Deleted	Added	Previous Publication
242.0-242.9	242.00-242.91	July/August 1996 (page 25)

72141-72158: MRI of the Spine

Deleted	Added	Previous Publication
724.00-724.7	724.00-724.70	March/April 1997 (page 57)
015.0	015.00-015.06	

70551-70553: MRI of the Brain

Deleted	Added	Previous Publication
013.0-013.3	013.00-013.36	March/April 1997 (page 55)

72192-72194: CT of the Pelvis

Deleted	Added	Previous Publication
719.4	719.45	March/April 1997 (page 58)

In addition, the following diagnoses have been added to the list of diagnoses for which CT of the pelvis may be covered:

789.03 789.04

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Fragmentation of Correct Code Pairs

Based on a review of claims data, it has come to the attention of Medicare Part B of Florida that certain providers have been reporting procedure code pairs identified under the Correct Coding Initiative on separate claims for the same date of service. This practice is referred to as fragmented billing. As a rule, providers should not fragment bills. All services for a single patient, for the same date of service should be submitted on a single claim.

Under the Correct Coding Initiative, payment is not made for a service which is considered a component of a more comprehensive procedure. Therefore, the component service should not be billed in addition to the comprehensive service. When the fee schedule allowance for the comprehensive procedure is greater the the fee for the comprehensive procedure, an overpayment will occur when the component procedure is processed first.

For example, when the following procedure code pair is billed on separate claims, an overpayment will occur when the component code is processed first.

	Code	Fee Schedule Amount (Loc. 4)
Component Code	93642	$726.38
Comprehensive Code	93640	$625.05
Overpayment Amount		$101.33

Medicare Part B of Florida will request refunds on overpayments due to fragmented billing.

For more information on the Correct Coding Initiative, refer to page 13 of the March/April 1997 Medicare B Update!

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Use of the 58 Modifier (Staged Surgical Procedures)

This article is to remind providers of Medicare's policy for the use of modifier 58 (staged or related procedure or service by the same physician during the postoperative period). This modifier is used to allow payment of a surgical procedure during the post-operative period of another surgical procedure because the subsequent procedure:

was planned prospectively at the time of the original procedure; or

was more extensive than the original procedure; or

was for therapy following a diagnostic surgical procedure.

However, the existence of the modifier 58 does not negate the global fee concept. Services which are included in the Physician's Current Procedural Terminology (CPT) as multiple sessions or are otherwise defined as including multiple services or events may not be billed with this modifier. An example of this is Moh's micrographic surgery (procedure codes 17304-17310), which is by definition staged surgeries. As another example, procedure codes 67141, 67145, 67208, 67218, 67227 and 67228 may not be billed with the 58 modifier during the global period of the same service to permit billing and payment for each session as if it were not part of the global service.

If the description of a procedure code is for one or more services, the Medicare fee schedule was established based on the total procedure. Separate reimbursement will not be made for each segment of the procedure.

If more than one physician is involved in a staged procedure, each physician must submit the claim using modifier 52 (reduced services); the claim is subject to individual consideration.

Some providers are circumventing this policy by using the 79 modifier (unrelated procedure or service by the same physician during the postoperative period) for additional sessions of staged (or serial) procedures. This is inappropriate.

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HCPCS Codes

A0320-A0999: Local Medical Review Policy for Ambulance Services

The Local Medical Review Policy for Ambulance Services has recently been revised to facilitate consistency between our Medicare Part A and Part B Programs. Additionally, this policy has expanded the medical necessity requirements and provided further definition to the term "bed confined." This revised policy is effective for claims processed June 16, 1997, and after.

Policy Introduction

The Medicare program includes an ambulance benefit. Covered services may be provided either by a freestanding ambulance supplier or a participating Part A provider such as a hospital or skilled nursing facility. Three basic requirements must be met for ambulance services to be covered:

The ambulance and crew must meet specific requirements outlined in the Medicare Carriers/Intermediary Manual.

The transportation must be medically reasonable and necessary as outlined in the Medicare Carriers/Intermediary Manual. This requires that other means of transportation be medically

contraindicated, in other words, that the patient cannot be safely transported by any other means.

The origin and destination requirements outlined in the Medicare Carriers/Intermediary Manual must be met.

HCPCS Codes

A0320 Ambulance service; basic life support (BLS), non-emergency transport,supplies included, mileage separately billed

A0322 Ambulance service; basic life support (BLS), emergency transport,supplies included, mileage separately billed

A0324 Ambulance service; advanced life support (ALS), non-emergency transport, no specialized ALS services rendered, supplies included,mileage separately billed

A0326 Ambulance service; advanced life support (ALS) non-emergency transport, specialized ALS services rendered, supplies included,mileage separately billed

A0328 Ambulance service; advanced life support (ALS), emergency transport no specialized ALS services rendered, supplies included, mileage separately billed

A0330 Ambulance Service; advanced life support (ALS), emergency transport,specialized ALS services rendered, supplies included, mileage separately billed

A0380 Basic life support (BLS) mileage, per mile

A0390 Advanced life support (ALS) mileage, per mile

A0420 Ambulance waiting time (ALS or BLS), one half hour increments

Waiting Time Table

Units	Time
1	1/2 to 1 hour
2	1 to 1-1/2 hours
3	1-1/2 to 2 hours
4	2 to 2-1/2 hours
5	2-1/2 to 3 hours
6	3 to 3-1/2 hours
7	3-1/2 to 4 hours
8	4 to 4-1/2 hours
9	4-1/2 to 5 hours
10	5 to 5-1/2 hours

Origin and Destination Modifiers

D Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes

E Residential, domicilliary, custodial facility

G Hospital-based dialysis facility (hospital or hospital-related)

H Hospital

I Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport

J Non-hospital based dialysis facility

N Skilled Nursing Facility (SNF)

P Physician's office (includes HMO non-hospital facility, clinic, etc.)

R Residence

S Scene of accident or acute event

X* Intermediate stop at physician's office en route to the hospital (includes HMO non-hospital facility, clinic, etc.)

* Destination code only

QM Ambulance service provided under arrangement by a provider of services

QN Ambulance service furnished directly by a provider of services

Indications and Limitations of Coverage and/or Medical Necessity

Situations in which a patient is considered to be in a life-threatening/acute condition or not able to be safely transported by other than an ambulance cannot be exhaustively defined. Nor can these "conditions" be represented accurately by the current ICD-9 diagnosis coding structure. Therefore, the conditions and ICD-9 diagnosis codes listed below are used as examples, and only to assume that the patient meets the above coverage requirements during routine claims processing.

The Carrier and Intermediary reserve the right to validate coverage based on the narrative description of the patient's condition and pertinent physical objective findings of the crew's patient assessment on a pre- or post-payment basis whenever it deems necessary to ensure appropriate payments.

Some of the most common situations which suggest transportation by ambulance was medically indicated are listed below followed by a listing of ICD-9 codes upon which the carrier and intermediary will presume medical necessity on a prepayment basis. In no case will transportation be reimbursed if the patient could have been transported by any others means.

Emergency Transports

The patient's condition necessitated emergency care and resulted from an acute injury or illness in which the patient was left in an unstable condition. Examples include a patient that has had a major bone compound fracture where bleeding and signs of shock are present, a patient who has suffered a serious cardiac event where blood pressure and pulse are unstable, and a patient who has suffered multiple trauma and a spinal cord injury is suspected.

The patient needed to be restrained to prevent injury to himself or others (e.g. combative, abusive, convulsive).

The patient was unconscious, unable to respond to stimuli.

The patient was in shock as evidenced by some of the following signs and symptoms secondary to the patient's condition: Blood pressure of less than 90/60, Pulse 100 or -, Respiration's greater than 24, significant changes in mental status, cold and/or cyanotic skin, excessive perspiration.

Emergency measures or treatment were required (e.g. administration of emergency drugs, CPR, continuous cardiac monitoring).

The patient required IV fluids to maintain adequate blood pressure (e.g. dehydration, bleeding, cardiac arrhythmias, etc.) or an access line was established to administer emergency medication(s).

The patient's acute condition required oxygen as part of the emergency treatment procedures enroute to destination (Only for patients not on oxygen on an ongoing basis.)

The patient required immobilization to prevent further injury of a fracture or possible fracture or was in a condition that movement by any other means of transportation would potentially make the condition worse.

The patient has sustained an acute stroke or myocardial infarction (this does not include patients who have a history of stroke or myocardial infarction and are able to be transported by other means because no acute medical condition exists).

The patient was experiencing symptoms indicative of a possible myocardial infarction or stroke.

The patient has or was experiencing a severe hemorrhage.

The patient's condition was such that he could be moved only by stretcher and any other method of transport would result in injury or would be detrimental to the patient's health.

Descriptors and Their ICD-9 Codes for Which Medical Necessity Will be Presumed

Severe Diabetic Complications

250.20 - 250.23
250.30 - 250.33
251.0

Corticoadrenal insufficiency

255.4

Acute Delirium/Psychosis requiring restraints

293.0, 298.8

Severe Seizure or Convulsive Activity

345.30, 345.31, 780.3

Acute Myocardial Infraction

410.00 - 410.92

Other cardiac problems causing chest pain or rhythm disturbances

411.0 -411.89, 413.0 - 413.9
414.10 - 414.19, 415.1, 426 - 427.9
786.50 - 786.59

Cardiac Arrest

427.5

Severe Heart Failure

428.0 - 428.9

Severe Cerebral Vascular Problems

430 - 434.9, 436

Asthma with status asthmaticus

493.01, 493.11, 493.21, 493.91

Severe Gastrointestinal Complication

531.00 - 531.21, 531.40 - 531.61
532.00 - 532.21, 532.40 - 532.61
533.00 - 533.21, 533.40 - 533.61
534.00 - 534.21, 534.40 - 534.61
535.01, 535.11, 535.21, 535.31,
535.41, 535.51, 535.61, 578.9

Childbirth, Emergency

669.1, 669.9

Severe Joint Pain causing immobility

719.49

Unconscious/Coma and Stupor

780.0 - 780.01

Syncope and Collapse

780.2

Shock

785.50 - 785.59

Severe Respiratory Distress

518.81, 518.82, 786.09

Severe Abdominal Pain

789.00 - 789.09

Respiratory Arrest

799.1

Severe Head Injury

854.0 - 854.1

Open wound of the eye

871.0 - 871.7

Poisoning/Toxic Effects/Drug Overdose

960.0 - 989.9

Spinal Injury

952.00 - 952.9

Severe Injuries to include those with open fractures, unstable fractures where movement could result in further injury, moderate to heavy bleeding, traumatic amputations, incapacitating pain.

959.0 - 959.3, 959.6 - 959.7

Multiple Injuries

959.8

Caisson Disease

993.3

Electrocution, electrical current/lightening

994.0, 994.8

Drowning/Nonfatal Submersion

994.1

Severe Hypothermia with decreased level of consciousness

991.6

Asphyxiation and Strangulation/Suffocation

994.7

Anaphylactic Shock

995.0, 995.6

***Please note that the descriptor listed is the condition which will be presumed to meet medical necessity criteria. It is not always the descriptor as it appears in the ICD-9 code book. An example is 789.0 which reads as "abdominal pain" in the book. This code is listed below with the descriptor of "severe abdominal pain" as only pain of a severe, incapacitating nature would meet the medical necessity criteria.

Non-emergency Transports

The patient's condition must be documented to include the reason why the patient was bed confined. Bed confined is defined as an inability to get up from bed without assistance, an inability to ambulate and an inability to sit in a chair, wheelchair or any type of furniture on their own. Bed confined is not synonymous with nonambulatory since the paraplegic or quadriplegic is nonambulatory but spends significant time in a wheelchair. Bed confined is also not equivalent to bedrest, which is a recommended state of affair that does not exclude an occasional ambulation to the commode or chair.

Reasons for Denial

Ambulance services will be denied when the patient's condition does not warrant its use either because the patient could have been safely transported by another means of transportation, independent of whether or not it was available, or if the patients condition did not require the skills of specially trained staff or equipment due to an acute condition or injury. As well as any time the origin and vehicle requirements are not met.

Coding Guidelines

Origin and destination modifiers are to be used with procedure codes A0300-A0999.

The charges for mileage must be coded on a "loaded" basis, (i.e., from the pick up of the patient to his/her destination). Separate charges for "unloaded" mileage should not be coded.

The waiting time codes may be used only in unusual circumstances. It is reasonable to assume that the ambulance personnel would spend up to one-half hour in the processing of paperwork in the delivery of a patient to the hospital. Therefore, the waiting time code should be used only if the patient's condition dictated a delay beyond that one-half hour. Procedural delays (i.e., those not related to the patient's condition) are not billable under this code.

Documentation Requirements (to be available for review upon request)

Appropriate documentation for review includes a trip sheet, an itemized breakdown of charges, and a copy of the notice of non-coverage (if applicable) signed and dated by the patient.

If an ICD-9 code cannot appropriately be selected which reflects the need for an ambulance transport, the claims should be accompanied by a trip sheet which clearly describes the medical conditions of the patient if submitting a paper claim or a narrative statement via EMC transmission.

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Place of Service Guidelines for New Psychotherapy Codes

As a result of the 1997 HCPCS Update, a series of new alpha-numeric "G" codes were developed to report psychotherapy services. A comprehensive article which included the descriptors for the new psychotherapy codes was published on page 15 of the January/February 1997 Medicare B Update! A subsequent article featuring a clarification on the Licensed Clinical Social Worker (LCSW) guidelines was published on page 27 of the March/April 1997 Medicare B Update!

Since the publication of those articles, the Health Care Financing Administration has clarified the place of service codes to be used with the new psychotherapy procedure codes. Due to variations between HCFA's guidelines and those established by Medicare Part B of Florida, place of service codes 32, 54, 55, and 56 may be billed with either Office or Other Psychotherapy codes (G0071-G0082) or the Inpatient Hospital, Partial Hospital or Residential Care Facilities codes (G0083-G0094) for services processed prior to June 16, 1997. For services processed on or after June 16, 1997, psychotherapy services billed using place of service codes 32, 54, 55, and 56 must be reported using procedure codes G0083-G0094).

Place of service code 22 may be used with either Office or Other Psychotherapy codes (G0071-G0082) or Inpatient Hospital, Partial Hospital or Residential Care Facilities codes (G0083-G0094) for claims processed prior to June 16, 1997. For services processed on or after June 16, 1997, psychotherapy services billed using place of service code 22 must be reported using procedure codes G0071-G0082.

Office or Other Outpatient Psychotherapy (G0071-G0082)

The codes that relate to "Office or Other Outpatient Psychotherapy" are most commonly furnished in the facilities listed below:

Place of Service	Code End Date
Office	11

Home	12	
Outpatient Hospital	22	
Emergency Room Hospital	23	
Nursing Facility	32	June 16, 1997
Adult Congregate Living Facility	33	
Hospice	34	
Community Mental Health Center	53	
Intermediate Care Facility/ Mentally Retarded	54	June 16, 1997
Residential Substance Abuse Treatment Facility	55	June 16, 1997
Psychiatric Residential Treatment Center	56	June 16, 1997

Inpatient Hospital, Partial Hospital or Residential Care Facilities (G0083-G0094)

The codes that relate to inpatient hospital, partial hospital or residential care setting may be used only for individual psychotherapy furnished in the facilities listed below:

Place of Service	Code	End Date
Inpatient Hospital	21	
Outpatient Hospital	22	June 16, 1997
Skilled Nursing Facility	31	
Nursing Facility	32	
*Hospice	34	
Inpatient Psychiatric Facility	51	
Psychiatric Facility Partial	52	

Hospitalization

Intermediate Care Facility/ 54

Mentally Retarded

**Community Mental 53

Health Center

Residential Substance 55

Abuse Treatment Facility

Psychiatric Residential 56

Treatment Center

Comprehensive Inpatient 61

Rehabilitation Facility

* Use G0083-G0094 only if the services are furnished in a hospice inpatient facility.

** Use G0083-G0094 only if the services are part of a partial hospitalization program; all other individual psychotherapy should be billed using G0071-G0082.

Please note that Clinical Psychologists (CPs) and Licensed Clinical Social Workers (LCSWs) should use the new odd-numbered G-codes that do not include "with medical evaluation and management" (E/M). The E/M services are represented by even-numbered G-codes.

Outpatient Mental Health Limitation

Medicare reimbursement for outpatient mental health services is limited to 62.5 percent of the Medicare allowed amount. This limitation is called the outpatient mental health limitation. This reduction will be applied to psychotherapy codes (G0071-G0094) rendered any place of service other than 21, 51 or 61.

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J1820: Injectable Insulin

Injectable insulin (procedure code J1820) is usually a self-administered drug. It is covered only when used during an emergency situation for diabetic coma. To ensure that payment is made only for medically necessary services, injectable insulin is covered only for the following diagnoses.

250.20-250.23

250.30-250.33

Advance Notice Requirement

Applies to medical necessity (see page 4).

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M0101: Routine Foot Care

The following article is a reprint of an article featured in the March/April 1997 Medicare B Update! All new information has been barred for easy identification.

Through the evaluation of aberrancies, identified by comparing Florida's procedure code utilization to that of the nation, Medicare Part B Focused Medical Review ensures that medical care is reasonable and necessary and that the Carrier's medical policies and review guidelines are consistent with accepted medical practice.

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

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

When a patient presents with an ulcer, wound or infection and the service, which would normally be considered routine, is a necessary and integral part of an otherwise covered service;

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

Diabetes mellitus*;

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

Buerger's disease (thromboangitis obliterans);

Chronic thrombophlebitis*;

Peripheral neuropathies involving the feet such as those

associated with malnutrition and vitamin deficiency*,

associated with carcinoma*,

associated with diabetes mellitus*,

associated with drugs and toxins*,

associated with multiple sclerosis*,

associated with uremia (chronic renal disease)*,

associated with traumatic injury,

associated with leprosy or neurosyphilis, or

associated with hereditary disorders

Hereditary sensory radicular neuropathy

Angiokeratoma corporis diffusum (Fabry's)

Amyloid neuropathy;

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

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

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

Also, for non-asterisked complicating conditions, except for peripheral neuropathy involving the feet associated with traumatic injury, the claim form must contain the following when the service is performed by a podiatrist:

The name of the M.D. or D.O. who diagnosed the complicating condition.

In addition to the complicating condition, the following medical information is required which describes the sign(s) and/or symptom(s) of the underlying systemic disease which are

categorized in classes A, B, or C. To fulfill the medical necessity requirements for routine foot care there must be:

One Class A finding, or

Two Class B findings, or

One Class B and two Class C findings.

Class A

Nontraumatic amputation of foot or integral skeletal portion thereof.

Class B

Absent posterior tibial pulse, or

Absent dorsalis pedal pulse, or

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

Hair growth (decrease or absence)

Pigmentary changes (discoloration)

Skin color (rubor and redness or blueness)

Nail changes (thickening)

Skin texture (thin, shiny)

Class C

Claudication (pain in calf when walking)

Temperature changes in the feet

Edema

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

Burning

Other Indications and Limitations of Coverage and/or Medical Necessity

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

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

Diagnosis Requirements

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

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

451.11*
451.19*
579.0*
579.1*
579.2*
579.3*
579.4*

585*
586*

Coding Guidelines

In order for M0101 (Routine Foot Care) to be a covered service, the patient must have one or more of the diagnoses listed under the "ICD-9 That Supports Medical Necessity" section in this policy. Otherwise, the service is noncovered and should be coded as A9160 (noncovered service by a podiatrist) or A9270 (noncovered item or service). On all claims for Routine Foot Care, except for peripheral neuropathy involving the feet associated with traumatic injury, the name of the M.D. or D.O. who diagnosed the problem must be indicated. In addition, for those diagnoses which are asterisked (*), the M.D. or D.O. must be actively treating the condition, and the date the patient was last seen by the actively treating M.D. or D.O. must be included on the claim.

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

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

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

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

Note: If the sole purpose of the encounter is to perform covered routine foot care services, a separate visit should not be billed. However, if treatment of an unrelated problem is provided in addition to the routine foot care, a separate visit can be billed using procedure code modifier 25.

Reasons for Denial

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

Documentation Requirements

In the event of either a pre- or post-payment review, the documentation guidelines outlined below must be followed.

The podiatrist must document the appropriate signs and symptoms as outlined in Classes A, B and/or C of the complicating condition(s)/ICD-9 list. In addition, the podiatrist must document the diagnosing M.D. or D.O. for those complicating conditions under the "ICD-9 That Supports Medical Necessity" which are not asterisked, with the exception of peripheral neuropathy involving the feet associated with traumatic injury.

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

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Anesthesia/Surgery

11975-11977: Contraceptive Capsules

Insertion, implantable contraceptive capsules (procedure code 11975) and removal with reinsertion (procedure code 11977) are not covered under Medicare Part B. Since these services are never covered, the provider may collect the full billed amount from the patient.

Removal, implantable contraceptive capsules (procedure code 11976) is not a covered service unless performed because the site has become infected. The history and physical and appropriate medical documentation of infection must be submitted with the claim.

Advance Notice Requirement

For procedure code 11976, advance notice applies to medical necessity (see page 4).

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19140-19240: Post-Operative Breast Cancer Surgical Care

Considerable attention has been focused recently on treatments for breast cancer. In particular, concerns have been expressed that efforts at cost containment may be resulting in women being required to receive surgical procedures on an outpatient basis in circumstances when such treatment is inappropriate. Concerns have also been expressed about premature discharges for inpatient procedures.

We have reviewed the available medical literature and concluded that caution is warranted in performing mastectomies or lymph node dissections. For many Medicare beneficiaries, advanced age, increased risk of post-surgical complications, presence of significant comorbidity, impaired functional status, and lack of social support may put them at increased risk if this surgery is performed in an outpatient setting or with insufficient hospital length of stay. The more extensive the surgical intervention (e.g., radical mastectomy), the more likely the patient is to be at increased risk from the procedure in the outpatient setting or from shortened length of stays. Given the current available evidence, it is not acceptable practice for providers or physicians to apply policies indiscriminately to all Medicare beneficiaries mandating surgical interventions for treatment of breast cancer in an outpatient setting or establishing a maximum length of an inpatient stay.

HCFA is neither requiring that all procedures be performed on an inpatient basis, nor establishing a minimum length of stay. In certain circumstances, with carefully selected patients, an outpatient setting or limited hospital stay may be appropriate. However, these practices may only be used when they have been determined to be appropriate by the patient and the patient's physician, after assessment of the individual circumstances.

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36430, 36440, 36450, 36455, 36460; P9010-P9022; 86850-86999: Blood Transfusions, Blood Products, and Blood Processing

The following information reiterates current Medicare Part B medical policy for blood transfusions, blood products, and blood processing.

Blood Transfusions

Blood transfusions are used to restore blood volume after hemorrhage, to improve the oxygen carrying capacity of blood in severe anemia, and to combat shock in acute hemolytic anemia.

The procedure codes used to report blood transfusions are:

36430:Transfusion, blood or blood components

36440:Push transfusion, blood, 2 years or under

36450:Exchange transfusion, blood; newborn

36455:other than newborn

36460:Transfusion, intrauterine, fetal

Transfusions are covered under Medicare Part B when treatment is reasonable and necessary for the individual patient. Blood is a biological and can be covered under Part B only when furnished by a physician or incident to his services.

Blood Products

Blood products (procedure codes P9010-P9022) refer to the unit of whole blood or to the components of the whole blood such as red blood cells, platelets or plasma (not a complete list of the components). The procedure codes used to report blood products are:

P9010 Blood (whole), for transfusion, per unit
P9011 Blood (split-unit), specify amount
P9012 Cryoprecipitate, each unit
P9013 Fibrinogen unit
P9014 Globulin, gamma, 1 ml.
P9015 Globulin, Rh immune, 1 ml.
P9016 Leukocyte-poor blood, each unit
P9017 Plasma, single donor, fresh frozen, each unit
P9018 Plasma protein fraction, each unit
P9019 Platelet concentrate, each unit
P9020 Platelet-rich plasma, each unit
P9021 Red blood cells, each unit
P9022 Washed red blood cells, each unit

Only the provider who actually supplies the blood or blood product should bill for the blood or blood product.

If a physician or supplier accepts a replacement unit of whole blood or packed red cells from a beneficiary or another individual acting on his behalf, the beneficiary may not be charged for the blood.

Blood Services

Blood services refer to the collection, processing, and storage of blood. The following procedure codes are used to report blood services:

86850 Antibody screen, RBC, each serum technique

86860 Antibody elution (RBC), each elution

86870 Antibody identification, RBC antibodies, each panel for each serum technique

86880 Antihuman globulin test)Coombs test); direct, each antiserum

86885 indirect, qualitative, each antiserum

86886 indirect, titer, each antiserum

86890 Autologous blood or component, collection processing storage; predeposited

86891 intra-or postoperative salvage

86900 Blood typing; ABO

86901 Rh (D)

86903 antigen screening for compatible blood unit using reagent serum, per unit screened

86904 antigen screening for compatible unit using patient serum, per unit screened

86905 RBC antigens, other than ABO or Rh (D), each

86906 Rh phenotyping, complete

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

86911 each additional antigen system

86915 Bone marrow, modification or treatment of eliminate cell (e.g., T-cells, metastatic carcinoma)

86920 Compatibility test each unit; immediate spin technique

86921 incubation technique

86922 antiglobulin technique

86927 Fresh frozen plasma, thawing, each unit

86930 Frozen blood, preparation for freezing, each unit

86931 with thawing

86932 with freezing and thawing

86940 Hemolysins and agglutinins, auto, screen, each;

86941 incubated

86945 Irradiation of blood product, each unit

86950 Leukocyte transfusion

86965 Pooling of platelets or other blood products

86970 Pretreatment of RBC's for use in RBC antibody detection, identification, and/or compatibility testing; incubation with chemical agents or drugs, each

86971 incubation with enzymes, each

86972 by density gradient separation

86975 Pretreatment of serum for use in RBC antibody identification; incubation with drugs, each

86976 by dilution

86977 incubation with inhibitors, each

86978 by differential red cell absorption using patient RBC's or RBC's of known phenotype, each absorption

86985 Splitting of blood or blood products, each unit

86999 Unlisted transfusion medicine procedure

Reasons for Denial for Blood Services

The collection, processing, and storage of blood that is either autologous (donated by the beneficiary for his/her own use) or donor-directed (by a relative or friend) for later transfusion into the beneficiary is not recognized as a separate service under Part B.

Procedure codes 86890 and 86891 are not recognized as a separate service under Medicare Part B for either autologous or donor-directed blood.

Procedure codes 86910 and 86911 are noncovered by Medicare.

Procedure code 86927 (Reimbursement for the thawing of fresh frozen plasma) is included in the basic allowance of the transfusion of blood or blood components

Routine screening laboratory work done for transfusions is not a benefit of Medicare B. As with all screening services, they are not performed to diagnose or treat a symptom, injury or illness.

Documentation Requirements

In case of medical review, the physician is expected to maintain specific patient information in the medical record to justify the need for services. This includes history, physical and office notes, if necessary.

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53670: Urine Specimen Collection in a Physician's Office

Urine specimen collection using a catheter is allowed in a physician's office when one or more of the following conditions is present:

It must be medically necessary for a physician to obtain the specimen by catheter.

If a patient can void (urinate) normally, it is not usually medically necessary to collect the urine specimen with a catheter.

If the patient uses a catheter for a medical condition (such as urinary retention or
incontinence), the urine specimen may be obtained from the existing catheter. The physician would not ordinarily insert another catheter for a specimen collection. Therefore, a separate charge for specimen collection would not be paid.

When the patient is receiving any cystoscopic procedure, a separate charge for a specimen collection will not be allowed, as the specimen is obtained during the course of the procedure.

Providers should use procedure code 53670 (Catheterization, urethra; simple) with the 52 modifier (to indicate reduced services) to bill for urine specimen collection using a catheter. The allowed amount is $5.00.

Be advised that it is not appropriate to use procedure code G0002 (Office procedure: insertion of temporary indwelling catheter, Foley type) to bill for the collection of a urine specimen using a catheter. A Foley catheter is indwelling, and is meant to remain in place for a longer period of time than it takes to obtain a urine specimen.

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55899: Coverage of Transurethral Microwave Thermotherapy (TUMT)

Benign Prostatic Hypertrophy (BPH) is fundamentally a disease that causes morbidity through the urinary symptoms with which it is associated. For many years prostatectomy, particularly transurethral prostatectomy, has been the standard treatment for symptomatic BPH. More recently, however, a plethora of competing therapies are being used to treat patients with symptomatic BPH. These treatments include transurethral incision for the prostate, laser prostatotomy, balloon dilation, hyperthermia, insertion of prostatic stents, a-adrenergic blocking drugs and hormonal therapy. In addition, a "watchful waiting" approach can be followed. This policy addresses one treatment option for BPH Transurethral Microwave Thermotherapy (TUMT).

Prostatron is a device that provides transurethral microwave thermotherapy for the treatment of symptomatic BPH. TUMT provides simultaneous microwave heating of the prostate with temperatures of 45-55 degree Celsuis and conductive cooling of the urethra. This treatment results in high-power microwave application deep

in the lateral lobes, leading to irreversible cell damage of prostatic tissue without damaging the urethra. TUMT effectively maintains temperatures in the urethra sphincter, and rectum at physiologically safe temperatures while targeting heat deep within the prostate transition zone. This is accomplished by combining use of a water-cooled catheter with microwave radiation to the prostate lobes.

Currently, the Prostatron device (EDAP Technomed, Inc.) is FDA-approved to provide microwave thermotherapy for patients with BPH. The Prostatron is intended to deliver a complete thermal therapy treatment during a single treatment.

As approved by the FDA, treatment of BPH with microwave thermotherapy is indicated and covered for dates of service May 3, 1996, and after for patients that meet the following criteria:

Prostatic lengths between 35-50 mm. as determined by ultrasound;

Duration of BPH longer than 3 months;

American Urology Association (AUA) symptom greater than 12 or Madsen symptom index greater than 8;

Free peak uroflow rate (PAR) less than 15cc/sec and/or voided volume less than 150cc;

Post void residual (PVR) less than 350cc.

The labeling for the Prostatron contains the following contraindications, warnings, and precautions:

Contraindications

1. Peripheral arterial disease with intermittent claudication or Leriches syndrome(i.e., claudication of the buttocks and perineum).

2. Clinical or histological evidence of prostatic cancer or bladder cancer.

3. Severe urethral stricture preventing easy catheterization.

4. Presence of a cardiac pacemaker, an implantable defibrillator, or a metallic implant in the region of the hip, pelvis, or femur.

Warnings

1. Studies have not been conducted on patients with evidence of latex sensitivity and therefore patients with this condition must be treated with caution.

2. In the Prostatron clinical study, patients with a pre-treatment post-void residual urine of greater than 150 mLs and a

prostate volume of greater than 40 mLs had a higher incidence of transient urinary retention after TUMT than other patients. The retention is likely to be due to a degree of detrusor failure in these men.

3. Prior to discharge, such patients should be carefully assessed to determine their risk of experiencing post-treatment retention. A reasonable period of catheterization may be prudent to avoid the occurrence of acute urinary retention post-discharge.

Precautions

1. The safety and effectiveness of treatment with the Prostatron have not been established in patient with the following conditions:

Interest in the preservation of future fertility.

Disorders of coagulation.

Renal impairment.

Neurological disorders which might affect bladder function.

Post-void residual urine volumes greater than 350 mL.

Urinary retention requiring an indwelling catheter.

Large median lobe of the prostate protruding into the bladder.

Active urinary tract infections.

Bacteriological evidence of bacterial prostatitis.

Bladder stones.

Previous pelvic surgery or pelvic radiotherapy.

Previous rectal surgery (other than hemorrhoidectomy).

2. The use of the Prostatron must be prescribed and administered under the direct supervision of a qualified and trained physician, after appropriate urologic evaluation of the patient. The treating physician should be present at all times during the treatment.

When the TUMT is performed, procedure code 55899 with diagnosis 600 (hyperplasia of prostate) must be submitted on a paper claim with documentation. A concise description of the procedure must be indicated in Item 19 of the HCFA-1500 claim form. The medical records such as office/progress notes must document the patient's prostatic length, duration of BPH, AUA symptoms or Madsen symptom index, the peak flow rate and post void residual. In addition, the operative report documenting the TUMT procedure must be received.

Note: An operative report is not required provided that the name of the device is clearly noted in the office/progress notes.

Advance Notice Requirement

Applies to medical necessity requirements (see page 4).

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68810-68815: ASC-Approved Procedures

The following procedures have been added as ASC-approved procedures effective for services furnished on or after January 1, 1997:

Code	Group					
68810	1	68811	2	68815	2	

Note: Claims for new ASC-approved procedures which were previously denied payment will be automatically adjusted for payment. It is not necessary to request reviews for these claims.

Effective for services furnished on or after April 1, 1997, procedure code 68825 is no longer an ASC-approved procedure.

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Diagnostic Tests

73000-73140, 73500-73660: Comparison X-Rays of the Extremities

Comparison x-rays are used to assess similarities. When they are performed to compare the corresponding extremity/opposite side in the absence of abnormal signs or symptoms, they are considered screening and are not covered by Medicare. There are, however, instances in which comparison x-rays would be considered medically necessary and reasonable. Local medical review policy was developed in 1996 to define this service and identify the circumstances under which Medicare Part B of Florida will consider it to be medically reasonable, necessary and, therefore, covered.

Medicare Part B will consider comparison x-rays to be medically necessary when performed in the following circumstances:

For children (infant-16 years of age) with possible injury involving the epiphysis of a bone.

When an extremity x-ray does not provide a definitive diagnosis and a subsequent x-ray of the opposite extremity is required for comparison.

If a beneficiary has an x-ray taken of an extremity which has symptomatology and a definitive diagnosis cannot be made, making it reasonable that a comparison x-ray would assist in diagnosis, then a comparison x-ray can be made. The provider must document the reason for the comparison x-ray. It is expected, however, that one would rarely see the need to perform a comparison x-ray.

Coding Guidelines

The appropriate procedure code with the applicable RT or LT modifier should be billed when these services are performed. Modifier 50 should not be used.

Reasons for Denial

One would not expect to see x-rays of the opposite extremities, for comparison, performed simultaneously unless the x-ray is taken on a child with possible epiphyseal injury, or on a beneficiary who exhibits symptomatology in an extremity which cannot be diagnosed without a comparison x-ray. Providers who routinely or frequently perform comparison x-rays may be subject to medical review and denial of reimbursement if the services are not found to be medically reasonable and necessary.

Advance Notice Requirement

Applies to medical necessity guidelines. (See page 4).

Documentation Requirements

Medical record documentation maintained by the referring and performing physician must indicate the medical necessity for a comparison x-ray. The original x-ray report, along with the indication and report of the comparison x-ray, should be maintained in the office/progress notes, and must be available upon request.

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G0095-G0098: Temporary Codes for New Lab Panels Approved

New laboratory panels were approved by the American Medical Association (AMA) Current Procedural Terminology (CPT) Board at their November 1996 meeting. CPT codes for these new laboratory panels will not be available for use until January 1, 1998.

The Health Care Financing Administration (HCFA) has decided to permit billing for the the new laboratory panels and has established temporary codes to be used from July 1, 1997, to December 31, 1997. (On January 1, 1998, the new CPT codes become effective.)

The new laboratory panel codes are effective for services rendered on or after July 1, 1997. Claims received with the new lab panel codes for services rendered before July 1, 1997, will be denied by the Medicare system as containing invalid codes.

The following table outlines the new laboratory panels, their component laboratory tests, and the CPT procedure codes for their component laboratory tests:

Temporary Code/Descriptor: G0095Hepatic Function Panel A (with Bilirubin

Tests Included in New Code: Albumin, serum (82040)Bilirubin, total AND direct (82251)Phosphatase, alkaline (84075)Transferase, aspartate amino (AST)(SGOT)(84450)Transferase, alanine amino (ALT)(SGPT)(84460)

Notes: The current Hepatic Function Panel, code 80058, includes Bilirubin (total OR direct) which when coded separately is code 82250. However, the new Hepatic Function Panel A includes Bilirubin (total AND direct) which when coded separately is code 82251.

Temporary Code/Descriptor: G0096Basic Metabolic Panel

Tests Included in New Code: Carbon dioxide (bicarbonate)(82374)Chloride; blood (82435)Creatinine; blood (82565)Glucose; quantitative (82947)Potassium; serum (84132)Sodium; serum (84295)Urea nitrogen; quantitative (84520)

Notes: NA

Temporary Code/Descriptor: G0097Electrolytes Panel

Tests Included in New Code: Carbon dioxide (bicarbonate)(82374)Chloride; blood (82435)Potassium; serum (84132)Sodium; serum (84295)

Notes: NA

Temporary Code/Descriptor: G0098 Comprehensive Metabolic Panel

Tests Included in New Code: Albumin; serum (82040)Bilirubin; total (82250) *Calcium; total (82310)Chloride; blood (82435)Creatinine; blood (82565)Glucose; quantitative (82947)Phosphatase; alkaline (84075)Potassium; serum (84132)Protein; total. except refractometry (84155)Sodium; serum (84295)Transferase; aspartate amino (AST)(SGOT)(84450)Urea nitrogen; quantitative (84520)

Notes: *Normally, CPT code 82250 may be used for either total or direct Bilirubin. The Comprehensive Metabolic Panel includes only the total Bilirubin. Code G0098 may be used only if total bilirubin is performed.

Coding Guidelines for the New Panel Tests

As with any other laboratory panel, all of the component tests included in the definition of the new laboratory panel codes must be performed in order to bill using those panel codes.

If the laboratory has a custom panel that includes other tests in addition to those included in the definition of CPT or HCPCS panels, the additional tests (whether on the list of automated tests or not) are billed separately in addition to the CPT or HCPCS panel code if any of the CPT or HCPCS panel code(s) is/are billed.

Each of these new panels is composed solely of tests which are subject to the automated profile payment rules. However, if additional automated tests are performed along with any one (or more) of the new automated profile codes, the laboratory may use one of the following billing options:

Option No. 1

Use the new automated profile panel codes (procedure codes G0095-G0098) and, as needed, other CPT disease and organ panel codes and/or individually listed codes of any additional automated tests performed (i.e., each additional test would be a separate line item using its appropriate CPT code). Do not use procedure codes 80002-80019 or G0058-G0060.

Option No. 2

Use the current automated multichannel procedure codes (procedure codes 80002-80019 and G0058-G0060) and any other current CPT codes that apply. Do not use the new automated profile codes G0095-G0098.

If a claim is submitted with both the new panel codes (procedure codes G0095-G0098) and the automated multichannel procedure codes (procedure codes 80002-80019 and G0058-G0060), it will be denied by the Medicare Part B system.

Providers are encouraged to bill using the first option, since effective January 1, 1998, this will be the only method by which laboratories will be allowed to bill these tests.

Payment for New Panels

The following pricing is effective for the new temporary codes:

G0095	$11.10
G0096	$11.60
G0097	$9.96
G0098	$12.81

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80500, 80502: Coverage for Clinical Pathology Consultations and Clinical Laboratory Interpretation Services

Analysis of January through June 1995 Medicare claims data for Florida indicated that the Florida carrier has allowed significantly more reimbursement per 1,000 Medicare beneficiaries than Medicare has paid nationally for procedure code 80500 for specialties 01 (General Practice), 22 (Pathology), 69 (Independent Lab), and 83 (Hematology/Oncology). In addition, medical records for clinical pathology consultations have been reviewed through the Provider Audit List process and revealed that clinical pathology consultations were often not documented and justified as medically necessary and reasonable. As a result of the above findings, and review of the previous policy, it was determined that there was widespread inappropriate billing for these codes. Therefore, it was concluded that a revision was needed to reflect the MCM requirements including medical necessity requirements for Clinical Pathology Consultations (procedure codes 80500 and 80502) and Clinical Interpretative Services. This revision of policy was developed with extensive input from the Pathology society, and is effective for claims processed June 17, 1997, and after.

A clinical pathology consultation and clinical lab interpretation are services generally rendered by the pathologist to assist the attending physician in planning care for his/her patient.

Clinical Pathology Consultations

A clinical pathology consultation results from a request from the attending physician for assistance in interpreting the results of a test (or tests) and advice on the plan of care for the patient in light of the patient s clinical condition. This consultation includes a written report containing the interpretive judgment and clinical recommendations of the pathologist. In order for Clinical Consultations (procedure codes 80500 and 80502) to be reimbursed by Medicare Part B, all of the following requirements must be met:

1. Medical necessity requirements. A Clinical Pathology Consultation is considered medically reasonable and necessary when the ordering physician is unsure of the clinical relevance of the result(s) of a complex or infrequently ordered test(s) and requires the medical judgment of a Pathologist to appropriately apply the data to the management of his/her patient. The results of the test(s) would generally be reviewed by the ordering

physician prior to a consultation being requested to determine the need for further consultation by a pathologist.

2. Are requested specifically by the patient's attending physician. The clinical record/medical documentation must clearly indicate that the attending physician requested a clinical pathology consultation and specifically what test or tests the consultation is to address. The need for this consultation must also be clear in the patient's record. The ordering of the test itself does not constitute an order for the consultation.

3. Relate to a test result or results that lie outside the clinically significant normal or expected range in view of the condition of the patient. It is not considered medically reasonable and necessary for a consult to be performed on test results that are not outside the clinically significant cant normal or expected range in view of the condition of the patient. Again, unless the medical reason for the clinical consultation is clearly documented in the clinical record/medical documentation, consultations performed on patients with normal test results will not be considered medically reasonable and necessary.

4. Result in a written narrative report included in the patient s record. This may be in the form of a consultative report, a clear notation in the progress notes or a narrative on the lab slip indicating the pathologist performing the service. Routine conversations a laboratory director has with attending physicians about test orders or results are not consultations unless all five requirements are met. Laboratory personnel, including the director, may from time to time contact attending physicians to report test results or to suggest additional testing or be contacted by attending physicians on similar matters. These contacts do not constitute clinical consultations. However, if in the course of such a contact, the attending physician requests a consultation from the pathologist, and if that consultation meets the other criteria and is properly documented, it is paid under the fee schedule.

5. Require the exercise of medical judgment by the consultant physician/pathologist.

Clinical pathology consultations are commonly billed for the following test result(s). In order to determine whether these consultations meet the above coverage requirements including medical necessity requirements, supporting medical documentation may be required. However, we would expect the need for consultative advice on these tests to be infrequent.

Cardiac Enzymes (82552, 83625)

Unusual Urine Sediment with exam and report

*Coagulation Profiles (Clotting inhibitors or anticoagulants [85300])

Minimum Inhibitory Concentrations

Glucose Tolerance Tests (82951-82952)

Endocrine Chemistry Battery

Lipoprotein Electrophoresis (83715)

Drug Screens (80100-80101)

Electrophoretic technique, not elsewhere classified (Alkaline Phosphatase Isoenzymes) [82664]

Body Fluid Cell counts and differential (89051)

Ova and Parasites direct smears, concentration and identification (87177)

Dark field exam, any source, without collection (87166)

Sensitivity studies, antibiotic; microtiter, minimum inhibitory concentration (MIC), any number of antibiotics (87186)

Hemoglobin, electrophoresis (eg, A2, S, C)(83020)

Molecular diagnostics; interpretation and report (83912)

Protein; electrophoretic fractionation and quantitation (84165)

Western Blot, with interpretation and report, blood or other body fluid (84181)

Western Blot, with interpretation and report, blood or other body fluid, immunological probe for band identification, each (84182)

Fibrinolysins; or coagulopathy screen, interpretation and report (85390)

Platelet; aggregation (in vitro) any agent (85576)

Fluorescent antibody; screen, each antibody (86255)

Fluorescent antibody; titer, each antibody (86256)

Immunoelectrophoresis; serum (86320)

Immunoelectrophoresis; other fluids (eg, urine, CSF) with concentration (86325)

Immunoelectrophoresis; crossed (2 dimensional assay) (86327)

Immunofixation electrophoresis (86334)

Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection (87164)

Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (eg, malaria, kala azar, herpes) (87207)

Protein analysis of tissue by Western Blot, with interpretation and report (88371)

Protein analysis of tissue by Western Blot, with interpretation and report; immunological probe for band identification, each (88372)

Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine) (89060)

The coverage of clinical pathology consultations for laboratory test(s) not listed above will be determined in a similar fashion. However, we would expect the medical reasonableness and necessity of such consultations to be uncommon. In addition, we expect the need for more than one clinical pathology consultation per day to be an infrequent occurrence. However, if additional consultations are billed, they must meet all the criteria of medical necessity and reasonableness.

Clinical Laboratory Interpretation Service

A clinical lab interpretation service provides a written interpretation of the result of a specific lab test by the pathologist for a specific patient, at the request of the attending physician. This interpretation includes a written narrative report by the pathologist and may include computer generated findings. Computer generated findings may not, however, substitute for, or be the only information provided, in the interpretation by the pathologist.

There are a limited number of clinical laboratory codes that have been identified as needing the pathologist to furnish an interpretation. Therefore, only for the laboratory tests listed below, will the clinical laboratory interpretation service be considered medically necessary. Additionally the following criteria must be met for the clinical laboratory interpretive service to be covered by Medicare Part B:

Are requested by the patient's attending physician;

Result in a written narrative report included in the patient's medical record; and

Require the exercise of medical judgment by the consultant physician.

In addition, the general criteria for physicians services in the hospital must be met. These are:

The services are personally furnished for an individual beneficiary by a physician;

The services contribute to the diagnosis or treatment of an individual beneficiary; and

The services ordinarily require performance by a physician.

Clinical interpretative services do not involve the patient s history or condition of the patient. When clinical interpretative services are performed on these tests, the applicable procedure code with a modifier 26 (professional component) should be billed. It is not appropriate to bill for a clinical pathology consultation (procedure codes 80500 or 80502) in addition to the interpretation unless the five requirements for a consultation are met. Finally, although computer-generated findings may be included with the interpretation, they cannot serve as the medical judgment of the pathologist. Therefore, the documentation of the interpretation should include a narrative statement from the pathologist.

The following laboratory tests are identified as clinical laboratory interpretative services:

83020 Hemoglobin, electrophoresis (eg, A2, S, C)

83912 Molecular diagnostics; interpretation and report

84165 Protein; electrophoretic fractionation and quantitation

84181 Western Blot, with interpretation and report, blood or other body fluid

84182 Western Blot, with interpretation and report, blood or other body fluid, immunological probe for band identification, each

85390 Fibrinolysins; or coagulopathy screen, interpretation and report

85576 Platelet; aggregation (in vitro) any agent

86255 Fluorescent antibody; screen, each antibody

86256 Fluorescent antibody; titer, each antibody

86320 Immunoelectrophoresis; serum

86325 Immunoelectrophoresis; other fluids (eg, urine, CSF) with concentration

86327 Immunoelectrophoresis; crossed (2 dimensional assay)

86334 Immunofixation electrophoresis

87164 Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection

87207 Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (eg, malaria, kala azar, herpes)

88371 Protein analysis of tissue by Western Blot, with interpretation and report

88372 Protein analysis of tissue by Western Blot, with interpretation and report; immunological probe for band identification, each

89060 Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)

Documentation Requirements

For clinical pathology consultation services, the clinical record/medical documentation must clearly indicate that the attending physician requested a clinical pathology consultation and specifically what test or tests the consultation is to address. The medical necessity for this consultation must also be clear from the documentation in the patients record. In addition, a copy of the lab test(s) result(s), and the written narrative of the pathologists findings is required.

For clinical laboratory interpretation services, the medical documentation must support that one of the eighteen listed procedure codes were ordered. In addition, the patient record must contain the lab results and a written narrative report from the pathologist.

Advance Notice Requirement

Applies to medical necessity (see page 4).

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82378: Carcinoembryonic Antigen (CEA)

Carcinoembryonic antigen (CEA) is a glycoprotein that can be elevated in certain types of malignancies, and thus is useful as a tumor marker.

Carcinoenbryonic antigen (CEA) is covered by Medicare Part B of Florida when it is medically reasonable and necessary for the

patient's condition. CEA (procedure code 82378) is considered medically reasonable and necessary and therefore covered provided it is used:

As a serum tumor marker to monitor the status of various kinds of malignant tumors (see covered ICD-9 list);

To determine the adequacy of antineoplastic therapy.

CEA is not useful for making a differential diagnosis of cancer since the sensitivity and specificity of this test makes it unreliable.Therefore, CEA is not indicated as a screening test for cancer. This policy is effective for claims processed on or after June 16, 1997.

Diagnosis Requirements

To ensure that payment is made only for medically necessary services, CEA is covered only when it is performed for the following diagnoses:
151.0-151.9
152.0-154.8
159.0
162.0-162.9
174.0-174.9
175.0-175.9
197.4
197.5
235.2
V10.03
V10.04
V10.05
V10.06
V10.11
V10.3

Documentation Requirements

Office records must include documentation in support of medical necessity, such as a history and physical, office/progress notes and lab reports.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

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86592, 86593: Syphilis Testing

Syphilis is an infectious, chronic venereal disease resulting in various lesions of structural and cutaneous nature. Symptoms range from a small red papule in the initial stage to

cardiovascular syphilis or neurosyphilis in the later stages of the disease. Syphilis testing is done to diagnose syphilis.

Medicare Part B will consider syphilis testing (CPT codes 86592, 86593) to be medically reasonable and necessary when performed under the following circumstances:

To assist in the diagnosis of primary and secondary syphilis and systemic lupus erythematosus;

To confirm primary or secondary syphilis in the presence of syphilitic lesions;

To monitor response to treatment for primary and secondary syphilis.

This policy is effective for claims processed on or after June 16, 1997.

Diagnosis Requirements

To ensure that payment is made only for medically necessary services, syphilis testing is covered only when it is performed for the following diagnoses:
042
090.0-090.9
091.0-091.9
092.0-092.9
093.0-093.9
094.0-094.9
095.0-095.9
096
097.0-097.9
099.0
104.0
290.0-290.9
356.9
710.0
V01.6

Coding Guidelines

The service should be billed with CPT code 86592 or 86593 and the appropriate ICD-9 diagnosis code.

It is expected that individuals with noncontagious diagnoses would receive one VDRL, RPR or ART to rule out the mimic disease of syphilis.

Reasons for Denial

Services submitted with diagnoses other than those listed as covered ICD-9 codes will not be eligible for coverage. Screening services are not a benefit of Medicare.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Documentation Requirements

The medical necessity of the test must be documented in the physician's office/progress notes. In addition, the test results should be included in the documentation.

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88348: Electron Microscope; Diagnostic

The electron microscope uses electron beams, instead of light, to form an image for viewing, allowing greater magnification and resolution. The image may be viewed on a fluorescent screen, or it may be photographed. The electron microscope has been used in the examination of biopsies for years; its efficacy, and therefore, its Medicare coverage is not in question. However, there are less costly methods for examining biopsies which are normally adequate.

Medicare Part B will consider electron microscopy (CPT code 88348) to be medically reasonable and necessary when used in the following circumstances:

To distinguish various types of nephritis from renal needle biopsies

When there is an uncertain diagnosis from the pathologist

When an uncertain diagnosis from the pathologist results from a less expensive method of examination, and an electron microscope examination is therefore necessary, both biopsy examinations are covered. Where the additional expense for an electron microscope examination is not warranted, payment is base upon the less costly methods of examining biopsies.

Diagnosis Requirements

Electron microscopy is covered when it is used for the following conditions/diagnoses:

274.0

580.0
580.4
580.81
580.89
580.9
581.0
581.1
581.2
581.3
581.81
581.89
581.9
582.0
582.1
582.2
582.4
582.81
582.89
582.9
583.0
583.1
583.2
583.4
583.6
583.7
583.81
583.89
583.9
586
588.1
588.8
593.9
599.7
710.0
753.10-753.19
753.3
756.89
759.81-759.89
V42.0

Coding Guidelines

Electron microscopy should be billed with CPT code 88348 and the appropriate ICD-9 diagnosis code.

Reasons for Denial

Any service billed with a diagnosis code other than those listed in the ICD-9 list for "Diagnosis Requirements" will be denied. Electron microscopy would never be allowed for screening purposes.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Documentation Requirements

Medical records must contain sufficient information to document medical necessity for using the electron microscope.

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MEDICINE

90780, 90781, 90782-90788: Coverage for Therapeutic or Diagnostic Infusions/Injections

Effective for claims processed June 16, 1997 and after, if an otherwise covered injectable drug/substance is denied payment, the corresponding therapeutic or diagnostic infusion (procedure codes 90780 and 90781) or therapeutic or diagnostic injection (procedure codes 90782-90788) will also be denied payment.

When a covered infusion/injection is the only service provided to a patient, the provider should bill the appropriate infusion/injection administration code and the appropriate code for the drug/injected substance.

If a noncovered infusion/injection is provided to a patient, both the drug/injected substance and the administration of the infusion/injection are noncovered items. In this instance, it is not appropriate to bill a covered CPT-4 code for the administration. If the provider wishes to submit a claim to Medicare for a noncovered service, the claim should be billed with HCPCS code A9270 (noncovered service).

Injections/Infusions Provided During the Course of an E/M Service

CPT code 99211 cannot be used to report a visit solely for the purpose of receiving an injection which meets the definition of CPT codes 90782, 90783, 90784 or 90788. Medicare Part B will not pay for CPT codes 90782-90788 if an evaluation and management (E/M) service was billed on the same day by the same physician because payment for the E/M service includes the payment for an injection that meets the definition of CPT codes 90782-90788 when it is provided on the same day as the E/M code.

If a covered injection is provided during the course of a significant, separately identifiable E/M service, the provider should bill the appropriate E/M code based on the level of care provided. In addition, the procedure code used to report the drug/injected substance may be billed. Procedure codes 90782-90788 should not be billed in addition to an E/M service. The reimbursement for the administration of the injection is included in the E/M service.

If a covered infusion is provided during the course of a significant, separately identifiable E/M service, the provider should bill the appropriate E/M code based on the level of care provided; the appropriate procedure code used to report the

drug/injected substance; and the appropriate infusion code (90780 or 90781).

If a noncovered infusion/injection is provided to a patient during the course of a covered E/M service, the provider may report the appropriate E/M service based on the level of care provided. The noncovered administration of the infusion/injection should be billed with HCPCS code A9270 (noncovered service) if the provider wishes to submit a claim to Medicare Part B.

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94642: Pentamidine Isethionate

The only place of service payable for Pentamidine Isethionate (procedure code 94642) is place of service 11 (office).

A comprehensive article on Pentamidine Isethionate was published on page 46 of the March/April 1997 Medicare B Update!

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92499: Computerized Corneal Topography

Computerized corneal topography (procedure code 92499) is covered by Medicare Part B when it is medically reasonable and necessary for the patient's condition. To ensure that payment is made only for medically necessary services, computerized corneal topography is covered only for the following diagnoses. Refer to the most current version of the ICD-9-CM coding book for complete descriptions.

372.42
371.60

371.46
371.48
371.41
V42.5
V45.6

Advance Notice Requirement

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

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94010-94240, 94360, 94375, 94620: Coding of E/M Services with Pulmonary Services

In the September/October 1996 Medicare Part B Update! you were notified that effective for claims processed October 14, 1996, and after, a 25 modifier must be submitted with an evaluation and

management service (procedure codes 99201-99353) if billed on the same day as pulmonary function studies (procedure codes 94010, 94060, 94070, 94150, 94160, 94200, 94240, 94360, 94375, and 94620). Effective immediately, this is no longer required. However, if an evaluation and management code is billed on the same day as the pulmonary studies, it must contain the required components for the E & M service billed (i.e., history, examination, and medical decision making).

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95900-95904, 95999: Nerve Conduction Studies/Current Perception Threshold Testing

Nerve conduction studies are standard procedures in the study of peripheral nerve disease. The measurement of nerve conduction is useful as an initial diagnostic tool because it can distinguish major categories of disease (axonal vs. demyelinating) and can localize entrapments and other mononeuropathies. A baseline measurement makes it possible to differentiate progression of the peripheral neuropathy from other clinical conditions at future points in time.

Another type of test for the quantitative evaluation of nerve integrity is Current Perception Threshold (CPT) Testing, which measures the functional integrity of a given sensory nerve by recording the current intensity level of a painless sensation perceived by the patient. These coverage guidelines are effective for claims processed June 16, 1997, and after.

Medicare Part B will consider nerve conduction studies to be medically reasonable and necessary when performed under the following circumstances:

Nerve conduction tests are indicated for the diagnosis of suspected, or the follow-up of known peripheral nerve disease affecting conductivity.

Nerve conduction studies are typically used to diagnose focal neuropathies or compressive lesions such as carpal tunnel syndrome or ulnar neuropathies. They are also useful for diagnosis or confirmation of suspected generalized neuropathies, such as diabetic, uremic or metabolic neuropathies. Traumatic nerve lesions may also require nerve conduction studies for diagnosis
and prognosis.

In the absence of a definitive diagnosis, symptom-based diagnoses such as pain or numbness in an extremity, can be an acceptable indication for nerve conduction studies provided the clinical history unequivocally supports the need for the study.

Diagnosis Requirements for Nerve Conduction Studies

Nerve conduction studies are covered when performed for the followingconditions/diagnoses:

250.61-250.63
354.0-354.9
355.0-355.6
355.71-355.79
355.8-355.9
356.0-356.9
357.0-357.9
722.80-722.83
723.1
723.4
724.4
729.5
780.7
782.0

Current Perception Threshold (CPT) Testing

Effective for services rendered June 16, 1997, and after, CPT testing (95999) is covered by Medicare Part B once a presumptive diagnosis of sensory nerve dysfunction has been made. Sensory nerve impairment has four basic categories, including polyneuropathy, compressive neuropathy, radiculopathy, and focal nerve lesions. CPT testing will be considered medically reasonable and necessary when performed under the following circumstances:

To identify and localize areas of abnormal function

To determine the severity of the abnormality

To aid in diagnosis, prognosis, and treatment

CPT testing should be performed on conditions being actively treated or on patients who are exhibiting symptomatology. Repeat testing would only be necessary to determine the progression or healing of actively treated conditions.

Diagnosis Requirements for Current Perception Threshold Testing

CPT testing is covered when performed for the following conditions/diagnoses:

250.61-250.63
350.1
354.0
354.2
355.0

355.1
355.3
355.5
355.9
357.2
357.4
357.5
585
722.71
722.72

722.73
722.81
722.83
723.1
723.2
723.3
723.4
724.3
724.4
724.5
729.2

Coding Guidelines

Claims for Nerve Conduction Studies should be billed using procedure codes 95900, 95903, and 95904. Claims for Current Perception Threshold (CPT) Testing should be billed using procedure code 95999. When using an unlisted code, a concise description of the procedure must be indicated in Item 19 of the HCFA-1500 claim form. Any claim reporting CPT Testing as nerve conduction and/or latency studies would not be appropriate and will be denied.

One would not expect to see both nerve conduction studies and current perception threshold testing billed during the same patient encounter or on alternate visits.

Use of technical component (TO) or professional components (26) modifier is appropriate in billing diagnostic procedures (for codes 95900, 95903, and 95904).

Reasons for Denial

Routine screening and medically unnecessary services are not covered by Medicare. Therefore, services for conditions not listed in the "Diagnosis Requirements" will be denied as either screening or not medically necessary.

Consistent excessive use of units of testing, repeated testing on the same patient, or testing every patient referred for pain, weakness, or paresthesia may become evident on review. In these cases, denial may occur.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Documentation Requirements

In the event of a pre- or post-payment review, the following documentation guidelines must be met.

The patient's medical records, including history and physical, office/progress notes, and nerve conduction or CPT test results, must clearly document the medical necessity of the test. Sensory nerve dysfunction should be documented in the patient's history.

Clinical examination should demonstrate qualitative signs of sensory dysfunction with the exception of patients with metabolic disorders such as diabetes mellitus. Frequently, these patients can be diagnosed with neuropathy prior to the presence of overt clinical symptoms.

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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 MFB by phone, facsimile, or by mail at the following:

Medicare Part B Provider Customer Service: (904) 634-4994

MFB Fax Line: (904) 791-6716-

Medicare Fraud Branch

P.O. Box 45087

Jacksonville, Florida 32231-0048

Please include as much detail as possible, including the name of at least one beneficiary 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, and the concerned individual will not be exposed.

Avoid Misunderstandings: Advise Your Patients

Simple misunderstandings are responsible for the majority of the fraud and abuse complaints received by the Florida carrier fraud unit. To avoid unnecessary fraud reviews, your patients should be reminded of the following things:

Co-payment and deductible responsibilities;

Office name changes such as mergers, additional physicians, etc.;

Anesthesiologists and CRNAs billing for the same surgical procedure time;

Unusually coded procedures/services, such as joint injection or blood drawing which are both listed under surgery procedure codes;

Services which are usually furnished outside of the office (i.e., referred laboratory charges); and

Care for certain inpatients may require help from unmentioned providers such as radiologists or cardiologists who interpret tests and X-rays.

Medical Necessity and Nursing Home Visits

The assessment and treatment of patients residing in nursing facilities must meet medical necessity requirements to qualify for Medicare reimbursement. Services of other providers ordered by the attending physician generally meet the medical necessity criteria, but not necessarily so. When the attending physician simply checks off services on an order sheet, there may not be clear evidence of medical necessity and the services may be denied. Likewise, if other practitioners, such as speech pathologists, physical and occupational therapists, podiatrists, ophthalmic providers, and mental health providers evaluate or treat nursing facility patients without clear evidence of medical necessity in the medical record, such services will be denied.

The HCFA's nursing facility regulations require a comprehensive assessment and a plan of treatment that embraces the full range of services the resident needs. Accordingly, medical reviewers will presume that the information needed to support payment of a claim is in the nursing facility's record, if the information exists.

Evidence of medical necessity in the medical record includes pertinent progress notes by the attending physician or evidence of a Resident Assessment Protocol (RAP) that a problem has arisen

which requires intervention by an appropriate provider. The patient or family may request intervention by a specific category of provider, but, again, there must be evidence in the record that such intervention is medically necessary and covered by Medicare regulations for Medicare to reimburse for those services. All providers are reminded that it is recommended that the attending physician be contacted whenever a nursing facility patient is tobe seen, unless the patient specifically requests otherwise.

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 to various state, federal, provider and beneficiary associations and agencies. They are highlighted in this section to further reach the Florida provider and beneficiary communities.

Misrepresentation of the Status of Inpatient Hospital Patients: A scheme was recently uncovered involving both Medicare Part A and B false billings for oncology services. Multiple hospital-based oncology centers have been identified as providing radiation therapy services to inpatients, and submitting these services as outpatient in an effort to gain reimbursement for the technical component of the service. Physicians have also been billing for the professional component of these same services as office/clinic services in an effort to obtain higher reimbursement.

Other identified components of this scheme include:

Up-coding of radiation therapy services from simple to complex;

Providing more complex treatment than is necessary; ie. more fields, blocks, wedges, than can be clinically justified; and,

Billing for medically unnecessary or undocumented services.

Inappropriate Billing for Psychotherapy Procedure Codes: Physicians have been found to be billing procedure code 90855 (interactive individual medical psychotherapy) when they are supplying 90862 (pharmacologic management with no more than minimal medical psychotherapy) should have been billed. Evidently, a psychiatric publication in mid-1993 stated that it was appropriate for physicians to bill for the higher level code as a method to improving reimbursement. Be advised that it is inappropriate for a provider of medical services to up-code a service in an effort to maximize reimbursement. This is considered fraud against the federal government.

Fraud and Abuse in the Provision of Services in Nursing Facilities: Some of the illegal practices that the OIG has uncovered in nursing facilities include, but are not limited to the following:

Claims for services not rendered or not provided as claimed (i.e., speech, physical/occupational therapy, psychotherapy and diagnostic services); and,

Falsification of claims to circumvent coverage limitations on medical specialties, (i.e., podiatry, optometry, and audiology services).

If you have knowledge of these issues, please call 1-800-HHS-TIPS

Home Health Referrals: A Reminder

Physicians have recently received notice from the HCFA which advises them that they may be fined up to $5,000.00 for inappropriately referring a beneficiary for home health care services. This was meant as an advisory to our physician population (i.e., that for home health care services to be a covered benefit under the Medicare program multiple criteria must be met to obtain covered services). Multiple audits of various Home Health Agencies throughout the nation have taken place in the recent months; the audits reveal that many services do not meet coverage criteria and were not medically necessary.

Please do not avoid home health referrals in an effort to safeguard yourself from potential financial liability. These services are an excellent mechanism for patients to return to their homes safely and at a lower cost to the Medicare program. Just be aware of this as a possibility and act according to your practice standards. For more information on the Medicare home health benefit and coverage criteria, consult your Regional Home Health Intermediary.

On-Site Audits of Provider Practice Settings

Multiple on-site audits are being performed by the carrier, the AHCA, and the HCFA on providers which appear to have aberrant billing practices or for particular service providers. This is being done to assure that the services are documented and medically indicated, that state and local laws are being upheld, and even to see if the provider has the equipment to provide the services they are billing. The Florida carrier has also been performing on-site evaluations in Dade and Broward counties of any new providers who want to become part of the Medicare provider network.

Plea Agreements

Ostomy Unlimited, Inc.: Multiple individuals pled guilty in a Michigan federal court in late February 1997, in a case that involved urinary incontinence and gastrostomy feeding supplies which were fraudulently billed to the Florida and Michigan carriers. The individuals charged agreed to withdraw any current/pending litigation and face up to $12 million in fines.

Settlements and Other Fraud News

Franklin Laboratory, Inc. Settlement: The owners of Franklin Laboratory, Inc. were ordered to make restitution of $5 million. The owners waived all rights to money withheld because of the suspension taken on the provider in 1996. The laboratory and its owners are permanently excluded from participation in any federal and state programs.

Corning to Pay $119 Million to Settle A Case of Medicare Billing by Damon: A subsidiary of Corning Inc. agreed to plead guilty to one count of criminal conspiracy. The diversified company will pay $119 million to settle charges that the subsidiary bilked Medicare in a billing scheme before acquisition by Corning. The settlement, which includes a $35 million criminal fine and an $84 million civil fine, is the largest settlement for a health care fraud prosecution. The Justice Department took pains to point out that Corning Labs stopped the phony billing scheme and took steps to ensure compliance with Medicare laws following its acquisition of Damon.

Sentencing

Dr. Wallace Pickett, who was convicted of filing false claims to Medicare, Medicaid, and Champus, was sentenced on January 22, 1997, in federal court in Orlando, Florida to 33 months incarceration, followed by three years of supervised release. During the time of Dr. Pickett's supervised release he will have to perform 150 hours of community service. Dr. Pickett was ordered to make restitution in the amount of $215,000.00, ($45,000.00 to Medicare) with a special assessment of $1,700.00 added to his fines related to court costs. Additionally, the Agency for Health Care Administration (AHCA) suspended Dr. Pickett's medical license for reasons related to his conviction.

The Office of the Inspector General has urged the Health Care Financing Administration to demand that Hospice of Florida Suncoast repay almost $9 million for patients the auditors believe were ineligible for Medicare's hospice benefits. The Largo, Florida hospice said the payments were proper.

Laboratory Corp. to pay $187 million for over billing Medicare and other government programs for blood tests. Laboratory Corporation will pay a $182 million civil fine, while its Allied Clinical Laboratory subsidiary in San Diego, CA, pleaded guilty to one criminal count and agreed to pay a $5 million fine and will be barred from Medicare and Medicaid.

The U.S. Attorney in Chicago, IL, sued a Kentucky diagnostic firm, Transcor, Inc., for allegedly cheating Medicare out of $1.6 million by miscoding EKG tests performed in nursing homes.

Horizon/CMS Healthcare Corporation agrees to pay $5.8 million to settle false Medicare and Medicaid reimbursement claims.

Spectra Labs agrees to pay $10.1 million to the federal government to settle allegations that it submitted false claims to Medicare and other federal health programs for lab tests on patients with end-stage renal disease.

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Primary Care Services Rendered by Optometrists

Medicare Part B has recently been made aware that a new concept called "Primary Care 2000" is being promoted to optometrists. "Primary Care 2000" encourages an optometrist to be a "comanager of medical conditions," including acne, carotid disease, hypertension, and diabetes. To further this promotion, classes have been held with titles like: Hypertension and the Eye, Vascular Disease and the Eye, Neurology and the Eye, Clinical Laboratory Testing for the Primary Care Optometrist and Dermatology and the Eye. A class was also conducted on examination techniques for ear, nose, throat, sinuses, heart, lungs, and the neurological system.

Section 1862 (a) (1) (a) of the Social Security Act provides that Medicare can pay only for "items and services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Medicare payment for evaluation and management services provided by optometrists can therefore only be made if the services are:

1) medically necessary; and,

2) permissible under the scope of practice requirements of state licensure law.

Optometrists are reminded that all services they provide to Medicare patients are subject to national and local medical

policy guidelines, and are subject to the state licensure scope of practice requirements.

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Sanctioned Provider Information Available on Internet

The Office of Inspector General (OIG) keeps public records of individuals/entities that are excluded from reimbursement under Medicare (Title XVIII of the Social Security Act). Previously, Medicare Part B of Florida published this information as it relates to Florida providers in the Medicare B Update!

As of March 17, 1997, the entire exclusion list is now available on the internet. Providers should visit www.arnet.gov/epls/ for the list of debarred, excluded and suspended providers and entities. The website will be updated daily.

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Billing Consultants Maximizing Revenue

The information below was recently published in the Medicare Part A Bulletin, and is being republished here to ensure that all providers are aware of the problem.

An investigation into laboratory billing irregularities in several Ohio hospitals has shown that the practice of fragmenting lab billings was promoted by consulting firms that promised to increase hospital revenue in return for a commission consisting of a percentage of the first year's increase. The department heads of several hospitals were interviewed for insight into the decision-making process which resulted in the submission of false laboratory claims by hospitals. When interviewed, technical and financial supervisors of Ohio hospitals indicated that there are a number of consulting firms which offer to maximize billings for radiology, emergency room, and laboratory services by discovering and correcting coding "errors" in return for a percentage of the resulting revenue increase.

There is little incentive for consultants to correct coding errors which do not increase their consulting fees. This arrangement is ripe for upcoding, unbundling, and other manipulation which increase costs to the Medicare program. However, hospital business managers tend to rely heavily on representations made by the consultant, and fixing responsibility in a hospital organization can be difficult. Organizational charts, reporting relationships, and lines of authority can and should be explored and documented in personal interviews with hospital officials. These can be essential elements in developing a criminal case.

This information was distributed in an attempt to ensure that all Medicare Part A providers are aware of this potential fraud situation. Educated consumers and providers are less likely to become victims of fraud scams. However, all providers should pay close attention to how their claims are billed, and that the items billed correctly reflect the service(s) provided. The ultimate responsibility for the integrity of any claims billed to Medicare rests with the provider.

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"Fellows," Approved Residency Programs, and Filing Claims to Medicare

Since the publication of the new Medicare policy for the services of teaching physicians (defined as physicians who involve residents in the care of their patients), there have been many inquiries about Medicare's policy on payment for the services of "fellows." The new policy did not change the guidelines for the definition of an approved medical residency program or the circumstances under which the services of residents and fellows are considered physicians' services payable by the carriers. However, the final rule did revise existing regulations for the services of residents, and also explained when teaching physicians may properly bill under Part B.

Questions have been raised about Medicare Part B's payment guidelines for the services of residents and "fellows".

The relationship between the teaching physician policy and the services of "fellows" might be unclear because the term "fellows" can be assigned to different individuals for different reasons. It can be used to designate:

An individual who has completed a basic residency program and is now in a formally organized approved subspecialty program which may or may not be recognized as an approved residency program under Medicare; or

An individual who has completed all residency programs but who is staying at the teaching hospital/medical school complex for a variety of reasons such as a faculty appointment or a chance to develop or refine his or her skills outside the context of a residency program.

Section 2020.8 of the MCM states:

Where a senior resident has a staff or faculty appointment or is designated, for example, a "fellow", it does not change the resident's status for the purposes of Medicare coverage and payment. As a general rule, services of interns and residents are paid as provider services by the intermediary.

This article discusses the payment policy for individuals designated as fellows under various conditions.

Fellows in an Approved Program

As defnined in 42 Code of Federal Regulations (CFR) 416.86(b), a "resident" means an intern, resident, or fellow who participates in an approved medical residency program including programs in osteopathy, dentistry, and podiatry. This defines an approved medical residency program as including:

a program approved by 1 of 4 national organization cited in 42 CFR 415.152;

a program that counts toward certification in a specialty or subspecialty listed in either the Directory of Graduate Medical Education Programs published by the American Medical Association (AMA) or the Annual Report and Reference Handbook published by the American Board of Medical Specialties (ABMS); or

a fellowship program in geriatric medicine approved by the Accreditation Council for Graduate Medical Education.

A fellow who is in a program meeting any of the above criteria is considered a resident in an approved program. Under the law, the costs associated with the services of the resident in an approved program in a hospital are payable as hospital services. It does not make any difference whether or not the hospital incurs compensation costs for the services of the resident. The hospital is entitled to receive direct GME payments for the time the resident or fellow spends working in the hospital (including all inpatient and outpatient settings that are a part of the hospital). For example, if the services are furnished in a clinic that is a part of the hospital, such as a component of the hospital outpatient department, the services are payable through the direct GME payment mechanism. The teaching physician presence policy would apply to any services in which residents are involved for which teaching physician seeks carrier payments.

If the fellow furnishes services in an entity which is not a part of a hospital, there is a provision under which the time the resident or fellow spends in nonprovider settings, such as a freestanding clinic, may be included in the hospital direct GME count. This pays the hospital for the resident's time. Such settings would then become "teaching settings." The time spent in the nonprovider setting must be spent in patient care activities, and there must be a written agreement between the hospital and the clinic indicating that the hospital bears the costs of the resident or fellow's time in the nonprovider setting. The teaching physician presence policy would apply to any services in which the residents or fellows are involved for which the teaching physician seeks carrier payments.

If there is no such agreement under which the time in the nonprovider setting is included in the direct GME count and the resident or fellow is fully licensed, the resident or fellow's services in the nonprovider setting may be covered and billable as physicians' services. The claims may be billed by the fellow or reassigned to the fellow's employer. Thus, there is more flexibility regarding the way the services of a fellow are paid outside the hospital setting.

Fellows Not in Any Formally Organized Program

Regarding the services of individuals designated as fellows who are not in any formally organized training program and who are fully licensed to practice are payable as physicians' services, the teaching physician presence policy does not apply to their services because these individuals are furnishing services in the capacity of physicians.

Fellows in an Unlisted Program

There have been many questions about the status of fellows who have completed a general residency program and who are in subspecialty programs not listed in either the AMA or the ABMS publications. The services of individuals who have successfully completed one or more residency programs and who are in another subspecialty program which does not meet the definition of an approved medical residency program are covered as physicians' services payable under the physician fee schedule. Virtually all physicians who fall into this category would be fully licensed; however, if this were not the case, for whatever reason, it might be appropriate to classify the individual as a resident not in an approved program.

"Moonlighting" Fellows

Services of "moonlighting" residents (which would include fellows in an approved program) are defined in 42 CFR 415.208 as services that licensed residents perform outside the scope of an approved GME program. Services are often performed in settings away from the site of the resident or fellow's training activities and may be payable as physicians' services under the physician fee schedule. In addition, "moonlighting" by a resident or fellow in the outpatient or emergency department of his or her program hospital may be payable under the physician fee schedule if certain conditions are met. However, the nature of some of the questions received seems to indicate that this provision is being explored by hospitals and faculty practice plans as a means of getting around the physician presence policy of the teaching physician rules. While it is possible to moonlight in one's program hospital, the information in the following paragraphs should be taken into account in these situations.

A residency program (including approved fellowship programs) in a hospital is generally a full-time activity that would include such elements as "on-call" time and the training of junior residents and others as well as the learning activities of an individual resident or fellow. In developing the direct GME payment policy, Medicare did not establish a standard number of hours for an approved resident program. It was recognized that programs would vary from specialty to specialty and hospital to hospital in this regard. There was a presumption that everything a resident did in the hospital was related to the residency program. Therefore, moonlighting services furnished by a resident in the same hospital that he or she is a resident in must be based on evidence that the services are furnished during off-hours and that rebuts the presumption that the services are being furnished as a part of the requirements of a residency or fellowship program.

The following moonlighting situations may be appropriate for billing outside the scope of one's training program:

An outpatient setting or emergency department (but not an inpatient unit) at the "home" or affiliated hospital where the fellow or resident trains when the conditions discussed above are met; or

An outpatient setting, emergency department, or inpatient unit at a hospital or institution not affiliated with the training program.

Some programs wish to employ moonlighting fellows or residents for certain inpatient settings. For example, there have been inquiries as to whether a fellow in a Pain Fellowship program can bill for inpatient anesthesia. Another frequent inquiry is whether fellows in a subspecialty of surgery or medicine may bill for general surgery procedures or general medicine services in inpatient units at the "home" hospital. Payment for the resident or fellow's services in connection with these services or procedures is made through the direct GME payment mechanism. The services of the resident or fellow are not payable as physician services, and teaching physician presence requirements would have to be met for carrier payment to be made.

For additional information about teaching physician guidelines, refer to the following issues of the Medicare B Update!:

March/April 1997, page 77

HCPCS Special Update, December 1997, page 16

September/October 1996, page 27.

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Where to Send Teaching Physician Exception Requests

Teaching facilities may apply for an exception to the teaching physician presence requirement for certain low-level evaluation and management services rendered by residents. To do so, a letter outlining certain information must be filed with Medicare Part B.

In the March/April 1997 Medicare B Update!, a sample letter for this exception was included. However, the address to send the request to was not included. Send requests for exceptions to:

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

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Updates To The Medigap Insurer Listing

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

Medigap Insurer Address Changes

Number	Insurer Name
26004	V.F.W. INSURANCE110 GIBRALTAR ROADHORSHAM, PA 19044

New Medigap Insurer Number

Number	Insurer Name
18057	AMERICAN PIONEERPO BOX 130PENSACOLA FL 32591

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
15110	UNITED MINE WORKERS
56028	UNITED MINE WORKERS

ITT Hartford

The Hartford has recently completed a major automation for electronic claim submission. They have consolidated their claims processing centers to receive claims electronically from an electronic clearinghouse operated by Mutual of Omaha.

Medigap insurer numbers were formerly developed to include various Hartford locations, Hartford claim processing centers, and Hartford Medigap policies. However, due to the automation to electronic crossover, most of Hartford's Medigap numbers are no longer needed.

A number of changes have been made to the Medigap insurer numbers formerly assigned to Hartford. They are outlined in the following sections.

Active Medigap Insurer Numbers for Hartford Alexandria Virginia Claim Office (Mutual of Omaha)

Number: 56037
Name/Address: HARTFORD HLTH CLM OFFICEPO BOX 11910ALEXANDRIA VA 22312
Number to use: Main Number

Number: 56036
Name/Address: HARTFORD INSURANCEPO BOX 11910ALEXANDRIA VA 23212
Number to use: X-REF to 56037

Number: 56013
Name/Address: HARTFORD LIFE INSPO BOX 11910ALEXANDRIA VA 22312
Number to use: X-REF to 56037

Number: 17049
Name/Address: HARTFORD INSURANCE COPO BOX 11910ALEXANDRIA VA 22312
Number to use: X-REF to 56037

Active Medigap Insurer Numbers for Hartford Des Moines Iowa Claim Office (Kirke-Van Orsdel)

Number	Name/Address
17011	KVI/ITT HARTFORD1776 WEST LAKES PKWYDES MOINES IA 50398
24002	MEDIPLUS/ITT HARTFORD1776 WEST LAKES PKWYDES MOINES IA 50398

Hartford Medigap Insurer Numbers Changed to Exempt/Deleted

The following Medigap insurer numbers for Hartford have been changed to an exempt status and noted in our insurer files as "NOT IN USE." We will not cross over to these Medigap insurer numbers; please use the ACTIVE Medigap insurer numbers for successful crossover. Please change the N to a Y in your Update.

* Number was formerly exempt

HARTFORD (Various Locations)

ID	#NAME
15048*	HARTFORD LIFE
17024*	HARTFORD LIFE
17025*	HARTFORD INS
17039	HARTFORD LIFE
17051*	HARTFORD
19240*	HARTFORD INS
19480*	HARTFORD LIFE
19517*	HARTFORD ACCIDENT
19579	HARTFORD
19758	HARTFORD
19847*	HARTFORD INS
19896	HARTFORD
19948*	HARTFORD
19968*	HARTFORD ITT
19974*	HARTFORD
19990	HARTFORD INS
20062*	HARTFORD INS
20069*	HARTFORD
23121*	HARTFORD LIFE
23212	HARTFORD INS
26018*	HARTFORD INS
35036	HARTFORD LIFE
39002*	HARTFORD FIRE
40042*	HARTFORD LIFE
40066*	HARTFORD INS
42073*	HARTFORD INS
42159*	HARTFORD

48066	HARTFORD
48091*	HARTFORD ACCIDENT
51002	HARTFORD INS
53027	HARTFORD
53057*	HARTFORD
90160*	HARTFORD (ITT)

HARTFORD CLAIM OFFICES

ID #	NAME
16015*	NATIONAL INS ADM
16113	NATL/INS ADM
16114	FEDERATION OF AMER CONSUMERS
18053	EMPLOYEE BENEFIT PLANS
20112	PARAGON BENEFITS
43038	INTERACTIVE MED SYSTEMS
45157*	SELMAN & COMPANY
53037	TOTAL PLAN SERVICE
61079	SEABURY & SMITH

KVI/ITT HARTFORD POLICIES

ID #	NAME
25041	AMER ASSN OF UNIV WOMEN
25042	AMER ASSN OF UNIV PROF
25043	AIR CRAFT OWNERS & PILOTS
25044	PREFERRED ASSN
25045	THE ASSN OF US ARMY
56006	RETIRED OFFICERS ASSOC

HARTFORD MEDIGAP POLICES

ID #	NAME

56039	AANA GRP INS
56040	ABI GRP INS
56041	ACADEMY OF MEDICINE
56042*	ACT MANAGEMENT CORP
56043	AMERICAN CHIRO ASSN
56044	AMERICAN OSTEOPATHIC ASSN
56045	AMER STND BENEFIT TRUST
56046	ARATEXT
56047	BETA SIGMAN PHI
56048	COMMUNITY HOSPITAL
56049	EASTERN FINANCIAL FED
56050	NATL FARMERS UNION
56051	GEORGIA BANKERS ASSN
56052	ALLEN MILLWORK
56053	AMSPEC CHEMICAL CORP
56054	BANCFLORIDA
56055	CHELSEA PROVIDENT BANK
56056	CHESTER TELEPHONE
56057	ENCYCLOPEDIA BRITANNICA
56058	FIDELITY FEDERAL
56059	G & H TOWING
56060	HOME INNOVATIONS INC
56061	INDEPENDENT LIFE
56062	JEFFERSON COUNTY
56063	JOURNAL PUBLISHING
56064	MARTHAS VINEYARD NATL
56065	MERCHANTILE BANCORP
56066	SPORTRAN INC

56067	TALLOWOOD BAPTIST CHURCH
56068	INDEPENDENT LIFE
56069	INFINITY TRUST
56070	INTL BROTHERHD OF TEAM
56071	MCM CORPORATION
56072	MEDI-PARK
56073	MEMBERS BENEFIT TRUST
56074	MERCHANTS INDUSTRY FUND
56075	MULTIPLE UNDER WRTN TRUST
56076	HAGIT NEW JERSEY DENT ASN
56077	PHYSICIANS BENEFIT TRUST
56078	PLUMERS & PIPEFITTERS
56079	PROFESSIONAL INS TRUST
56080	RETIRED AIRLINE PILOTS
56081	RODNEY HUNT COMPANY
56082	SEVEN LAKES LANDOWNERS
56083	TRUSTEES FOR INS EDUCATION
56084	MEMBERSHIP ASSN HLTH INS
56085	NATL ASSN OLDER WOMANS
56086	NATIONAL COLLEGIATE INS
56087	UNITED SENIOR ASSOC
56088	UNITED STOCKYDS CORP
56089	PALMER CAY/CARSWELL
56090	US CONFERENCE OF MAYORS
56091	ZAGAR
56092	ZIONIST ORGTN OF AMERICA
56093	AMER SR CITIZENS ASSN
56094	BENEFITS ADVISORY TST
56095*	AF & AM OF OREGON

56096	BROWARD NELSON FTN
56097	CLAYTON COUNTY WATER AUTH
56098	COLTS PLASTICS
56099	EASTERN BANCORP
56100	HAPPY APPLIQUES
56101	JEWISH COMM CNTR RICHMOND
56102	JOHNSON CONTROLS
56103	MARTIN COUNTY
56104	OKEECHOBEE
56105	OTTO CANDIES
56106	ROYCO
56107	AKAR ALUMINUM
56108	TOWN OF ABINGDON
56109	INTL UNION OF OPER ENG
56110	MAXIMUM GROUP TRUST
56111	MOOSE INTL INC
56112	MOUNTAIN AMER
56113	NATL TRUST
56114	NETWORK TRUST
56115	W JEFFERSON MED CNTR
56116	YALE UNIVERSITY
56117	AF & AM OF OREGON
56118	BRICKELL PLACE CONDO
56119	FLORIDA DENTAL ASSN
56120	AMER GEN LIFE INS
56121	ATLANTIC BOTTLING CO
56122	CORPUS CHRISTI
56123	DIAMOND MARINE OF BROWARD

56124 DURHAM COCA COLA

56125 NATL AGRICULTURAL ASSN

56126 SISTER OF ST DOMINIC

56127 STEWARTS PRIVATE BLEND

56128 UNIVERSITY OF TAMPA

56129 WC & AN MILLER CO

56130 HUNT VALVE CO

56131 INDEPENDENT

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Overpayment Interest Rates

Medicare Part B assesses interest on overpaid amounts which are not refunded in a timely manner. The interest rate was implemented to help ensure the timely repayment of overpaid funds due to the Medicare program.

The interest rate is based on the higher of the following rates: the Private Consumer Rate (PCR) or the Current Value of Funds (CVF). The following table lists the current interest rates assessed to overpaid funds.

Period	Interest Rate
October 24, 1995-January 29, 1996	13.875%
January 30, 1996-April 29, 1996	13.75%
April 30, 1996-July 18, 1996	13.625%
July 19, 1996-October 23, 1996	13.50%
October 24, 1996-January 22, 1997	13.375%
January 23, 1997-April 23, 1997	13.625%
April 24, 1997 to present	13.50%

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Heart, Liver, and Lung Transplant Centers in Florida

Below is a list of Medicare-approved heart transplant centers and liver transplant centers in Florida. (There are no approved lung or heart-lung transplant centers in Florida.)

Medicare Heart Transplant Centers

Name and Address Effective Date

Tampa General HospitalDavis Islands, P. O. Box 1289Tampa, Florida 33601 August 19, 1988

Shands Hospital(University of Florida)Box J-286, JHMHCGainesville, Florida 32610 January 19, 1990

Jackson Memorial Hospital1611 N.W. Twelfth AvenueMiami, Florida 33136 September 29, 1995

Medicare Liver Transplant Centers

Name and Address Effective Date
Jackson Memorial Hospital1611 N.W. Twelfth AvenueMiami, Florida 33136 February 15, 1995
Shands Hospital at University of FloridaP.O. Box 100251Gainsville, Florida 32610-0251 June 2, 1995

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Claim Completion Requirements for Hospital-Based Physicians

The following information is a reminder on how to complete items 24K and 33 when submitting claims for services rendered by a hospital-based physician. These guidelines apply to both paper and electronically submitted claims.

Item 24K

Enter the carrier-assigned Provider Identification Number (PIN) of the hospital-based physician.

Item 33

Enter the name, address, ZIP code and phone number of the hospital. Enter the hospital number of the hospital where physician is based.

Failure to adhere to these claim filing requirements will result claim processing delays or denials.

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Return all Additional Development Information

An additional development letter is generally sent when information is needed to process a claim or make a coverage decision.

Depending on the type of information requested, a provider usually has thirty or forty-five days from the date of the letter to respond. These responses must be received timely to avoid unnecessary claim denials. When responding to additional

development letters, providers must submit all information requested by the carrier. Failure to do so or a partial response may result in a reduction in allowance or a claim denial.

To avoid additional development requests, insclude all supporting documentation (progress notes, history and physical, office records/notes, etc.) with the original claim submission if the type of service being billed requires you to do so. If you are submitting electronic claims, include supporting documentation via a certificate of medical necessity if one is available.

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MSP Electronic Payment Sheets Available

Did you know that since January 1, 1994, Medicare B of Florida has been able to receive Medicare Secondary Payer claims electronically? If your office submits claims electronically, it is no longer necessary to generate paper HCFA-1500 forms for Medicare Secondary Payer (MSP) claims in order to attach a payment sheet.

As we work toward a total electronic environment, HCFA designed all the necessary fields to contain information from payment sheets into the electronic claims submission National Standard Formats (NSF and ANSI).

If your practice has the need to submit these type claims, contact your electronic claims submission software support vendor to find out if they have the required records and fields available. If not, they may be willing to develop them at your request.

Note: All the electronic specification manuals for software support vendors and programmers are available under the EMC Support section on the Medicare BLine BBS electronic bulletin board for downloading.

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