1997 January/February 1997 Medicare Part B Update
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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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PAYERID Effective April 1, 1997

Background

In response to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), HCFA is pursuing a plan to have PAYERID adopted as the national standard for health plans and employers through formal rulemaking. In addition, HCFA is proposing to implement PAYERID for Medicare only, on a voluntary basis for providers.

This voluntary approach allows Medicare providers, insurers, billing software vendors and clearinghouses choices about whether to use the PAYERID, while at the same time allowing HCFA to move forward to improve Medicare operations.

What Is PAYERID?

PAYERID is a project spearheaded by the Health Care Financing Administration (HCFA) in which a unique identifier, called a PAYERID, will be assigned to every payer of health care claims. Payers may be public entities, such as the Medicare program and Medicaid State agencies, as well as private entities, such as insurers, self-insured employers or third party administrators, that have contractual responsibility for health care payments.

PAYERID is a 9-position number.

HCFA will keep the PAYERID identifiers in a database containing the payer name, billing addresses, and other business information, such as contact persons and electronic routing addresses.

Why Do We Need a PAYERID?

The Medicare Transaction System (MTS), which will revolutionize information management and claims processing for Medicare, is dependent upon common systems and standardized identifiers. This effort will support MTS and the industry s recommendation for standardization and uniformity of health care data transmitted electronically.

In addition, this initiative will provide uniformity for effective editing and reporting of Medicare claims data; assist in the accurate and timely routing of claims when Medicare is the secondary payer; provide a mechanism for reducing or eliminating errors in transferring claims to Medigap and other supplemental payers; and simplify claim completion and processing.

Medicare claims processing contractors often cannot transfer claims to Medigap or other supplemental insurers because complete information about a payer is missing, or because the payer has multiple names. The PAYERID on a Medicare claim will allow Medicare contractors to get the information needed to transfer claims information electronically to the appropriate insurer.

Where Do I Find It?

There are several sources for the provider to find the PAYERID for an insurance company or other payer:

The beneficiary s insurance card: In time, insurers will put their PAYERID on insurance cards so that it is readily available to providers and beneficiaries. Until this practice becomes widespread, you may use one of the other sources listed below.

Hardcopy or diskette directories will be available from the PAYERID Registrar. You will be notified when they are available and how to order copies.

Private publishers or clearinghouses of government information: You may purchase the PAYERID directory information from many private sources who publish government information for the general public.

Your Medicare contractor bulletin board: Medicare contractors will make the PAYERID directory available on their bulletin boards for you to browse.

Your Medicare contractor: If you have exhausted the options above, you may call your Medicare contractor for assistance. The contractor may identify the PAYERID number in the Registry, or will determine that no PAYERID number exists for that payer. If no PAYERID exists, the contractor will contact the PAYERID

Registry to obtain a number and will communicate the number to you so that the claim may be submitted.

How to Use the PAYERID

Use the PAYERID on claims forms where you formerly put the insurer name or carrier-assigned payer number.

When to Start Using the PAYERID

On April 1, 1997, Medicare claims may be submitted with the PAYERID instead of an insurer name and address. Claims without a PAYERID will be processed, but crossover may be delayed or impossible if the insurer information is not complete or accurate.

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What s New

Approved Procedures for Independent Physiological Laboratories

As a result of the 1997 HCPCS Update and the 1996 Final Rule, revisions have been made to the procedures for which an independent physiological laboratory may be covered. See page 19 for complete details.

Limiting Charge Civil Monetary Penalties

The Health Insurance Portability and Accountability Act of 1996 increased the amount of civil monetary penalties for providers who violate the limiting charge provision. See page 26 for complete details.

1997 Prevailing Fees

Page 27 includes a list of the 1997 prevailing fees for all payment localities.

New CLIA Waived Test

The Center for Disease Control granted waived status to the QUIDEL Quick-Vue One-Step H on October 10, 1996. See page 38 for billing guidelines as well as a current list of all CLIA waived tests.

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A Physician s Focus

Influenza and Pneumococcal Campaigns

The flu season is here! Please remember to promote the influenza vaccine, which is a Medicare-covered preventative health care benefit. There has recently been some confusion about how often Medicare will pay for a flu shot. Medicare allows one shot each flu season, not one every 12 months as you may have heard. Therefore, it is perfectly acceptable to get this year s shot in December and next year s in November. Research has shown that the administration of influenza vaccines to Medicare beneficiaries greatly reduces hospital admissions for pneumonia and deaths due to complications from the flu. Research also shows that systems-oriented provider and beneficiary interventions work in promoting influenza vaccinations.

Systems-oriented interventions that increase immunization rates are standing written physician orders in hospitals and clinics for both influenza and pneumococcal vaccines, distributing pamphlets, and offering the vaccine before hospital discharge. Although Medicare does not require standing orders for ordering or administering influenza vaccines, standing orders are required for the pneumococcal vaccine. The implementation of standing orders in hospitals and clinics is the single intervention most likely to raise vaccination rates. It would be considered a missed opportunity if a beneficiary were discharged from a hospital without being offered (and receiving) an influenza vaccination, only later to be readmitted for influenza-related complications. We recommend that hospital physicians and nurses promote influenza vaccinations for Medicare beneficiaries prior to discharge.

Providers in outpatient settings also play a significant role in influencing beneficiaries to have a flu shot. During the influenza season, providers should promote the vaccine by hanging posters on their office walls as a reminder to themselves and their patients, using chart reminders to track immunized patients, and sending postcard reminders about the vaccine to beneficiaries.

Providers are also instrumental in promoting the pneumococcal vaccine and may apply many of the same techniques used for promoting influenza vaccinations. Although pneumococcal vaccines are available throughout the year, these vaccines are generally administered once in a lifetime to persons at high risk of pneumococcal diseases. Considered at high risk are persons over age 65, persons who have certain chronic illnesses (e.g., diabetes, cardiovascular or pulmonary disease, alcoholism, smokers), and individuals with compromised immune systems (e.g., chronic renal failure, Hodgkin s disease, HIV infection). If a

high-risk patient is unsure of his/her pneumococcal vaccination status, revaccination may be warranted.

Providers are the most influential factor in promoting influenza and pneumococcal immunizations. Simply put, Medicare beneficiaries are most likely to get a vaccination when their physician recommends it. We ask that providers realize their significant roles and discuss and promote influenza and pneumococcal vaccinations with their patients.

For more information on Medicare s influenza and pneumococcal campaigns, including the new instructions for patient specific or roster billing, please refer to the extensive article beginning on page 47 of the November/December 1996 Medicare B Update!. If you have any questions about the influenza or pneumococcal benefits, or would like flu posters or brochures for display in your office, please contact our Provider Customer Service representatives at (904) 634-4994.

Thank you for your help in bringing this important preventative health-care benefit to the attention of Medicare patients.

Sincerely,

Sidney R. Sewell, M.D.

Medical Director

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Advance Notice Requirement

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

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

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

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

Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice

(utilization screen - i.e., there is a specified number of services within a specified timeframe for which the service may be covered).

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

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

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

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

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

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

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1997 HCPCS

The articles in this section of the Update! provide information regarding the effects of the 1997 HCPCS update on the procedure codes listed in the December 1996 . Providers offices should pay close attention should pay close attention to the information in this section as it will affect their billing practices.

Policy Changes Relating to the 1997 HCPCS Update

The HCPCS update for 1997 is effective for services furnished January 1, 1997 and after. Listings of procedure codes added, revised and deleted as part of this update were published under the December 1996 Medicare B Update! Special Issue: 1997 HCFA Common Procedure Coding System Update and Medicare Physician Fee Schedule Database Update. While there is a grace period during which deleted or invalid procedure codes may still be used for 1997 service dates (received before April 1, 1997), we encourage all providers to complete the transition to the new 1997 codes as soon as possible to prevent possible delays in claim payment. The coverage for the following procedures which have been added or revised for 1997 have been included in existing policies. To assist providers in adjusting to the new coding structure, a reference to past publications outlining Medicare s coverage requirements is outlined below:

Added/Revised Codes: G0051, G0052, G0053
Related Codes(s) or Policy: 17000-17002, 17100-17104
Publication: January/February 1997, pg 14, 20October 1996 Special Issue pg 8-9

Added/Revised Codes: G0071-G0076, G0083-G0088
Related Codes(s) or Policy: 90842-90844
Publication: January/February 1997, pg 15-17, 18May/June 1996, pg 41

Added/Revised Codes: G0077-G0082, G0089-G0094
Related Codes(s) or Policy: 90855
Publication: January/February 1997, pg 15-17, 18May/June 1996, pg 43

Added/Revised Codes: J7310
Related Codes(s) or Policy: Vitrasert ImplantNote: Use procedure code 67299 for insertion of implant
Publication: October 1996 Special Issue, pg 14

Added/Revised Codes: 11720, 11721
Related Codes(s) or Policy: 11700, 11701, 11710, 11711
Publication: January/February 1997, pg 14September/October 1995, pg 20-21 (Policy)September/October 1996, pg 39 (Modifier Q1)

Added/Revised Codes: 90901
Related Codes(s) or Policy: Biofeedback Therapy
Publication: May/June 1995, pg 14

Added/Revised Codes: 92980-92984, 92995 - 92996
Related Codes(s) or Policy: Interventional cardiology
Publication: September/October 1996, pg 48

Added/Revised Codes: 93312-93317
Related Codes(s) or Policy: Echocardiography, transesophageal
Publication: September/October 1995, pg 31

Added/Revised Codes: 94160
Related Codes(s) or Policy: 94010, 94150

Publication: January/February 1997, pg 45 October 1996 Special Issue pg 52 September/October 1996, pg 52 July/August 1996, pg 38-39

Added/Revised Codes: 98940, 98941, 98942, 98943 (NC)
Related Codes(s) or Policy: A2000
Publication: January/February 1997, pg 20 September/October 1996, pg 35 May/June 1996, pg 13, 23 March/April 1996, pg 16, 18

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LC LD and RC Modifier Use

The following modifiers were established with the 1997 HCPCS Update, and are effective for services rendered on or after January 1, 1997:

LC Left circumflex coronary artery
LD left anterior descending coronary artery
RC Right coronary artery

Be advised that the modifiers should only be used with the following six procedure codes:

92980 Percutaneous placement of intracoronary stent(s)
92981 Percutaneous placement of each additional vessel
92982 Percutaneous balloon angioplasty
92984 Percutaneous balloon angioplasty, each additional vessel
92996 Percutaneous transluminal coronary atherectomy, each additional vessel
92999 Percutaneous transluminal coronary atherectomy

Medical policy is being developed for these codes and modifiers, and will be published in a future edition of the Medicare B Update!

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Coverage for Skin Lesion Destruction Codes

Effective for services rendered January 1, 1997, HCPCS codes 17000-17002, 17100-17104 are no longer valid for Medicare payment purposes. These codes are being replaced by the following procedure codes:

G0051 Destruction by any method, including laser with or without surgical curettement of all benign or premalignant lesions (e.g., actinic keratosis) other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia; initial lesion

G0052 second through 14 lesions, each (G0051 plus G0052; equal 14 lesions)*

G0053 15 lesions or more (includes G0051 and G0052; that is, G0053 may not be reported in addition to G0051 and G0052)

* The number of lesions treated must be entered in the Days or Units field on the HCFA-1500 or the equivalent EMC field. The maximum number of lesions that may be reported using code G0052 is 13.

The following examples illustrate how to properly complete claims for the destruction of lesions:

One Lesion

12 Lesions

15 Lesions

Procedure codes G0051-G0053 are subject to the same policy guidelines as procedure codes 17000-17002, 17100-17104. For additional information, refer to the pages 8-9 of the October 1996 Medicare B Update! Special Issue: New Local Medical Review and Focused Medical Review Policies.

Important Note: To ensure providers have adequate time to adjust their billing patterns a grace period, where either coding methodology may be used (17000-17002, 17100-17104 or G0051-G0053), has been established until March 31, 1997. Procedure codes 17000-17002, 17100-17104 should continue to be used for all service dates prior to January 1, 1997.

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53 Modifier to Replace XR and XU Modifiers

Effective for services rendered on or after January 1, 1997, providers should use the new 53 modifier (Discontinued procedure) instead of the modifiers XR (Terminated procedure after induction of anesthesia) and XU (Terminated procedure before induction of anesthesia). As with other 1997 HCPCS changes, providers have a grace period to ensure that they have adequate time to adjust their billing patterns. This grace period ends March 31, 1997.

For additional information about the 53 modifier, see page 16 of the December 1996 Medicare B Update! Special Issue: 1997 HCFA Common Procedure Coding System and Medicare Physician Fee Schedule Database Update.

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Debridement of Nails

As a result of the 1997 HCPCS update the following procedures have been created to report debridement of nails:

11720 Debridement of nail(s) by any method(s); one to five

11721 Debridement of nail(s) by any method(s); six or more

Procedure codes 11700, 11701, 11710 and 11711 have been deleted as a result of the 1997 HCPCS update.

Procedure codes 11720 and 11721 should never be billed together. The reimbursement for procedure code 11721 includes that of procedure code 11720.

Procedure code modifier 59 (Distinct procedural service) should not be used with this code combination.

Procedure codes 11720 and 11721 are subject to the same policy guidelines as procedure codes 11700, 11701, 11710 and 11711. For additional information, refer to the pages 20-21 of the September/October 1996 Medicare B Update! (Policy) andpage 39 of the September/October 1996 Medicare B Update! (Modifier Q1).

Important Note: To ensure providers have adequate time to adjust their billing patterns a grace period, where either procedure codes 11700, 11701, 11710, and 11711 or the new debridement codes (11720 and 11721) will be accepted, has been established until March 31, 1997. Procedure codes 11700, 11701, 11710 and 11711 should continue to be used for all service dates prior to January 1, 1997.

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Appropriate Use of New Psychotherapy Procedure Codes

Description of New Codes

Effective January 1, 1997, CPT procedure codes 90842, 90843, 90844 and 90855 are no longer recognized for Medicare purposes. They have been designated as invalid for Medicare use. The first three CPT codes are replaced by alphanumeric HCPCS Level II procedure codes that identify those services as insight-oriented, behavior modifying and/or supportive psychotherapy. Each of the three psychotherapy services is distinguished by whether it includes or excludes medical evaluation and management. Each service is also distinguished by the setting in which it is furnished, i.e., an inpatient or outpatient setting. As a result, there are four sets of new alphanumeric HCPCS Level II procedure codes to replace the existing CPT codes 90842, 90843 and 90844. A total of 12 Level II HCPCS procedure codes have been added to describe these services.

CPT procedure code 90855 is, by definition, interactive psychotherapy. Therefore, the coding changes for this type of service are designed to recognize three different time values. Each of those three services is distinguished by whether the service includes or excludes medical evaluation and management, as well as the setting (inpatient or outpatient) in which the service is furnished. Therefore, there are also four sets of new alphanumeric HCPCS Level II procedure codes for interactive psychotherapy. This resulted in a total of 12 Level II HCPCS procedure codes to describe these services.

Existing codes 90842, 90843, 90844 and 90855 are to be mapped to the new alphanumeric codes as shown below.

CROSSWALK TO NEW PSYCHOTHERAPY CODES
NEW ALPHANUMERIC CODES

(1)Insight-Oriented w/o Medical Evaluation and Management
(2)Insight-Oriented with Medical Evaluation and Management
(3)Interactive w/o Medical Evaluation and Management
(4)Interactive with Medical Evaluation and Management

Current CPT Code:	(1) O/P*	(1) I/P**	(2) O/P*	(2) I/P**	(3) O/P*	(3) I/P**	(4) O/P*	(4) I/P**
90842	G0075	G0087	G0076	G0088	N/A	N/A	N/A	N/A
90843	G0071	G0083	G0072	G0084	N/A	N/A	N/A	N/A
90844	G0073	G0085	G0074	G0086	N/A	N/A	N/A	N/A

90855:

	(1) O/P*	(1) I/P**	(2) O/P*	(2) I/P**	(3) O/P*	(3) I/P**	(4) O/P*	(4) I/P**
20-30 min.	N/A	N/A	N/A	N/A	G0077	G0089	G0078	G0090
45-50 min.	N/A	N/A	N/A	N/A	G0079	G0091	G0080	G0092
75-80 min.	N/A	N/A	N/A	N/A	G0081	G0093	G0082	G0094

* Office or outpatient setting
** Inpatient, partial hospitalization or residential care setting

The new alphanumeric HCPCS Level II codes and their descriptors are listed
below:

New Psychotherapy Code Descriptors

Code Code Descriptor

G0071 Individual psychotherapy (e.g., insight-oriented), office or outpatient, 20-30 minutes

G0072 Individual psychotherapy (e.g., insight-oriented), office or outpatient, 20-30 minutes, with medical evaluation and management

G0073 Individual psychotherapy (e.g., insight-oriented), office or outpatient, 45-50 minutes

G0074 Individual psychotherapy (e.g., insight-oriented), office or outpatient, 45-50 minutes, with medical evaluation and management

G0075 Individual psychotherapy (e.g., insight-oriented), office or outpatient, 75-80 minutes

G0076 Individual psychotherapy (e.g., insight-oriented), office or outpatient, 75-80 minutes, with medical evaluation and management

G0077 Individual psychotherapy, interactive (nonverbal), office or outpatient, 20-30 minutes

G0078 Individual psychotherapy, interactive (nonverbal), office or outpatient, 20-30 minutes, with medical evaluation and management

G0079 Individual psychotherapy, interactive (nonverbal), office or outpatient, 45-50 minutes

G0080 Individual psychotherapy, interactive (nonverbal), office or outpatient, 45-50 minutes, with medical evaluation and management

G0081 Individual psychotherapy, interactive (nonverbal), office or outpatient, 75-80 minutes

G0082 Individual psychotherapy, interactive (nonverbal), office or outpatient, 75-80 minutes, with medical evaluation and management

G0083 Individual psychotherapy (e.g., insight-oriented), inpatient hospital, partial hospital or residential care setting, 20-30 minutes

G0084 Individual psychotherapy (e.g., insight-oriented), inpatient hospital, partial hospital or residential care setting, 20-30 minutes, with medical evaluation and management

G0085 Individual psychotherapy (e.g., insight-oriented), inpatient hospital, partial hospital or residential care setting, 45-50 minutes

G0086 Individual psychotherapy (e.g., insight-oriented), inpatient hospital, partial hospital or residential care setting, 45-50 minutes, with medical evaluation and management

G0087 Individual psychotherapy (e.g., insight-oriented), inpatient hospital, partial hospital or residential care setting, 75-80 minutes

G0088 Individual psychotherapy (e.g., insight-oriented), inpatient hospital, partial hospital or residential care setting, 75-80 minutes, with medical evaluation and management

G0089 Individual psychotherapy, interactive (nonverbal), inpatient hospital, partial hospital or residential care setting, 20-30 minutes

G0090 Individual psychotherapy, interactive (nonverbal), inpatient hospital, partial hospital or residential care setting, 20-30 minutes, with medical evaluation and management

G0091 Individual psychotherapy, interactive (nonverbal), inpatient hospital, partial hospital or residential care setting, 45-50 minutes

G0092 Individual psychotherapy, interactive (nonverbal), inpatient hospital, partial hospital or residential care setting, 45-50 minutes, with medical evaluation and management

G0093 Individual psychotherapy, interactive (nonverbal), inpatient hospital, partial hospital or residential care setting, 75-80 minutes

G0094 Individual psychotherapy, interactive (nonverbal), inpatient hospital, partial hospital or residential care setting, 75-80 minutes, with medical evaluation and management

Please note that the appropriate procedure codes for services provided in a skilled nursing facility (SNF) are G0083-G0094. A SNF is considered to be a residential care setting.

Covered Services

National policy provides for coverage of services furnished by CPs and CSWs for the diagnosis and treatment of mental illnesses. Accordingly, the Medicare program covers these types of services when they are medically necessary and furnished by CPs and CSWs if they are legally authorized to perform them under State law. CPs and CSWs are not authorized by State law or the Medicare program to furnish drug management services, such as prescribing or monitoring drug prescriptions.

In most cases the services of CPs and CSWs are reported using the new alphanumeric G codes under the category, Office or Other Outpatient Psychotherapy except when the descriptor of the respective code indicates medical evaluation and management services. CPs and CSWs will not be reimbursed for alphanumeric G codes which include a medical evaluation and management component.

There are also restrictions on the use of the alphanumeric G codes under the category, Inpatient Hospital, Partial Hospital or Residential Care Facilities for CSWs. CSW services do not include services furnished to hospital inpatients. Therefore, these services are not covered under the CSW benefit. Also, CSW services do not include services furnished to patients in skilled nursing facilities (SNFs) that are part of the services that the facility is required to provide under the SNF requirements for participation. CSWs need to coordinate with the SNF for reimbursement of psychotherapy services. Hence, these services are not covered under the CSW benefit. These non-covered CSW services should not be reported using these G codes.

Correction: The November/December 1996 Medicare B Update! incorrectly stated that CSW services provided in a Partial Hospitalization Program (Place of Service Code 52) may be billed to Medicare Part B. These services must be billed to Medicare Part A by the hospital.

Services that CSWs furnish to partial hospitalization patients under the partial hospitalization benefit, either in the hospital outpatient department or community mental health center (CMHC) setting, are bundled. This means that, when CSWs furnish services to patients in either of these settings under the partial hospitalization benefit, the hospital or the CMHC must bill the intermediary for their services as partial hospitalization services. Accordingly, CSW services furnished under partial hospitalization programs should not be reported using these new alphanumeric G codes.

When furnished by physicians, all of the services represented by the new alphanumeric G codes are covered as physician services.

Clinical Psychologist and Clinical Social Worker Fee Schedule Amounts

Effective for services rendered on and after January 1, 1997, the Clinical Psychologist (CP) fee schedule was set at 100 percent of the physician fee schedule amount for the same service. This payment guidance applies to all CP services, including the new G services listed herein as well as services for which coding changes do not occur in 1997. This payment methodology is prompted by the implementation of the new G codes, which allow the reporting of individual psychotherapy services without medical evaluation and management. As a result, we believe it is reasonable and equitable to pay CPs the same amount as physicians for equivalent services.

The list of psychotherapy coding changes for 1997 is presented on page 15. All changes are effective January 1, 1997. However, the codes 90842, 90843, 90844 and 90855 may be used during the January 1 through March 31, 1997 grace period. CP services billed using those codes will be paid at the CPI-U updated amount, i.e., the 1996 amount adjusted by 1.028.

For the Clinical Social Worker (CSW) fee schedule, amounts remain set by law at 75 percent of the CP fee schedule for corresponding services. Diagnostic procedures (e.g., 90801, 90820, etc.), which were previously paid at 100 percent of the physician fee schedule will be reimbursed at 75 percent of the fee schedule effective for services rendered January 1, 1997 and after.

Mandatory assignment is required on all covered services furnished to Medicare beneficiaries by CPs and CSWs. As a result there is no five percent reduction in the approved amount when billing for diagnostic or therapeutic procedures. Additionally, limiting charges for these services are not applicable.

For payment purposes, approved charges for CP and CSW services are the lower of the billed amount or the fee schedule amount. Therapeutic services are subject to the outpatient services limitation of 62.5 percent. This payment limitation is not applicable for diagnostic services.

For 1997, the payment localities for Florida will be changed from four to three localities. Localities 01 and 02 are combined into one single locality; whereas, localities 03 and 04 remain the same.

Important Note: Effective January 1, 1997, CPs must report their name in item 17 and the surrogate UPIN (OTH000) in item 17a of the HCFA-1500 claim form when billing for codes 96105-96117 (Central Nervous System Assessments/Tests).

The fee schedule rates for CPs and CSWs are listed below. If you have any questions regarding these fees, please contact the Provider Customer Service department at: (904) 634-4994.

	Clinical Psychologist			Clinical Social Worker		
CODE	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
G0071	47.24	49.81	52.03	35.43	37.36	39.02
G0073	73.55	77.57	81.07	55.16	58.18	60.80
G0075	124.43	131.78	138.13	93.32	98.84	103.60
G0077	59.25	63.23	66.71	44.44	47.42	50.03
G0079	79.57	83.99	87.84	59.68	62.99	65.88
G0081	113.22	118.37	122.84	84.92	88.78	92.13
G0083	51.18	53.84	56.13	NC	NC	NC
G0085	79.92	84.08	87.69	NC	NC	NC
G0087	134.44	142.01	148.53	NC	NC	NC
G0089	61.58	65.04	67.80	NC	NC	NC
G0091	85.76	90.17	93.94	NC	NC	NC
G0093	126.71	133.00	138.86	NC	NC	NC
90801	110.63	115.91	120.42	82.97	86.93	90.32
90820	105.81	109.72	113.05	79.36	82.29	84.79
90825	BNDL	BNDL	BNDL	BNDL	BNDL	BNDL
90846	79.14	83.48	87.16	59.36	62.61	65.37
90847	89.38	93.85	97.68	67.04	70.39	73.26
90849	27.64	29.29	30.66	20.73	21.97	23.00
90853	27.64	29.29	30.66	20.73	21.97	23.00
90857	24.85	26.04	27.05	18.64	19.53	20.29
90875	47.24	49.81	52.03	NC	NC	NC

90876	73.55	77.57	81.07	NC	NC	NC
90880	90.21	94.70	98.42	67.66	71.03	73.82
90882	NC	NC	NC	NC	NC	NC
90887	BNDL	BNDL	BNDL	BNDL	BNDL	BNDL
90900	59.58	64.18	67.83	44.69	48.14	50.87
90901	22.66	24.13	25.26	17.00	18.10	18.95
90911	76.04	84.25	92.08	57.03	63.19	69.06
96100	63.27	71.55	78.43	NC	NC	NC
96105	63.27	71.55	78.43	NC	NC	NC
96110	NC	NC	NC	NC	NC	NC
96111	63.27	71.55	78.43	NC	NC	NC
96115	63.27	71.55	78.43	NC	NC	NC
96117	63.27	71.55	78.43	NC	NC	NC
97770	23.73	25.34	26.67	NC	NC	NC

NC denotes noncovered procedure BNDL denotes procedure code is bundled with other services. Separate payment cannot be made for this service. In addition, no payment can be collected from the patient/beneficiary.

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Injectable Drug Descriptor Changes

As a result of the 1997 HCPCS update, the descriptors for the following injectable drugs have been revised. These revisions have resulted in the billing changes noted below:

Desmopressin Acetate (J2597)

The descriptor for this injectable drug changed from per 4 mcg in 1996 to per 1 mcg in 1997. Therefore, the Days or Units fieldon the HCFA-1500 or the equivalent EMC field must be adjusted accordingly. The 1997 maximum allowance for this injection is $5.50 per 1 mcg.

Sargramostim (J2820)

The descriptor for this injectable drug changed from per 250 mcg in 1996 to per 50 mcg in 1997. Therefore, the Days or Units field on the HCFA-1500 or the equivalent EMC field must be adjusted accordingly. The 1997 maximum allowance for this injection is $23.56 per 50 mcg.

BotulinumToxin (J0585)

The descriptor for this injectable drug changed from per 100 units in 1996 to per 1 unit in 1997. Therefore, the Days or Units field on the HCFA-1500 or the equivalent EMC field must be adjusted accordingly. The 1997 maximum allowance for this injection is $3.99 per 1 unit

Currently Botulinum Toxin Type A (Botox) is available only in a 100 unit size. Once Botox is reconstituted in the physician s office, it has a shelf life of only four hours. Often a patient receives less than a 100 unit dose. This is a very expensive drug and we encourage physicians to schedule patients is such a way that they can use Botox most efficiently. However, if a physician must discard the remainder of the vial after administering it to a Medicare patient, the Medicare program covers the amount of the drug discarded along with the amount administered.

Thus, if a physician schedules three Medicare patients to receive 30 units Botox on the same day and during the shelf life of the drug, Medicare will allow 30 units for the first two patients. Reimbursement for the third patient will be based on 40 units (30 units given plus 10 units waste) of Botox. However, if a physician has only one patient scheduled to receive Botox, Medicare reimbursement to that physician will be based on 100 units of Botox.

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1997 Physician Fee Schedule Allowance Revisions

The Health Care Financing Administration has revised the fee schedule allowances for the following psychotherapy codes effective for services furnished January 1, 1997 and after. Please disregard the payment amounts published in the 1997 Physician Fee Schedule Allowances book.

Code	Loc 1/2	Loc 3	Loc 4
G0084	68.41	72.86	77.37
G0089	61.58	65.04	67.80
G0090	74.92	78.67	81.68
G0091	85.76	90.17	93.94
G0092	95.76	100.39	104.35
G0093	126.71	133.00	138.86
G0094	141.27	147.87	154.00

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Revision to Site of Service Payment Rule

The site of service payment rules for 1997 dates of service and the procedures subject to these rules were published in the December 1996 Medicare B Update! Special Issue: 1997 HCPCS and MPFSDB Update (pages 23 and 39-40).

Since that publication, a revision has been made to the list of procedures subject to the site of service payment rules as follows: procedure code 53420 is no longer subject to these rules effective for services furnished on and after January 1, 1997. Providers of this service should make note of this revision.

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Computerized Dynamic Posturography

Computerized dynamic posturography (procedure code 92548) is used in the detection and differential diagnosis of vestibular dysfunction, whether peripheral (PVD) or central (CVD). Dynamic posturography utilizes a computer-driven platform and surrounding visual field that are manipulated to test the subjects response to demands on postural equilibrium control.

Indications and Limitations of Coverage and/or Medical Necessity

At this time there is insufficient evidence to determine the clinical effectiveness of computerized dynamic posturography. The existing studies fail to provide adequate data to evaluate this technology as a diagnostic test. The evidence is insufficient to determine whether dynamic posturography distinguishes between peripheral and central vestibular dysfunction. Payment will not be allowed for the computerized dynamic posturography at this time.

Advance Notice Requirement

Applies to the investigation status of this procedure (see page 4).

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Approved Procedures for Independent Physiological Laboratories

The following revisions have been made to the procedures for which an independent physiological laboratory (IPL) may be covered:

As a result of the 1997 HCPCS update, the following procedures have been added and may be covered when they are furnished by an IPL effective for services furnished on and after January 1, 1997: 93303, 93304, 95921, 95922, 95923.

As a result of the 1997 HCPCS update, the following procedure codes have been deleted or are invalid for Medicare purposes and are, therefore, no longer covered when furnished by an IPL effective for services furnished on and after January 1, 1997: 78350, 93220, 93221, 94160. However, these procedures may still be billed and covered through the 1997 HCPCS grace period (claims received prior to April 1, 1997 with 1997 dates of service).

As a result of the 1996 Final Rule, separate payment is no longer made for procedure code R0076 (Transportation of portable EKG) effective for services furnished on and after January 1, 1997; payment is now bundled into the payment for the EKG.

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Coverage for Indocyanine Green Angiography

Indocyanine green angiography (IGE) is a diagnostic study where indocyanine green dye is injected intravenously and photographs are taken of the retina at intervals as increasing intensity of retinal and choroidal circulation is displayed.

Applicable Procedure Code

92240 Indocyanine green angiography (includes multiframe imaging) with interpretation and report

Indications for Coverage

Indocyanine Green (ICG) Angiography is effective when used in the diagnosis and treatment of ill-defined choroidal neovascularization (e.g., associated with age-related macular degeneration). It is used as an adjunct to fluorescein angiography.

Diagnosis Requirements

Indocyanine Green Angiography is a valuable diagnostic adjunct to fluorescein angiography in evaluating the following conditions:

362.16 Subretinal neovascular membrane

362.42 Serous detachment of retinal pigment epithelium

362.43 Hemorrhagic detachment of retinal pigment epithelium

362.81 Subretinal hemorrhage

Documentation Requirements

Office notes should indicate one of the following:

Evidence of ill-defined subretinal neovascular membrane or suspicious membrane on previous fluorescein angiography

Clinical retinal pigment epithelium detachment (RPE) does not show subretinal neovascular membrane on current fluorescein angiography

Presence of a subretinal hemorrhage or hemorrhagic retinal pigment epithelium detachment (RPE).

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

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Billing of Doppler Echocardiography and Color Flow Velocity Mapping

As a result of the 1997 HCPCS update, procedure codes 93320-93321 (Doppler echocardiography) and 93325 (Doppler color flow velocity mapping) have been revised. According to their CPT description, if these procedures are billed, they should be billed as secondary procedures (i.e., add on procedures) in addition to their primary procedures (i.e., stand-alone procedures) as follows:

If 93320 or 93321 is billed, it should be billed as a secondary procedure to one of the following primary procedures: 93307, 93308, 93312, 93314, 93315, 93316, 93317, 93350.

If 93325 is billed, it should be billed as a secondary procedure (add-on) to one of the following primary procedures: 76825, 76826, 76827, 76828, 93307, 93308, 93312, 93314, 93320, 93321, 93350.

Therefore, procedure codes 93320, 93321, and 93325 should not be billed as stand-alone procedures. However, the primary procedures may be billed as stand-alone procedures.

As a note, the fee schedule allowances for the primary procedures may have been adjusted to reflect a reduction for the secondary procedures.

For complete guidelines on secondary procedures, refer to page 25 of the December 1996 Medicare B Update! Special Issue: 1997 HCPCS and MPFSDB Update.

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Coverage for Chiropractic Manipulative Treatment

Effective for services rendered January 1, 1997, HCPCS code A2000 is no longer valid for Medicare payment purposes. Code A2000 is being replaced by the following procedure codes:

98940 Chiropractic manipulative treatment (CMT); spinal, one to two regions
98941 spinal, three to four regions
98942 spinal, five regions
98943 extraspinal, one or more regions

Note: Code 98943 (Chiropractic manipulative treatment (CMT); extraspinal, one or more regions) is not covered by Medicare.

For purposes of CMT, the five spinal regions referred to are defined as follows:

Cervical region (includes atlanto-occipital joint);

Thoracic region (includes costo-vertebral and costotransverse joints);

Lumbar region;

Sacral region; and

Pelvic (sacro-iliac joint) region

Code selection is based upon the number of regions selected. For example, if the chiropractic physician adjusts C-5,6,7, through T-1,2,3, procedure code 98940 (one to two regions should be billed. Medical records must clearly document the number of regions manipulated.

Procedure codes 98940-98942 are subject to the same policy guidelines as
procedure code A2000. The utilization limit for procedures codes A2000, 98940-98942 will be applied on a cumulative basis using any combination of codes. For additional information, refer to the following publications:

Update	Page
September/October 1996	35
May/June 1996	13, 23
March/April 1996	16, 18

Important Note: To ensure providers have adequate time to adjust their billing patterns, a grace period, where both procedure code A2000 and the new CMT codes will be accepted, has been established until March 31, 1997. Procedure code A2000 should continue to be used for all service dates prior to January 1, 1997.

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Global Period for Code G0053

The list of minor procedures with 10 follow-up days for 1997 service dates was published on page 44 of the December 1996 Medicare B Update! Special Issue: 1997 HCPCS and MPFSDB Update. Since that publication, the following procedure code has been added to that list:

G0053 Destruction by any method, including laser, with or without surgical curettement of all benign or premalignant lesions (e.g., actinic keratosis), other than skin tags or cutaneous vascular proliferation lesions, including local anesthesia; 15 lesions or more (includes G0051and G0052; that is, G0053 may not be reported in addition to G0051 and G0052)

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Coverage for Stress Echocardiography

Echocardiography is used to image cardiac structures and function and also flow direction and velocities within cardiac chambers and vessels. Usually these images are obtained from several positions on the chest wall and abdomen using a hand-held transducer.

Applicable Procedure Code

93350

Echocardiography, transthoracic, real-time with image documentation (2D, with or without M-mode recording), during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharma-cologically induced stress, with interpretation and report

Note: According the CPT coding guidelines, the appropriate stress testing code from the 93015-93018 series should be reported in addition to 93350 to capture the exercise stress portion of the study.

Indications for Coverage

Stress echocardiography will be considered medically reasonable and necessary and, therefore, covered by Medicare Part B of Florida for any one of the following conditions:

The patient has symptoms which require further investigation via stress testing and the patient has a significantly abnormal

baseline EKG which would make interpretation of a standard exercise test (without imaging) inaccurate.

The patient has abnormal or non-diagnostic standard exercise test and stress echocardiography is being performed to evaluate stress induced cardiac abnormality.

The patient has symptoms which require further investigation by stress testing and the patient is on a medication (such as digoxin) which would interfere with the interpretation of a standard exercise
test.

The patient has a cardiac condition, such as mitral valve prolapse or other anatomic abnormality of the heart, which would interfere with the interpretation of a standard exercise stress test.

The patient has confirmed coronary artery disease or congestive heart failure and stress echocardiography is necessary to evaluate the extent or significance of disease.

Claims submitted for stress echocardiography performed at unusually frequent intervals will be reviewed by Medicare to make certain that the services were medically reasonable and necessary.

To ensure that payment is made only for medically necessary services, stress echocardiography is covered only for the following diagnoses/conditions:

411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00-414.03, 414.10, 414.11, 414.19, 414.8, 414.9, 424.0, 426.2, 426.3, 426.4, 426.50, 426.51, 426.52, 426.53, 426.54, 426.6, 426.7, 427.31, 428.0, 428.1, 428.9, 440.21-440.24, 794.31, 960.7, 995.2, E942.0, E942.1, V67.0, V67.51, V67.59

Medicare Part B cannot provide coverage for stress echocardiography performed as a screening test for coronary artery disease.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of echocardiography studies covered by the Medicare program. Also, the results of echocardiography studies covered by the Medicare program must be included in the patient s medical record.

If the provider of echocardiography studies is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring

physician s order for the studies. When ordering echocardiography studies from an independent physiological lab or other provider, the ordering/referring physician must state the reason for the echocardiography studies in his order for the test.

Advance Notice Requirement

Applies to diagnosis requirements and utilization screen (refer to page 4).

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Bone Mineral Density Studies

Procedure code G0062 (Peripheral skeletal bone mineral density studies [e.g., radius, wrist, heel]) is considered not medically effective in the treatment/diagnosis of the patient. Therefore, the service is not medically necessary and is not covered by Medicare Part B.

Advance Notice Requirement

Applies to medical necessity (refer to page 4).

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General Information

Correct Coding Initiative

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

Use of GB and 59 Modifiers

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

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

Dispute of CCI Relationships

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

National Correct Coding Initiative

AdminaStar Federal, Inc.
P.O. Box 50469
Indianapolis, IN 46250-0469

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

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

Deleted Relationships Effective January 1, 1997

The following correct coding relationships have been deleted effective for services furnished on and after January 1, 1996 for claims processed January 1, 1997 and after. These deletions have been reviewed and approved by the American Medical Association. Payment for the procedure in Column II (component code) is no longer included in the payment for the procedure in Column I (comprehensive code) when they are billed for the same date of service by the same provider.

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

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

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Limiting Charge Civil Monetary Penalties

The Social Security Act Amendments of 1994 state that physicians, other practitioners, or suppliers are liable for charges which exceed the federal limiting charge on services to which they apply. If a physician, other practitioner, or supplier willfully, knowingly and repeatedly exceeds the limiting charge, then they are subject to sanctions.

The Health Insurance Portability and Accountability Act of 1996 amends the civil monetary provisions of Section 1128(a) of the Social Security Act by increasing the amount of the penalty from $2,000 to $10,000 for each item or service involved. It also increases the assessment which a person may be subject to from not more than twice the amount to not more than three times the amount claimed for such item or service in lieu of damages sustained by the United States or a State agency because of such a claim. In addition, the physician, other practitioner, or supplier may still be excluded from the Medicare program for up to five years. This amendment is effective for only those services rendered on or after January 1, 1997.

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Practitioner Alert: Incorrect Billings for Bundled Hospital Services

The Medicare program has recently learned that some physicians have been billing incorrectly for services provided to hospital patients. Section 1862(a)(14) of the Social Security Act provides that every service to hospital inpatients and outpatients, except for the professional services of physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists, as well as qualified psychologist services must be provided by the hospital directly, or by others under arrangements made by the hospital, and only the hospital may bill its Medicare intermediary for the services. If the services are not provided and billed for in this way, they are not covered by Medicare. This is sometimes referred to as the hospital bundling provision. This provision is applicable to all hospital patients where a Medicare payment can be made to the hospital, including patients in psychiatric hospitals.

This means that services and supplies that would normally be covered incident to in an office setting, such as the services of nurses and other clinical assistants that you hire and supervise, are not billable by you in hospital settings. Therefore, if you utilize the services of your own employees in a hospital setting and you merely supervise their services, you are not eligible for a payment from Medicare. Although your employees might meet the supervision and employment requirements generally applicable to incident to services in other settings, their services are nevertheless not payable as incident to services to you when furnished in a hospital setting. Their services would only be payable to the hospital, because of the bundling provisions described above, but the hospital could in turn purchase the services from you when furnished in a hospital setting. Also, you are not eligible for a payment from Medicare because supervision alone does not constitute a reimbursable practitioner service. You must personally perform the practitioner service for which you bill in order for it to be payable in a hospital setting. If you do not personally perform the service, you are not entitled to any practitioner payment.

When your staff provides services to hospital patients (such as the services of nurses or therapists, diagnostic tests, etc.), the Medicare payment for those services is included in the Medicare payment to the hospital. You may not seek payment from the beneficiary for such services. You may, however, seek payment from the hospital. Neither you nor the hospital may charge the beneficiary. Section 1866(g) of the Social Security Act authorizes civil money penalties for any person who bills for services in violation of the bundling requirement; this provision applies to improper billings of the beneficiary as well as to improper billings to a Medicare contractor.

Please feel free to contact the Provider Customer Service department at (904) 634-4994 if you have any questions regarding this notice.

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1997 Prevailing Fees

The following list includes the prevailing fees for services/items furnished January 1, 1997 and after. The prevailing fees are based on charge data collected during the twelve month period that ended June 30, 1996. The prevailing charge is the 75th percentile of the customary charges within a given locality. A minimum of four customaries is used to establish a locality prevailing allowance. For nonphysician services, the Inflation-Indexed Charge (IIC) is used as an additional limitation in determining the reasonable charge. The IIC is developed from the previous years customary and prevailing charge amounts.

Note: The prevailing fees listed for these procedures represent the maximum allowance for the indicated procedure. However, the actual allowance for a particular provider may be lower based on their individual customaries or the billed amount.

NC = Noncovered

IC = Allowance is determined on an individual consideration basis.

Code	Loc 1	Loc 2	Loc 3	Loc 4
A0021	NC	NC	NC	NC
A0030	IC	IC	IC	IC
A0040	IC	IC	IC	IC
A0050	NC	NC	NC	NC
A0080	NC	NC	NC	NC
A0090	NC	NC	NC	NC
A0120	NC	NC	NC	NC
A0140	NC	NC	NC	NC
A0225	NC	NC	NC	NC
A0320	118.63	166.35	166.49	153.89
A0322	125.65	167.16	173.78	155.14
A0324	245.00	286.30	292.50	286.04
A0326	253.41	291.50	292.50	286.04
A0328	253.41	291.50	292.50	286.04
A0330	253.41	291.50	292.50	286.04
A0380	4.03	4.61	5.97	6.70
A0390	4.03	4.61	5.97	6.70
A0420	15.88	15.88	15.88	15.88
A0422	NC	NC	NC	NC
A0424	IC	IC	IC	IC
A0888	NC	NC	NC	NC
A0999	IC	IC	IC	IC
A4202	1.85	1.85	1.85	1.85
A4580	50.00	50.00	50.00	50.00
A4581	10.00	10.00	10.00	10.00
A4590	55.89	55.89	55.89	55.89

G0008	3.67 3.67 4.14 4.51			
G0009	3.67 3.67 4.14 4.51			
G0010	3.67 3.67 4.14 4.51			
P9010	54.00	54.00	54.00	54.00
P9011	54.00	54.00	54.00	54.00
P9012	22.00	23.20	25.50	28.50
P9013	66.70	70.50	77.40	86.70
P9014	17.10	18.00	19.80	22.20
P9015	16.30	17.20	18.90	21.10
P9016	79.76	76.90	81.41	81.41
P9017	35.80	37.90	41.50	46.50
P9018	19.50	20.70	22.60	25.20
P9019	24.31	25.70	28.34	31.69
P9020	29.30	30.90	34.00	38.10
P9021	55.51	55.51	55.51	55.51
P9022	54.00	54.00	54.00	54.00
V2630	410.00	410.00	410.00	410.00
V2631	270.00	270.00	270.00	270.00
V2632	315.00	315.00	315.00	315.00
76092	63.34	63.34	63.34	63.34
76092 TC	43.07	43.07	43.07	43.07
76092 26	20.27	20.27	20.27	20.27
86850	31.77	31.77	36.79	31.77
86860	34.00	34.00	34.00	34.00
86870	53.50	56.80	62.00	70.00
86880	15.00	18.00	21.07	18.61
86885	11.12	11.12	11.12	11.12
86886	18.00	17.50	18.00	18.00
86890	115.00	115.00	115.00	115.00
86891	80.00	59.25	64.80	73.00
86900	9.05 11.23	6.78 10.59		
86901	12.97	17.36	11.43	15.88
86903	7.90 7.90 7.90 7.90			
86904	23.00	23.00	23.00	23.00
86905	6.00 6.00 6.00 6.00			
86906	11.00	11.00	11.00	11.00
86910	NC NC	NC NC		
86911	NC NC	NC NC		
86915	94.10	94.10	94.10	94.10
86920	38.22	38.22	38.22	38.22
86921	55.00	55.00	55.00	55.00
86922	59.50	59.50	59.50	59.50
86927	16.20	17.20	18.80	21.20
86930	31.60	33.50	36.70	41.30
86931	16.20	17.20	18.80	21.20
86932	113.10	120.30	128.10	144.40
86945	IC IC	IC IC		
86950	77.90	77.90	77.90	77.90
86965	11.50	11.50	11.50	11.50
86970	35.20	35.20	35.20	35.20
86971	59.00	59.00	59.00	59.00
86972	64.90	64.90	64.90	64.90
86975	20.80	20.80	20.80	20.80
86976	8.80 8.80 8.80 8.80			
86977	23.60	23.60	23.60	23.60
86978	13.91	13.91	13.91	13.91
86985	IC IC	IC IC		

HCPCS Codes

Jurisdiction for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

The following table outlines the currect claims jurisdiction for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). As a guide, the following terms explain the jurisdiction requirements:

Local Carrier - All claims for these items should be submitted to Medicare Part B of Florida.

DMERC (DME Regional Carrier) - All claims for these items should be submited to the DME Regional Carrier (Palmetto GBA).

Joint - Dependent on the situation, claims for these items may be submitted to either Medicare Part B of Florida or the DMERC.

Procedure Code(s):A4190-A4209 Description: Medical, surgical and self-administered injection supplies Jurisdiction: Joint Local carrier if incident to a physician s service DMERC if other
Procedure Code(s):A4210 Description: Needle free injection device
Jurisdiction: DMERC
Procedure Code(s):A4211-A4250 *A4220 Description: Medical, surgical and self-administered injection supplies
Jurisdiction: Joint Local carrier if incident to a physician s service DMERC if other *A4220 is local carrier only
Procedure Code(s):A4253-A4259 Description: Blood glucose test, lancets, calibrator solution Description: DMERC
Procedure Code(s):A4260 Description: Levonorggestrel implant
Jurisdiction:Local carrier
Procedure Code(s):A4262-A4263 Description: Lacrimal duct implants
Jurisdiction: Local carrier
Procedure Code(s):A4265 Description: Paraffin:
Jurisdiction Joint Local carrier if incident to a physician s service DMERC if other
Procedure Code(s):A4270 Description: Endoscope sheath
Jurisdiction: Local carrier
Procedure Code(s):A4300-A4301 Description: Implantable catheter
Jurisdiction: Local carrier
Procedure Code(s):A4305-A4306 Description: Disposable drug delivery system
Jurisdiction: Joint Local carrier if incident to a physician s service DMERC if other
Procedure Code(s):A4310-A4335 Description: Incontinence supplies/urinary supplies

Jurisdiction: Joint Local carrier if furnished in a physician s office for a temporary condition (incident to) DMERC if furnished in a physician s office or other setting for a permanent condition (prosthetic)
Procedure Code(s):A4338 Description: Indwelling catheter, foley type
Jurisdiction: Joint Local carrier if furnished in a physician s office for a temporary condition (incident to) DMERC if furnished in a physician s office or other setting for a permanent condition (prosthetic)
Procedure Code(s):A4340 Description: Indwelling catheter, specialty type
Jurisdiction: Joint Local carrier if furnished in a physician s office for a temporary condition (incident to) DMERC if furnished in a physician s office or other setting for a permanent condition (prosthetic)
Procedure Code(s): A4344-A4346 Description: Indwelling catheter, foley type
Jurisdiction: Joint Local carrier if furnished in a physician s office for a temporary condition (incident to) DMERC if furnished in a physician s office or other setting for a permanent condition (prosthetic)
Procedure Code(s):A4347-A4359 Description: Incontinence/urinary supplies
Jurisdiction: Joint Local carrier if furnished in a physician s office for a temporary condition (incident to) DMERC if furnished in a physician s office or other setting for a permanent condition (prosthetic)
Procedure Code(s):A4361-A4421 Description: Ostomy supplies
Jurisdiction:Joint Local carrier if furnished in a physician s office for a temporary condition (incident to) DMERC if furnished in a physician s office or other setting for a permanent condition (prosthetic)
Procedure Code(s):A4454-A4455 Description: Tape; adhesive remover
Jurisdiction: Joint Local carrier if incident to a physician s service DMERC if other
Procedure Code(s):A4460 Description: Elastic bandage
Jurisdiction: Joint Local carrier if incident to a physician s service DMERC if used as a secondary surgical dressing
Procedure Code(s):A4465 Description: Non-elastic binder for extremity
Jurisdiction: DMERC
Procedure Code(s):A4470 Description: Gravlee jet washer
Jurisdiction: Local carrier
Procedure Code(s):A4480 Description: Vabra aspirator
Jurisdiction: Local carrier
Procedure Code(s):A4481 Description: Thracheostoma filter
Jurisdiction:Joint Local carrier if incident to a physician s service DMERC if other
Procedure Code(s):A4490-A4510 Description: Surgical stockings
Jurisdiction: DMERC
Procedure Code(s):A4550 Description: Surgical trays
Jurisdiction: Local carrier
Procedure Code(s):A4554 Description: Disposable underpads
Jurisdiction: DMERC

Procedure Code(s):A4556-A4558 Description: Electrodes, lead wires, conductive paste
Jurisdiction: Joint Local carrier if incident to a physician s service DMERC if other
Procedure Code(s):A4560-A4572 Description: Pessary, sling, splint, rib belt
Jurisdiction: DMERC
Procedure Code(s):A4575 Description: Topical hyperbaric oxygen chamber, disposable
Jurisdiction: Local carrier
Procedure Code(s):A4580-A4590 Description: Casting supplies and material
Jurisdiction: Local carrier
Procedure Code(s):A4595 Description: TENS supplies
Jurisdiction: DMERC
Procedure Code(s):A4610 Description: Medication supplies for DME
Jurisdiction: Local carrier
Procedure Code(s):A4611-A4613 Description: Oxygen equipment batteries and supplies
Jurisdiction: DMERC
Procedure Code(s):A4615-A4629 Description: Oxygne and tracheostomy supplies
Jurisdiction: Joint Local carrier if incident to a physician s service DMERC if other
Procedure Code(s):A4630-A4640 Description: DME supplies
Jurisdiction: DMERC
Procedure Code(s):A4641-A4646 Description: Imaging agent; contrast material
Jurisdiction: Local carrier
Procedure Code(s):A4647 Description: Contrast material
Jurisdiction: Local carrier
Procedure Code(s):A4649 Description: Miscellaneous surgical supplies
Jurisdiction: Joint Local carrier if incident to a physician s service DMERC if other
Procedure Code(s):A4650-A4705 Description: Supplies for ESRD
Jurisdiction: DMERC
Procedure Code(s):A4712 Description: Water, sterile
Jurisdiction: Joint Local carrier if incident to a physician s service DMERC if other
Procedure Code(s):A4714-A4927 Description: Supplies for ESRD
Jurisdiction: DMERC
Procedure Code(s):A5051-A5093 Description: Additional ostomy supplies
Jurisdiction: Joint Local carrier if furnished in a physician s office for a temporary condition (incident to) DMERC if furnished in a physician s office or other setting for a permanent condition (prosthetic)
Procedure Code(s):A5102-A5149 Description: Additional incontinence and ostomy supplies
Jurisdiction: Joint Local carrier if furnished in a physician s office for a temporary condition (incident to) DMERC if furnished in a physician s office or other setting for a permanent condition (prosthetic)
Procedure Code(s):A5500-A5507 Description: Therapeutic shoes
Jurisdiction: DMERC
Procedure Code(s):A6020 Description: Surgical dressing

Jurisdiction: DMERC
Procedure Code(s):A6025 Description: Silicone gel sheet
Jurisdiction: not applicable (code not valid for Medicare purposes)
Procedure Code(s):A6154 Description: Wound pouch
Jurisdiction: Joint Local carrier if incident to a physician s service DMERC if other
Procedure Code(s):A6196-A6199 Description: Alginate dressing
Jurisdiction: Joint Local carrier if incident to a physician s service DMERC if other
Procedure Code(s):A6203-A6224 Description: Surgical dressings
Jurisdiction: Joint Local carrier if incident to a physician s service DMERC if other
Procedure Code(s):A6228-A6230 Description: Gauze
Jurisdiction: Joint Local carrier if incident to a physician s service DMERC if other
Procedure Code(s):A6234-A6248 Description: Surgical dressings
Jurisdiction:Joint Local carrier if incident to a physician s service DMERC if other
Procedure Code(s):A6250-A6266 Description: Surgical dressings
Jurisdiction:Joint Local carrier if incident to a physician s service DMERC if other
Procedure Code(s):A6402-A6406 Description: Gauze
Jurisdiction: Joint Local carrier if incident to a physician s service DMERC if other
Procedure Code(s):A9150 Description: Non-prescription drugs
Jurisdiction: Local carrier
Procedure Code(s):A9160-A9170 Description: Administrative, miscellaneous, and investigational
Jurisdiction: Local carrier
Procedure Code(s):A9190-A9270 Description: Noncovered items or services
Jurisdiction: Joint (Local carrier or DMERC)
Procedure Code(s):A9300 Description: Exercise equipment
Jurisdiction: DMERC
Procedure Code(s):A9500-A9505 Description: Imaging agents
Jurisdiction: Local carrier
Procedure Code(s):B4034-B9999 Description: Enteral and parenteral therapy
Jurisdiction: DMERC
Procedure Code(s):D0120-D9999 Description: Dental procedures
Jurisdiction: Local carrier
Procedure Code(s):E0100-E0105 Description: Canes Jurisdiction: DMERC
Procedure Code(s):E0110-E0116 Description: Crutches
Jurisdiction: DMERC
Procedure Code(s):E0130-E0159 Description: Walkers
Jurisdiction: DMERC
Procedure Code(s):E0160-E0179 Description: Commodes
Jurisdiction: DMERC
Procedure Code(s):E0180-E0239 Description: Decubitus care equipment Jurisdiction: DMERC
Procedure Code(s): E0241-E0246 Description: Bath and toilet aids
Jurisdiction: DMERC

Procedure Code(s):E0249 Description: Pad for heating unit Jurisdiction: DMERC
Procedure Code(s):E0250-E0297 Description: Hospital beds Jurisdiction: DMERC
Procedure Code(s):E0305-E0326 Description: Hospital bed accessories Jurisdiction: DMERC
Procedure Code(s):E0350-E0352 Description: Electronic bowel irrigation system Jurisdiction: DMERC
Procedure Code(s):E0370 Description: Other decubitus care equipment Jurisdiction: DMERC
Procedure Code(s):E0424-E0480 Description: Oxygen and related respiratory equipment Jurisdiction: DMERC
Procedure Code(s):E0500 Description: IPPB machine Jurisdiction: DMERC
Procedure Code(s):E0550-E0585 Description: Compressors Jurisdiction: DMERC
Procedure Code(s):E0600-E0606 Description: Suction pump/room vaporizers Jurisdiction: DMERC
Procedure Code(s):E0607-E0609 Description: Monitoring equipment Jurisdiction: DMERC
Procedure Code(s):E0610-E0615 Description: Pacemaker monitor Jurisdiction: DMERC
Procedure Code(s):E0621-E0635 Description: Patient lifts Jurisdiction: DMERC
Procedure Code(s):E0650-E0673 Description: Pnuematic compressor and appliances Jurisdiction: DMERC
Procedure Code(s):E0690 Description: Ultraviolet cabinet Jurisdiction: DMERC Procedure Code(s):E0700 Description: Safety equipment Jurisdiction: DMERC
Procedure Code(s):E0710 Description: Restraints Jurisdiction: DMERC
Procedure Code(s):E0720-E0745 Description: Electrical nerve stimulators Jurisdiction: DMERC
Procedure Code(s):E0746 Description: EMG device Jurisdiction: Local carrier
Procedure Code(s):E0747-E0749 Description: Osteogenic stimulators Jurisdiction: DMERC
Procedure Code(s):E0751-E0753 Description: Implantable nerve stimulator Jurisdiction: Local carrier
Procedure Code(s):E0755-E0776 Description: Stimulator; pole Jurisdiction: DMERC
Procedure Code(s):E0781 Description: Ambulatory infusion pump Jurisdiction: Joint DMERC when the infusion is initiated in the physician s office but the patient does not return during the same business day
Procedure Code(s):E0782-E0783 Description: Infusion pumps, implantable Jurisdiction: Local carrier

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Biofeedback Devices Not Covered

The jurisdiction for the receipt and processing of claims for procedure code E0746 (Electromyography [EMG], biofeedback device)

is with the local carrier (Medicare Part B of Florida). The following information is the coverage policy for this device:

A biofeedback device differs from electromyography, which is a diagnostic procedure. A biofeedback device is not medically reasonable and necessary and it is not appropriate to allow the purchase nor rental of this device in any circumstance. Therefore, claims for procedure code E0746 will be denied payment as not medically necessary. An acceptable advance notice of Medicare s denial of payment must be given to the patient if the provider does not want to accept financial responsibility for the device.

Anesthesia/Surgery

Billing for Femoral-Popliteal Reoperation

The following is a reminder of proper billing for procedure code 35700 (Reoperation, femoral-popliteal or femoral (popliteal)-anterior tibial, posterior tibial, peroneal artery or other distal vessels, more than one month after original operation [List separately in addition to code for primary procedure]).

Providers should remember that it is only appropriate to bill the procedure code 35700, a reoperation code, with the following procedure codes:

35556 Bypass graft, with vein; femoral-popliteal

35566 Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels

35571 Bypass graft, with vein; popliteal-tibial, peroneal artery or other distal vessels

35583 In-situ vein bypass; femoral-popliteal

35585 In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery

35587 In-situ vein bypass; popliteal-tibial, peroneal

35656 Bypass graft, with other than vein; femoral-popliteal

35666 Bypass graft, with other than vein; femoral-anterior tibial, posterior tibial, or peroneal artery

35671 Bypass graft, with other than vein; popliteal-tibial or -peroneal artery

It is not appropriate to bill procedure code 35700 with any code not referenced above.

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Clarification: Coverage for Benign or Premalignant Skin Lesion Removal

This is a clarification of the article on Coverage for Benign or Premalignant Skin Lesion Removal which was published on page 8 of the October 1996 Medicare B Update! Special Issue: New Local Medical Review and Focused Medical Review Policies.

All physicians are advised that it was not the intent of the above mentioned policy to require the use of fluorourcil for the treatment of multiple or single actinic keratoses. The intent was to create yet another criteria for Medicare coverage for the removal of actinic keratoses. Specifically, if a lesion or lesions fail to resolve after treatment with fluorouracil then Medicare would consider their removal or destruction medically necessary and would provide coverage since they would no longer be considered asymptomatic.

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Sterilization Procedures

Sterilization is used as a means of preventing pregnancy.

Covered Conditions

Payment may be made only where sterilization is a necessary part of the treatment of an illness or injury, e.g., removal of a uterus because of a tumor, removed or diseased ovaries (bilateral oophorectomy), or bilateral orchidectomy in case of cancer of the prostate. Claims for sterilization procedures will be denied payment when the pathological evidence of the necessity to perform the procedure to treat an illness or injury is absent; and

Sterilization of a mentally retarded beneficiary is covered if it is a part of the treatment of an illness or injury.

Such surgeries will be monitored closely to determine whether in fact the surgery was performed as a means of treating an illness or injury or only to achieve sterilization.

Noncovered Conditions

Elective hysterectomy, tubal ligation and vasectomy, if the stated reason for these procedures is sterilization;

A sterilization that is performed because a physician believes another pregnancy would endanger the overall general health or the woman is not considered to be reasonable and necessary for the diagnosis or treatment of illness or injury. The same conclusion would apply where the sterilization is performed only as a measure to prevent the possible development of, or effect on, a mental condition should the individual become pregnant; and

Sterilization of a mentally retarded person where the purpose is to prevent conception, rather than the treatment of an illness or injury.

Insertion of an intrauterine device (IUD) (procedure code 58300) is not a benefit of Medicare.

Removal of an IUD (procedure 58301) for birth control purposes is not a covered service; however, removal of an IUD for medical necessity such as infection, would be a covered service.

The codes contained in this policy are all related to sterilization only procedures, therefore, all will be denied as not medically necessary on the initial claim submitted. However, if there are true medical necessity issues to be presented, claims for these procedures may be submitted with the appropriate unlisted procedure code and include documentation which supports the medical need for the surgery.

55250 Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)

55400 Vasovasostomy, vasovasorraphy

55450 Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)

56301 Laparoscopy, surgical; with fulgration of oviducts (with or without transection)

56302 Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)

57170 Diaphragm or cervical cap fitting with instructions

58300 Insertion of intraterine device (IUD)

58301 Removal of intraterine device (IUD)

58600 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral

58605 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum unilateral or bilateral, during same hospitalization (separate procedure)

58611 Ligation or transection of fallopian tube(s) when done at time of cesarean section or intra-abdominal surgery (not a separate procedure)

58615 Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach

For sterilization procedures, which do not reflect medical necessity, use the ICD-9 V-code appropriate to the condition; V25 (range) encounter for contraceptive management.

Documentation Requirements

The following documentation is required for medically necessary sterilization procedures:

History and physical/statement of medical necessity; and

Operative report.

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Diagnostic Tests

Guidelines for Purchased Diagnostic Tests

Effective for services rendered January 1, 1997, and after, the following, all inclusive list of procedure codes will be subject to the purchased diagnostic tests rules (see next page).

Important Reminder: Procedure code modifier ZD (Technical component - diagnostic test not purchased) is no longer valid. Item 20 of the HCFA-1500 claim form (or the equivalent EMC field) must be completed when billing for diagnostic tests subject to purchase price limitations.

Personally Performed Diagnostic Tests

When a diagnostic test is personally performed, no must be indicated in item 20 of the HCFA-1500 claim form. A no indicates no purchased tests are included on the claim. Procedure code modifier ZD (Technical component - diagnostic test not purchased) was a local modifier developed by the Florida carrier to indicate that the diagnostic service provided was performed by the physician or his employee. Due to the revised HCFA-1500 claim filing requirements, a no in item 20 now satisfies this requirement. EMC senders should contact their software vendor for specific instructions on where to enter this information in their system.

Example

Purchased Diagnostic Tests

When the technical component of a procedure subject to the purchased diagnostic test rules is purchased from an outside supplier, it must be submitted on a separate line from the professional component and billed with procedure code modifier WU (Technical component - purchased test). The professional component must be billed with procedure code modifier 26 (Professional component only).

When a physician purchases the technical component from another physician/outside supplier, item 20 of the HCFA-1500 claim form must be checked yes . The acquisition or purchase cost should be placed in item 20 under $CHARGES. The name, Medicare provider number and address of the supplier/physician from whom the test was purchased must be provided in item 32 of the HCFA-1500 claim form. If this information is not provided, the technical component will be denied payment.

When billing for multiple purchased diagnostic tests, each test must be submitted on a separate claim form. EMC senders should contact their software vendor for specific instructions on where to enter this information in their system.

Example

Important Note: Diagnostic tests (i.e., professional, technical or global components) billed by one of the following providers are not subject to purchased diagnostic test rules:

Portable x-ray suppliers

Independent laboratories

Independently practicing audiologists

Independent physiological laboratories

Procedures Subject to Purchased Test Rules

*Technical component only (It is not necessary to bill procedure code modifier TC with these procedures)

**Procedure codes added for 1997

G0005*, G0006*, G0015*, G0030, G0031, G0032, G0033, G0034, G0035, G0036, G0037, G0038, G0039, G0040, G0041, G0042, G0043, G0044,

G0045, G0046, G0047, G0062**, G0063**, Q0035,
Q0092*, 70010, 70015, 70030, 70100, 70110,
70120, 70130, 70134, 70140, 70150, 70160,
70170, 70190, 70200, 70210, 70220, 70240,
70250, 70260, 70300, 70310, 70320, 70328,
70330, 70332, 70336, 70350, 70355, 70360,
70370, 70371, 70373, 70380, 70390, 70450,
70460, 70470, 70480, 70481, 70482, 70486,
70487, 70488, 70490, 70491, 70492, 70540,
70541, 70551, 70552, 70553, 71010, 71015,
71020, 71021, 71022, 71023, 71030, 71034,
71035, 71036, 71038, 71040, 71060, 71090,
71100, 71101, 71110, 71111, 71120, 71130,
71250, 71260, 71270, 71550, 72010, 72020,
72040, 72050, 72052, 72069, 72070, 72072,
72074, 72080, 72090, 72100, 72110, 72114,
72120, 72125, 72126, 72127, 72128, 72129,
72130, 72131, 72132, 72133, 72141, 72142,
72146, 72147, 72148, 72149, 72156, 72157,
72158, 72170, 72190, 72192, 72193, 72194,
72196, 72200, 72202, 72220, 72240, 72255,
72265, 72270, 72285, 72295, 73000, 73010,
73020, 73030, 73040, 73050, 73060, 73070,
73080, 73085, 73090, 73092, 73100, 73115,
73120, 73130, 73140, 73200, 73201, 73202,
73220, 73221, 73500, 73510, 73520, 73525,
73530, 73540, 73550, 73560, 73562, 73564,
73565, 73580, 73590, 73592, 73600, 73610,
73615, 73620, 73630, 73650, 73660, 73700,
73701, 73702, 73720, 73721, 74000, 74010,
74020, 74022, 74150, 74160, 74170, 74181,
74190, 74210, 74220, 74230, 74235, 74240,
74241, 74245, 74246, 74247, 74249, 74250,
74251, 74260, 74270, 74280, 74283, 74290,
74291, 74300, 74301, 74305, 74320, 74327,
74328, 74329, 74330, 74340, 74350, 74355,
74360, 74363, 74400, 74405, 74410, 74415,
74420, 74425, 74430, 74440, 74445, 74450,
74455, 74470, 74475, 74480, 74485, 74710,
74740, 74742, 74775, 75552, 75553, 75554,
75555, 75600, 75605, 75625, 75630, 75650,
75658, 75660, 75662, 75665, 75671, 75676,
75680, 75685, 75705, 75710, 75716, 75722,
75724, 75726, 75731, 75733, 75736, 75741,
75743, 75756, 75774, 75790, 75801, 75803,
75805, 75807, 75809, 75810, 75820, 75822,
75825, 75827, 75831, 75833, 75840, 75842,
75860, 75870, 75872, 75880, 75885, 75887,
75889, 75891, 75893, 75898, 75945**, 75946**,
75970, 75992, 75993, 75994, 75995, 75996,
76000, 76001, 76003, 76010, 76020, 76040,
76061, 76062, 76065, 76066, 76070, 76075,
76080, 76086, 76088, 76090, 76091, 76093,
76094, 76095, 76096, 76098, 76100, 76101,
76102, 76120, 76125, 76150*, 76350*, 76355,
76360, 76365, 76370, 76375, 76380, 76400,
76499, 76506, 76511, 76512, 76513, 76516,

76519, 76529, 76536, 76604, 76645, 76700,
76705, 76770, 76775, 76778, 76800, 76805,
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76872, 76880, 76930, 76932, 76934, 76945,
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78003, 78006, 78007, 78010, 78011, 78015,
78016, 78017, 78018, 78070, 78075, 78099,
78102, 78103, 78104, 78110, 78111, 78120,
78121, 78122, 78130, 78135, 78140, 78160,
78162, 78170, 78172, 78185, 78190, 78191,
78195, 78199, 78201, 78202, 78205, 78215,
78216, 78220, 78223, 78230, 78231, 78232,
78258, 78261, 78262, 78264, 78270, 78271,
78272, 78278, 78282, 78290, 78291, 78299,
78300, 78305, 78306, 78315, 78320, 78350,
78399, 78414, 78428, 78445, 78455, 78457,
78458, 78460, 78461, 78464, 78465, 78466,
78468, 78469, 78472, 78473, 78478, 78480,
78481, 78483, 78499, 78580, 78584, 78585,
78586, 78587, 78591, 78593, 78594, 78596,
78599, 78600, 78601, 78605, 78606, 78607,
78610, 78615, 78630, 78635, 78645, 78647,
78650, 78655, 78660, 78699, 78700, 78701,
78704, 78707, 78710, 78715, 78725, 78726,
78727, 78730, 78740, 78760, 78761, 78799,
78800, 78801, 78802, 78803, 78805, 78806,
78807, 78999, 86485*, 86490*, 86510*, 86580*,
86585*, 86586*, 88104, 88106, 88107, 88108,
88125, 88160, 88161, 88162, 88170, 88171,
88172, 88173, 88180, 88182, 88199, 88300,
88302, 88304, 88305, 88307, 88309, 88311,
88312, 88313, 88314, 88318, 88319, 88342,
88346, 88347, 88348, 88349, 88355, 88356,
88358, 88362, 88365, 88399, 89350*, 89360*,
91000, 91010, 91011, 91012, 91020, 91030,
91032, 91033, 91052, 91055, 91060, 91065,
92552*, 92553*, 92555*, 92556*, 92557*,
92561*, 92562*, 92563*, 92564*, 92565*,
92567*, 92568*, 92569*, 92571*, 92572*,
92573*, 92574*, 92575*, 92576*, 92577*,
92578*, 92579*, 92580*, 92582*, 92583*,
92584*, 92585, 92587, 92588, 92589*, 92596*,
93005*, 93012*, 93017*, 93024, 93041*,
93225*, 93226*, 93231*, 93232*, 93236*,
93270*, 93271*, 93278, 93303**, 93304**,
93307, 93308, 93312, 93314, 93315**, 93317**,
93320, 93321, 93325, 93350, 93555, 93556,
93721*, 93724, 93731, 93732, 93733, 93734,
93735, 93736, 93737, 93738, 93740, 93770,
93799, 93875, 93880, 93882, 93886, 93888,
93922, 93923, 93924, 93925, 93926, 93930,
93931, 93965, 93970, 93971, 93975, 93976,
93978, 93979, 93980, 93981, 93990, 94010,
94060, 94070, 94150, 94200, 94240, 94250,
94260, 94350, 94360, 94370, 94375, 94400,
94450, 94620, 94680, 94681, 94690, 94720,

94725, 94750, 94760v*, 94761*, 94762*, 94770, 94772, 94799, 95805, 95807, 95808v, 95810, 95812, 95813v, 95816v, 95819, 95822, 95824, 95827v, 95829, 95858, 95860, 95861v, 95863, 95864, 95867, 95868, 95869, 95872, 95875, 95900, 95903, 95904, 95920, 95921v**, 95922v**, 95923**, 95925, 95926, 95927v, 95933, 95934v, 95935, 95936, 95937, 95950, 95951v, 95953, 95954, 95955, 95956v, 95957, 95958, 95961v, 95962

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Billing Guidelines for A-Scans Clarified

The October 1996 Medicare B Update! Special Issue: New Local Medical Review and Focused Medical Review Policies contained an article on page 21 titled Coverage for A-Scans . This article incorrectly stated that procedure code 76519 (Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation) may be reported with procedure code modifiers RT (right) and LT (left). Procedure code 76519 is considered a bilateral procedure and should not be billed with an RT or LT modifier.

The reimbursement for the global procedure includes the technical component for both eyes and the professional component of one eye (the eye scheduled for surgery). When surgery is scheduled for one eye, the claim for the A-scan should be submitted as follows:

When a surgery is scheduled for both eyes, the second professional component can be paid in addition to the global procedure when the A-scan is performed on both eyes on the same date of service. The claim should be submitted as follows:

OR

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Coverage for Myocardial Perfusion Imaging

Myocardial perfusion imaging (procedure code 78460) 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, myocardial perfusion imaging is covered only for the following diagnoses. Refer to the most current version of the ICD-9-CM coding book for complete descriptions.

411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.10, 414.11, 414.19,

414.8, 414.9, 424.0, 426.2, 426.3, 426.4, 426.50, 426.51, 426.52, 426.53, 426.54, 426.6, 426.7, 427.31, 428.0, 428.1, 428.9, 440.21-440.24, 794.31, 960.7, 995.2, E942.0, E942.1, V67.0, V67.51, V67.59

Advance Notice Requirement

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

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Correction: Diagnosis Lists for Certain FMR and LMR Policies

The October 1996 Medicare B Update! Special Issue: New Local Medical Review and Focused Medical Review Policies included articles listing the diagnosis requirements for the following procedures:

Chest X-Rays (page 15-17)

Prostate Specific Antigen (page 33)

Electrocardiograms (page 41-42)

Hyperbaric Oxygen Therapy (page 46)

Since the publication of these articles, the following corrections/clarifications have been made:

Chest X-rays

466.0-466.1 should have read 466.0-466.19

482.80-482.83 should have read 482.81-482.83

943.34 should have read 942.34

Clarification: As a result of Medicare Part B of Florida s revised coverage policy on chest x-rays, ICD-9-CM code V72.84 (Preoperative examination, unspecified) is no longer a covered diagnosis for chest x-rays. Effective for services processed November 18, 1996 and after, the actual condition warranting the preoperative chest x-rays must be reported.

Prostate Specific Antigen

185.5 should have read 188.5

Electrocardiograms

The following diagnoses were published in error and are not covered for electrocardiograms:

066.0-066.9

071

073.0-073.9

Hyperbaric Oxygen Therapy

The following diagnoses were omitted from the original list, and are covered for hyperbaric oxygen therapy:

730.10-730.19

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Approved Procedures for Portable X-Ray Suppliers

A list of approved procedures for portable x-ray suppliers was published on page 22 of the July/August 1996 Medicare B Update! Since that publication, the following revisions have been made to the list of approved procedures:

Effective for claims processed on and after December 2, 1996, procedure codes 70110-70134 are covered when furnished by a portable x-ray supplier.

As a result of the 1996 Final Rule, separate payment is no longer made for procedure code R0076 effective for services furnished on and after January 1, 1997. Payment for this procedure is now bundled into the payment for the EKG.

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1997 Fees for Clinical Laboratory Procedures

The 1997 fee schedule allowances for the following new/revised clinical laboratory procedure codes have been established. The fees are effective for services furnished January 1, 1997, and after.

Code	Fee
80197	25.58
83902	15.00

82523 26.36
84484 15.00

83898 27.12

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Additional CLIA Waived Test

On October 10, 1996, the Center for Disease Control (CDC) granted waived status to the QUIDEL Quick-Vue One-Step H. Pylori test for whole blood. Only the test system and the test system instructions approved by CDC through this review process are waived. In addition, the agreed upon fail safe mechanism of a positive and negative control is based on CDC s review of information submitted by QUIDEL indicating that the test kit size will not exceed thirty tests per kit and the requirement for controls to be run with each change in operator for each kit. This information must be included in the product labeling and the user must also be notified of this information.

This is the second waived test system for this analyte. However this test is performed on whole blood as opposed to a gastric biopsy. Therefore, it has been assigned CPT procedure code 86318, plus modifier QW. This CPT procedure code is for single step method systems (e.g. reagent strips). Procedure code 86318QW is effective for services performed on or after October 10, 1996.

The 1997 clinical laboratory fee schedule amount for procedure code 86318QW is $18.38.

On the following page is a revised CLIA waived test table.

Tests Granted Waived Status Under CLIA

Revised 10/29/96

Test Name: Dipstick or tablet reagent urinalysis non automated for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrate, pH, protein, specific gravity, and urobilinogen
Manufacturer: Various
CPT Code(s): 81002
Use: Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections

Test Name: Fecal occult blood
Manufacturer: Various
CPT Code(s):82270
Use: Detection of blood in feces from whatever cause, benign or malignant (colorectal cancer screening)

Test Name: Ovulation tests by visual color comparison for human luteinizing hormone

Manufacturer: Various
CPT Code(s): 84830
Use: Detection of ovulation (optimal for conception)

Test Name: Urine pregnancy tests by visual color comparison
Manufacturer: Various
CPT Code(s):81025
Use: Diagnosis of pregnancy

Test Name: Erythrocyte sedimentation rate non automated
Manufacturer:Various
CPT Code(s):85651
Use: Nonspecific screening test for inflammatory activity, increased for majority of infections, and most cases of carcinoma and leukemia

Test Name: Hemoglobin by copper sulfate non automated
Manufacturer: Various
CPT Code(s):83026
Use: Monitors hemoglobin level in blood

Test Name: Blood glucose by glucose monitoring devices cleared by the FDA for home use
Manufacturer:Various
CPT Code(s):82962
Use: Monitoring of blood glucose levels

Test Name: Blood count; spun microhematocrit
Manufacturer:Various
CPT Code(s):85013
Use: Screen for anemia

Test Name: Hemoglobin by single instrument with self contained or c omponent features to perform specimen/reagent interaction, providing direct measurement and readout
Manufacturer:HemoCue
CPT Code(s):85018QW (effective 10/1/96)
Use: Monitors hemoglobin level in blood (HCPCS code Q0116 should be discontined for this test 9/30/96)

Test Name: HemoCue B Glucose Photometer
Manufacturer:HemoCue
CPT Code(s):82947QW , 82950QW, 82951QW, 82952QW (effective 10/1/96)
Use: Diagnosis and monitoring of blood glucose levels (HCPCS codes G0055, G0056 and G0057 should be discontinued for this test 9/30/96)

Test Name: Chemtrak Accumeter
Manufacturer: Chemtrak

CPT Code(s):82465QW
Use: Cholesterol monitoring

Test Name: Advanced Care
Manufacturer: Johnson & Johnson
CPT Code(s):82465QW
Use: Cholesterol monitoring

Test Name: Boehringer Mannheim Chemstrip Micral
Manufacturer:Boehringer Mannheim
CPT Code(s):82044QW
Use: Monitors low concentrations of albumin in urine which is helpful for early detection in patients at risk for renal disease

Test Name: Cholestech LDX
Manufacturer:Cholestech
CPT Code(s):82465 83718QW 84478QW 82947QW
Use: Monitors total cholesterol, HDL cholesterol, triglycerides and glucose levels

Test Name: Serim Pyloritek Test Kit
Manufacturer:Serim
CPT Code(s):87072QW
Use: Presumptive identification of Helicobacter pylori in gastric biopsy tissue, which has been shown to cause chronic active gastritis (ulcers)

Test Name: Quick Vue In Line One Step Strep A Test
Manufacturer:Quidel
CPT Code(s):86588QW
Use: Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever

Test Name: Boehringer Mannheim Accu Chek InstantPlus Cholesterol
Manufacturer:Boehringer Mannheim
CPT Code(s):82465QW
Use: Cholesterol monitoring

Test Name: All qualitative color comparison pH testing body fluids (other than blood)
Manufacturer:Various
CPT Code(s):83986QW
Use: pH detection (acid base balance) in body fluids such as semen, amniotic fluid and gastric aspirates

Test Name: SmithKline Gastroccult
Manufacturer:SmithKline

CPT Code(s):82273QW
Use: Rapid screening test to detect the presence of gastric occult blood

Test Name: QuickVue One Step H.Pylori Test for Whole Blood
Manufacturer:Quidel
CPT Code(s):86318QW
Use: Immunoassay for rapid, qualitative detection of IgG antibodies specific to Helicobacter pylori in whole blood.

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Coverage Requirements for Erythrocyte Sedimentation Rate

Pages 8-10 of the January/February 1996 Medicare B Update! outlined the coverage requirements for erythrocyte sedimentation rate (procedure codes 85651-85652). That article indicated that this service is subject to a utilization screen when it is furnished by a rheumatologist.

Medicare claims data indicates that this procedure has been billed at unusually frequent intervals by multiple specialties. As a result, effective for services furnished December 16, 1996, and after, erythrocyte sedimentation rate furnished by any provider may be covered when its frequency is furnished within the established utilization screen. Claims for services furnished in excess of the established limit will be denied payment unless documentation (i.e., history and physical, lab reports) is provided which substantiates the medical need for the services.

Diagnosis Requirements

Erythrocyte sedimentation rate (procedure codes 85651 and 85652) 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, erythrocyte sedimentation rate is covered only for the following diagnoses. Refer to the most currect version of the ICD-9-CM coding book for complete descriptions.

200.20, 200.21, 200.22, 200.23, 200.24,
200.25, 200.26, 200.27, 200.28, 201.40,
201.41, 201.42, 201.43, 201.44, 201.45,
201.46, 201.47, 201.48, 201.50, 201.51,
201.52, 201.53, 201.54, 201.55, 201.56,
201.57, 201.58, 201.60, 201.61, 201.62,
201.63, 201.64, 201.65, 201.66, 201.67,
201.68, 201.70, 201.71, 201.72, 201.73,
201.74, 201.75, 201.76, 201.77, 201.78,
201.90, 201.91, 201.92, 201.93, 201.94,
201.95, 201.96, 201.97, 201.98, 202.00,
202.01, 202.02, 202.03, 202.04, 202.05,
202.06, 202.07, 202.08, 202.80, 202.81,

202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 279.4, 391.0, 391.1, 391.2, 391.8, 410.00-410.02, 410.10-410.12, 410.20-410.22, 410.30-410.32, 410.40-410.42, 410.50-410.52, 410.60-410.62, 410.70-410.72, 446.0, 446.5, 447.6, 556.0-556.9, 696.0, 710.0, 710.1, 710.2, 710.4, 710.9, 714.0, 714.1, 714.2, 714.30, 714.81, 714.9, 716.59, 719.49, 720.0, 725, 729.1, 733.99, V10.72

Advance Notice Requirement

Applies to utilization screen and diagnosis requirements (refer to page 4).

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Coverage for Allergen-Specific IgE Tests

Procedure codes 86003 and 86005 (allergen-specific IgE tests) are defined as follows:

86003

Allergen-specific IgE; quantitative, each allergen

86005

Allergen-specific IgE; qualitative, multiallergen screen (dipstic, paddle, or disk)

Indications for Coverage

In order to determine the medical necessity of the services, the following criteria is used in reviewing claims for procedure codes 86003 and 86005:

Allergen-specific IgE testing should be used as an adjunct to a careful and complete allergic history and physicial examination. It is essential to correlate the number of tests and the type of allergen(s) tested with the patient s clinical presentation.

Allergen-specific IgE testing often is preferred in the following circumstances once IgE mediated allergic disease has been determined:

In patients with extensive dermatitis or dermographism;

In patients who cannot be withdrawn from medication which interferes with proper skin testing;

Occasionally, in patients who are otherwise very uncooperative or refuse skin testing and in patients at extremes of age.

If intradermal or percutaneous testing has previously been performed, in vitro testing (allergen-specific IgE) should not be repeated for the same allergens by the same physician.

Utilization Parameters

Allergin-specific IgE tests (procedure codes 86003 and 86005) is covered when its frequency/duration is rendered within the accepted standards of medical practice Claims for allergen-specific IgE testing which exceed the accepted standards of medical practice must include the following documentation:

A history and physicial documenting a complete allergic history and physicial examination, including the duration and severity of symptoms. The patient s clinical history should correlate with the allergens tested.

Progress notes.

Advance Notice Requirement

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

Reasons for Noncoverage

Allergen-specific IgE testing is not covered in the following circumstances:

Patients with mild symptoms and a short allergy season.

Patients with disease conditions unlikely to be IgE mediated.

Symptomatic patients where the treating physician has already performed a negative intradermal skin test.

Billing Guidelines

The description for procedure code 86003 indicates each allergen, so the number billed should reflect the number of allergens per test (e.g., 14 allergens would be reported with a number billed of 14). Payment for this procedure is based on each allergen. The 1997 fee schedule allowance for procedure code 86003 is $7.41 effective for services furnished on or after January 1, 1997.

The description for procedure code 86005 indicates multiallergen screen. Payment for this procedure is based on multiple allergens per day. Therefore, the number billed for this procedure should always be 1 per day. The 1997 fee schedule allowance for procedure code 86005 is $11.32, effective for services furnished on or after January 1, 1997.

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Surgical Pathology Coverage Guidelines

Surgical pathology consists of examination of tissue(s) by gross/microscopic technique, and are typically done for any surgical removal of tissue. The information in this article applies to the following CPT codes:

88300 Level I - Surgical pathology, gross examination only

88302 Level II - Surgical pathology, gross and microscopic examination

88304 Level III - Surgical pathology, gross and microscopic examination

88305 Level IV - Surgical pathology, gross and microscopic examination

88307 Level V - Surgical pathology, gross and microscopic examination

88309 Level VI - Surgical pathology, gross and microscopic examination

For the above-listed levels, (88300-88309), see CPT for specific sites/descriptors.

88311 Decalcification procedure (List separately in addition to code for surgical pathology examination)

88312 Special stains (List separately in addition to code for surgical pathology examination); Group I for microorganisms (e.g., Gridley, acid fast, methenamine silver), each

88313 Special stains (List separately in addition to code for surgical pathology examination); Group II, all other, (e.g., iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each

88314 Special stains (List separately in addition to code for surgical pathology examination); histochemical staining with frozen section(s)

88329 Pathology consultation during surgery

88331 Pathology consultation during surgery; with frozen section(s), single specimen

88332 Pathology consultation during surgery; each additional tissue block with frozen section(s)

Coding Guidelines

Services 88300 through 88309 include accession, examination, and reporting. They do not include the services designated in codes 88311 through 88365 and 88399, which are coded in addition when provided.

The unit of service for codes 88300 through 88309 is the specimen. A specimen is defined as tissue or tissues that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. Two or more such specimens from the same patient (e.g., separately identified endoscopic biopsies, skin lesions, etc.) are each appropriately assigned an individual code reflective of its proper level of service.

Service code 88300 is used for any specimen that in the opinion of the examining pathologist can be accurately diagnosed without microscopic examination. Service code 88302 is used when gross and microscopic examination is performed on a specimen to confirm identification and the absence of disease. Service codes 88304 through 88309 describe all other specimens requiring gross and microscopic examination, and represent additional ascending levels of physician work. Levels 88302 through 88309 are specifically defined by the assigned specimens.

Any unlisted specimen should be assigned to the code which most closely reflects the physician work involved when compared to other specimens assigned to that code.

Reimbursement for gross examination only (88300) is allowed in addition to gross and microscopic examinations (88302-88309) when specimens are taken from separate sites which may be contiguous, when performed on the same day by the same physician.

Pathology consultations during surgery (88329) may be reimbursed in addition to pathology consultation with frozen section, single specimen or tissue block with frozen section (88331-88332), if a different anatomical site/separate specimen is identified.

To avoid unnecessary delays and/or denials when submitting claims for surgical pathology services, providers should pay close attention to the following claim filing tips:

Providers should not fragment bills. All services for a single patient, for the same date of service, must be submitted on a single claim.

If a procedure code is repeated, providers may report such services in the following manner:

Accurately record the number of procedures performed in the days or units field.

For example, if procedure code 83305 (Surgical pathology, gross and microscopic examination) and 88311 (Decalcification procedure) were performed on two separate specimens requiring individual examination (e.g., biopsy of the colon and duodenum), all services must be submitted on a single claim as follows:

Documentation Requirements

In the event of a postpayment review request, documentation should include a pathology report reflecting the procedure performed.

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Medicine

90724: Important Information

We would like to clarify two important policies related to Medicare s flu shot benefit. A misunderstanding by providers of these two policies could mean that beneficiaries will be charged for flu shots when, in fact, Medicare will pay for the shots.

Some providers believe that Medicare has a 365 day rule, which mandates that Medicare will pay for only one flu shot in a 365-day period. This is incorrect; Medicare covers one flu shot per flu season. For example, if a beneficiary receives a flu shot in December 1995 and receives another flu shot in September 1996, Medicare covers both shots. In fact, Medicare will cover more than one flu shot in a flu season if it is medically necessary. (Note that Medicare does not define the flu season. However, the vaccine is generally available during the months of September through January.)

Some mass immunizers providing shots at vaccination clinics may not understand that they cannot collect donations for flu or pneumococcal shots from Medicare beneficiaries. A mass immunizer submitting claims for flu or pneumococcal vaccine on a roster bill has agreed to accept assignment as a condition for using the roster billing method. Therefore, the mass immunizer may not accept a donation for a flu or pneumococcal shot from a beneficiary. In addition, all providers of services, including mass immunizers, must submit claims to Medicare for flu and pneumococcal vaccinations given to beneficiaries.

If you need more information about Medicare s flu shot benefit, you may contact Provider Customer Service at (904) 634-4994.

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Ophthalmological Diagnostic Procedures

Diagnosis policies are outlined below for the following procedure codes:

92250 Intraocular photography

92284 Dark adaptation examination

92285 Extraocular photography

92286 Endothelial cell photography

92287 Special anterior segment photography

Intraocular Photography

Intraocular photography (procedure code 92250) 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, intraocular photography (procedure code 92250) is covered only for the following diagnoses. Refer to the most current version of the ICD-9-CM coding book for complete descriptions.

036.0-036.9, 041.2, 041.5, 045.00-045.93, 046.0-046.9, 047.0-047.9, 048, 049.0-049.9, 053.0-053.9, 054.40-054.49, 054.72, 055.71-055.79, 061, 074.0-074.8, 076.0-076.9, 077.0-077.99, 080, 081.0-081.9, 084.9, 090.0-090.9, 094.0-094.9, 098.40-098.49, 099.3, 115.02, 115.09, 115.12, 115.19, 115.90, 115.92, 115.99, 124, 128.0, 130.1, 130.2, 130.9, 135, 136.1, 139.1, 190.0-190.9, 191.0-191.9, 192.0-192.9, 194.3, 198.3, 198.4, 200.00-200.01, 200.10-200.11, 200.80-200.81, 224.5, 224.6, 228.03, 234.0, 234.8, 238.8, 239.8, 250.50-250.51, 282.5, 282.60, 340, 341.0-341.9, 342.0-342.92, 343.0-343.9, 344.00-344.9, 360.00-360.04, 360.11-360.19, 360.20-360.29, 360.30-360.34, 360.40-360.44, 360.50-360.69, 361.00-361.9, 362.01-362.9, 363.00-363.9, 364.41-364.42, 365.00-365.9, 377.00, 377.01, 377.02, 377.03, 377.04, 377.10, 377.11, 377.12, 377.13, 377.14, 377.15, 377.16, 377.21-377.24, 377.30-377.34, 377.39, 377.41-377.42, 377.49, 379.21-379.29, 379.31, 379.32, 379.33, 379.34, 758.1, 794.11, 871.0-871.9, 921.9, 950.0-950.9

Advance Notice Requirement

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

Dark Adaptation Examination

Dark adaptation examination (procedure code 92284) 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, dark adaptation examination (procedure code 92284) is covered only for the following diagnoses. Refer to the most current version of the ICD-9-CM coding book for complete descriptions.

264.5

362.74

365.20

368.60

Advance Notice Requirement

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

Extraocular Photography

Extraocular photography (procedure code 92285) 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, extraocular photography (procedure code 92285) is covered only for the following diagnoses. Refer to the most current version of the ICD-9-CM coding book for complete descriptions.

041.81-041.85, 049.9, 053.20-053.29, 054.40-054.49, 077.0-077.99, 117.9, 136.1, 136.8, 171.0, 172.1, 173.1, 190.0, 190.3, 198.2, 198.4, 216.1, 224.0, 224.3-224.4, 232.1, 234.0, 238.1-238.2, 238.8, 239.2, 239.8, 242.00-242.01, 279.8, 351.0, 360.00-360.04, 360.11-360.19, 360.50-360.69, 362.81-362.89, 364.21, 364.3, 364.41-364.42, 364.51, 364.61, 365.62, 366.11, 366.20-366.23, 370.00-370.07, 370.21, 370.22, 370.50-370.59, 370.60, 370.8, 371.00, 371.20-371.24, 371.40-371.49, 371.50-371.58, 371.60-371.62, 372.13, 372.30-372.39, 372.40-372.45, 372.51, 372.72, 372.9, 373.11, 373.13, 373.2, 373.9, 374.00, 374.10, 374.20, 374.30, 374.32, 374.34, 374.84, 374.87, 375.30, 376.30, 378.00-378.87, 379.00, 379.03, 379.04, 379.26, 379.31-379.39, 379.40-379.49, 694.61, 695.1, 710.9, 743.46, 743.63, 743.9, 921.3, 930.0-930.9, 940.0, 940.2, 940.3, 977.9, 995.2, 996.51, 998.5, V43.1

Advance Notice Requirement

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

Endothelial Cell Photography

Endothelial cell photography (procedure code 92286) 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, endothelial cell photography (procedure code 92286) is covered only for the following diagnoses. Refer to the most current version of the ICD-9-CM coding book for complete descriptions.

371.20, 371.21, 371.22, 371.23, 371.57, 371.58, 379.31, 743.35, V43.1,

Advance Notice Requirement

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

Special Anterior Segment Photography

Special anterior segment photography (procedure code 92287) 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, special anterior segment photography (procedure code 92287) is covered only for the following diagnoses. Refer to the most current version of the ICD-9-CM coding book for complete descriptions.

190.0, 250.50-250.53, 364.00-364.8, 365.41-365.44, 365.52, 365.63, 365.64, 365.82, 743.00-743.48,
Advance Notice Requirement

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

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Coverage for Duplex Scan of Lower Extremity Arteries

Duplex scanning is a technique that combines the information provided by two-dimensional imaging with pulsed-wave doppler techniques which allows sampling of a particular imaged blood vessel with analysis of the blood flow velocity.

Applicable Codes

93925

Duplex scan of lower extremity arteries

93926

Followup or limited study

Indications for Coverage

Medicare Part B will consider duplex scanning of lower extremity arteries to be medically necessary for any of the following conditions:

The patient is found on physical examination to have absence or marked diminution of pulses (suspected to be secondary to obstruction of lower extremity arteries) of one or both lower extremities.

The patient has developed sudden pallor, numbness, and coolness of an extremity and vascular obstruction (embolism or thrombosis) is suspected.

The patient has intermittent claudication.

The patient has previously undergone a surgical revascularization procedure of one or both lower extremities and follow up non-invasive studies are necessary to evaluate the patient s condition.

The patient has an aneurysm or arteriovenous malformation of a lower extremity artery.

The patient has sustained lower extremity trauma with possible vascular injury or the patient has sustained iatrogenic vascular injury.

The patient has arteriosclerosis with claudication, rest pain, nonhealing ulcer, or gangrene.

Claims submitted for duplex scanning of lower extremity arteries performed at unusually frequent intervals will be reviewed by Medicare to make certain that the services were medically reasonable and necessary.

Diagnosis Requirements

To ensure that payment is made only for medically necessary services, procedure codes 93925 and 93926 are covered only for the following diagnoses/conditions. Refer to the most current version of the ICD-9-CM coding book for complete descriptions.

440.21, 440.22, 440.23, 440.24, 442.3, 443.1, 443.9, 444.0, 444.22, 444.81, 447.0, 447.1, 782.0, 782.61, 820.00-820.09, 820.10-820.19, 820.20-820.22, 820.30-820.32,

820.8, 820.9, 821.00-821.01, 821.10-821.11, 821.20-821.29, 821.30-821.39, 822.0-822.1, 823.00-823.02, 823.10-823.12, 823.20-823.22, 823.30-823.32, 823.80-823.82, 823.90-823.92, 824.0-824.9, 825.0-825.1, 825.20-825.29, 825.30-825.39, 827.0-827.1, 828.0-828.1, 835.00-835.03, 835.10-835.13, 836.0-836.4, 836.50-836.59, 836.60-836.69, 837.0-837.1, 838.00-838.09, 838.10-838.19, 904.0, 904.1, 904.40, 904.41, 904.50, 904.51, 904.53, 904.6, 904.7, 904.8, 904.9, 924.00-924.01, 924.10-924.11, 924.20-924.21, 924.4, 924.5, 924.8, 924.9, 928.00-928.01, 928.10-928.11, 928.20-928.21, 928.8, 998.11-998.13, 998.2, V67.0

Screening tests performed on asymptomatic patients without medical problems, cannot be covered by Medicare.

Reimbursement for a unilateral or limited duplex scan of the lower extremity arteries or arterial bypass grafts (93926) is included in the allowance of a complete bilateral study (93925) when billed for the same date of service by the same provider.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of duplex scan of lower extremity arteries covered by the Medicare program. Also, the results of duplex scan of lower extremity arterial studies covered by the Medicare program must be included in the patient s medical record.

If the provider of duplex scan of lower extremity arterial studies is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician s order for the studies. When ordering duplex scan of lower extremity arterial studies from an independent physiological lab or other provider, the ordering/referring physician must state the reason for the duplex scan of lower extremity arteries in the order for the tests.

Advance Notice Requirement

Applies to diagnosis requirements and utilization screen (see page 4)

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Diagnosis Requirements for Photochemotherapy

The diagnoses for which photochemotherapy (procedure codes 96910, 96912, 96913) may be covered was published on page 53 of the September/October 1996 Medicare B Update! Since that publication, the following condition has been added as a covered diagonsis:

202.10-202.18

Advance Notice Requirement

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

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Spirometry and Functional Residual Capacity

Since the initial publication of the coverage requirements for Spirometry and Functional Residual Capacity in the July/August 1996 Medicare B Update! (pgs 38-39), additional comments regarding the local medical review policy were received. As a result of these comments, the indications for these tests have been expanded to include the information obtained from the Global Initiative for Asthma . Therefore, Pulmonary Function Tests will be considered medically necessary for the following conditions:

Preoperative evaluation of the lungs and pulmonary reserve when:

thoracic surgery will result in loss of functional pulmonary tissue (i.e., lobectomy); or

patients are undergoing major abdominal surgery and the physician has some reason to believe the patient may have a pre-existing pulmonary limitation (e.g., long history of smoking); or

the patient s pulmonary function is already severely compromised by other diseases such as chronic obstructive pulmonary disease (COPD).

Initial diagnostic workup for the purpose of differentiating between obstructive and restrictive forms of chronic pulmonary disease. Obstructive defects (e.g., emphysema, bronchitis, asthma) occur when ventilation is disturbed by an increase in airway resistance. Expiration is primarily affected. Restrictive defects (e.g., pulmonary fibrosis, tumors, chest wall trauma) occur when ventilation is disturbed by a limitation in chest expansion. Inspiration is primarily affected.

To assess the indications for and effect of therapy in diseases such as sarcoidosis, diffuse lupus erythematosus, and diffuse interstitial fibrosis syndrome.

Evaluate patient s response to a newly established bronchodilator/antiinflammatory therapy.

To monitor the course of asthma and the patient s responses to therapy (i.e., especially to confirm home peak expiratory flow measurements).

Evaluate patients who continue to exhibit increasing shortness of breath after initiation of bronchodilator/antiiinflammatory therapy.

Initial evaluation for a patient that presents with new onset (within one month) of one or more of the following symptoms: shortness of breath, cough, dyspnea, wheezing, orthopnea, or chest pain.

Initial diagnostic workup for a patient whose physical exam revealed one of the following: overinflation, expiratory slowing, cyanosis, chest deformity, wheezing, or unexplained crackles.

Initial diagnostic workup for a patient with chronic cough. It is not expected that a patient has a repeat spirometry without new symptomatology.

Re-evaluation of a patient with or without underlying lung disease that presents with increasing SOB (from previous evaluation) or worsening cough and related qualifying factors such as abnormal breath sounds or decreasing endurance to perform ADL s.

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What s New for EMC?

A Closer Look at the NSF 1.04 And 2.00 Format Changes Effective January 1, 1997

As a result of the Health Care Financing Administration s (HCFA) 1997 revision to the Health Care Procedure Coding System (HCPCS), certain procedure codes which have special instructions for electronic submission are being deleted and new codes have been assigned for 1997. Please review these changes tocensure your software has been updated.

Nail Debridement (Procedure Codes 11700, 11701, 11710 and 11711)

Effective for services rendered on or after January 1, 1997, two new procedure codes have been established for nail debridement: 11720 and 11721. Additionally, nail debridement requires the submission of the Q1 modifier or the completion of fields EAO 38 and FAO 33.

For services redered before January 1, 1997, providers should continue to bill 11700, 11701, 11710 and 11711.

Chiropractic Services (Procedure Code A2000)

Effective for services rendered on or after January 1, 1997, three new procedure codes have been established for chiropractic services: 98940, 98941 and 98942. Also, spinal manipulation requires the submission of a GCO record.

For services rendered before January 1, 1997, providers should continue to bill A2000.

Care Plan Oversight (CPO) (Procedure Code 99375)

As a result of HCFA s Final Rule for 1997, when billing for CPO services, the Home Health Agency (HHA) or hospice number must be entered in record EAO field 50, position 290-295. Effective for services rendered on or after January 1, 1997, two new procedure codes have been established for care plan oversight services: G0064 and G0065.

For services rendered before January 1, 1997, providers should continue to bill 99375 with the above-mentioned record completed.

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Nail Debridement Revisions

There have been some recent changes which will affect the way providers bill nail debridment claims, whether billing electronically or on paper. Effective for services rendered on or after January 1, 1997, procedure codes 11700, 11701, 11710 and 11711 will be deleted. Nail debridement codes 11720 and 11721 are the new codes which are effective January 1, 1997.

When transmitting claims electronically, providers must complete field FAO-9 positions 60-64.

If the service dates are prior to January 1, 1997, procedure codes 11700, 11701, 11710 and 11711 can be billed.

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Changes To Filing Chiropractor Services

Medicare Part B of Florida has made some changes regarding claims filed for chiropractic manipulations. Effective for services rendered on or after January 1, 1997, procedure code A2000 has been changed to a non-covered service. If the dates of service are prior to January 1, 1997, procedure code A2000 can be transmitted using the FA0 record field 5 positions 40-47. Effective for services rendered on or after January 1, 1997, chiropractors should use one of the following new procedure codes: 98940, 98941, 98942 and 98943.

When billing for spinal manipulation, ensure that the ICD9-CM diagnosis code identifies all physical findings which resulted from the specific level of subluxation.

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Release of NSF Combined Manual for Versions 1.04 and 2.00

There is now only one NSF Manual; versions 1.04 and 2.00 have been combined. For instructions on downloading the NSF manual, access the file NSFCLAIM . Hard copy manuals will not be mailed unless requested from PES Marketing at (904) 791-8767.

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Electronic Billing of Specific Unlisted Codes

Providers were previously unable to bill specific unlisted codes electronically due to the inability to provide a narrative description. That limitation has been eliminated for the following codes:

A4641 A4645 97039 99429 A4644 A4646 97139 28288

When billing for these codes, the HA0 record field 5, positions 40-320 must be completed prior to transmitting the claim. This will allow the narrative information to be transmitted with the claim. We encourage you to make these changes for your customers needing this transmission ability.

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Reminder: Procedures for Receiving Notification of Changes

Effective October 1, 1996, all manual updates and Health Care Financing Administration (HCFA)-mandated changes are distributed via the Medicare B B-Line Bulletin Board System (BBS). This process will work as follows:

A flyer/memo (similar to this) will be mailed indicating changes are being added to the BBS.

You should then access our BBS by dialing (904) 791-6991.

For assistance with the Medicare B B-Line BBS, call (904) 791-8384.

Paper copies of manuals and/or changes will not be mailed unless requested from PES Marketing at (904) 791-8767.

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ANSI 270/271 Eligibility Inquiry and Response

The American National Standards Institute (ANSI) Eligibility Inquiry and Response records will be available 01/01/97. These records will provide the most current data available on a patient s entitlement, deductible and Health Maintenance Organization (HMO). To obtain Eligibility information, the provider or supplier must be participating and must be submitting claims in either the ANSI or National Standard Format (NSF). Claims submission rates must equal or exceed 90 percent of the Eligibility requests made on a monthly basis for the first 3 months the provider has Eligibilty access. After the initial 3-month phase-in period, submission rates must equal or exceed 95 percent. If this criteria is not being met, the provider will receive an educational contact from our office. If the behavior continues, the provider will lose Eligibility inquiry access. Access to Eligibility will be on a toll basis (the provider will incur all wire charges). Data requested will be returned within 24 business hours, unless the request is for a patient who resides outside the State of Florida. In this case, the response could take up to 3 business days. Eligibility data will be released on a beneficiary-specific basis only. If a requested beneficiary is not on file, the provider must use the usual billing procedures in effect independent of this data access. When requesting Eligibility, the following information will be required: Medicare number Surname (first 6 characters as shown on the patients Medicare card) First initial Gender Eligibility data obtained must be used only for submitting an accurate claim. Services must be rendered independent of the data in accordance with state and local laws regarding access to care. The Eligibility data provided will not represent definitive eligibility status. Medicare Eligibility information is confidential. The penalties under the Privacy Act for illegal disclosure are being found guilty of a misdemeanor and fined not more than $5,000.00. Providers who want to access Eligibility information need to complete the Electronic Eligibility Access Request Form (page 58 September/October 1996 Medicare B Update!) and return to the address shown on the form. Vendors may obtain specifications for Eligibility from the Medicare B Line Bulletin Board System (BBS) by dialing (904) 791-6691. Technical support for the BBS is available via voice mail at (904) 791-8384.

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Notification of NSF Changes Available on Medicare B BBS

The format specifications for changes to both NSF Versions 1.04 and 2.00 effective January 1, 1997, are now available on the Medicare B B-Line Bulletin Board System (BBS).

The January 1, 1997, format changes primarily impact those providers/suppliers who submit the following claim types:

Chiropractic spinal manipulation

Care plan oversight (CPO)

Nail debridement

ANSI 270/271 eligibility inquiry and response

Technical questions regarding the NSF should be directed to (904) 791-8016 or (904) 791-8769.

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Electronic Funds Transfer: Requirements to Qualify Removed!

Electronic funds transfer (EFT) is a payment option offered to all providers which allows for direct deposit of Medicare Part B payments into either a checking or savings account. This is identical to other direct deposit operations such as with paycheck deposits. You are probably now eligible to use this option! The Health Care Financing Administration recently approved the expansion of EFT to paper claim submitters. For electronic claim submitters, the 90 percent claim submission requirement has been eliminated, as has the requirement to accept the Electronic Remittance Notice (ERN). As a result, you can have your payments directly deposited into your account and still get a Provider Claims Summary.

If you decide to use this feature, there is just one step for you to take. Complete the EFT enrollment form on page XX, attached a copy of a canceled/voided check and send it in to us. We will do the rest! Questions? Call (904) 791-8767.

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Questions and Answers About EFT

Q

What is Electronic Funds Transfer?

A

EFT is a form of direct deposit which allows for the transfer of Medicare B payments directly from the carrier s bank to the provider s bank.

Q

How do I know whether my bank has the capability to accept electronic payment transfers?

A

The formats used in this process are standardized formats developed by the banking industry. Since EFT is a form of direct deposit, any bank which accepts direct deposit can accept EFT payments.

Q

What are the requirements to qualify for direct deposit (EFT) of Medicare B payments?

A

There are no requirements to utilize this feature. All providers (participating or non-participating, paper or electronic claim submitters) are eligible.

Q

How do I enroll in the direct deposit (EFT) program?

A

Complete the EFT enrollment form on page 50 and send it to:Medicare B of FloridaMedicare EDI Department -6TP.O. Box 44071Jacksonville, Florida 32231-4071ATTN: Electronic Funds Transfer

Note: The form must have original signatures; copies, facsimiles, or stamped signatures will not be accepted. To ensure validity of deposit information, please include a copy of a canceled or voided check for the bank and the account in which you want your monies to be deposited.

Q

How long after I enroll will it take to actually start receiving electronic payments?

A

Once we receive a completed enrollment form, we will make the necessary system changes to begin electronic transfer four weeks from the date of receipt. This timeframe will allow for testing of the account information provided to ensure transmissions will be accepted by both banks involved.

Q

Can I have my payments deposited into more than one account?

A

No. Payments can be deposited into either a provider s checking or savings account, but not split into both.

Q

Will the frequency of Medicare payment generation be affected by EFT?

A

No. Medicare Part B will still generate payments on a nightly basis, but the EFT process will eliminate delays caused by mailing these payments and will credit them directly to a provider s account within 24-48 hours of the check date depending on the providers bank distribution procedures.

Q

Will I still receive a paper copy of my remittance (Medicare Remittance Notice [MRN])?

A

Yes, however, you may find that the paper copy is no longer required if you are also receiving electronic remittance. To find out more about this application and how you might be able to eliminate the unnecessary receipt of paper copies of the MRN, read the attached article on electronic remittance.

Q

How do I inform Medicare B of Florida of changes in the account I want my payments deposited into or find an error in the account data I provided to you?

A

You should contact the Provider Electronic Services area at (904) 791-8767 and we will send you another EFT enrollment form. Indicate in the appropriate space on the form that this is a change in current enrollment, and complete the remainder of the form. Changes in account information will be subject to the standard four week effective date to allow for testing of this new information.

Q

I am enrolled in EFT for my private practice; however, I also perform services as a member of a PA group that is not enrolled in EFT. How will I be paid?

A

For services you perform in your private practice, you will receive payment via EFT. However, for services you perform as a member of a PA group, the group will continue to be paid directly via a paper check. The group s EFT status, not the EFT status of its members, determines how the group is paid.

Q

How do I inform Medicare B of Florida if I feel there is a problem in the transfer of funds for a particular day or time period?

A

Contact us at (904) 791-6076 and we will quickly research the situation and get back to you with a response.

Q

Who should I contact if I have other questions about the EFT program?

A

Call the Provider Electronic Services marketing department at (904) 791-8767 for answers to questions about EFT and other electronic applications which might benefit your office operation.

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Electronic Remittance Notification Saves Time

You have expressed an interest in having your Medicare B payments received via direct deposit, probably to improve the speed with which you receive your Medicare B payments. So why not receive the payment information just as fast using electronic remittance notification?

By utilizing electronic remittance notification (ERN):

payment information can be retrieved via your computer the same day as the check is generated (versus waiting for the paper Medicare Remittance Notice to arrive in the mail)

payments can also be posted automatically to your accounts receivable system, eliminating the need for manual posting and balancing

staff time devoted to posting can be used for other purposes

secondary insurance can be filed sooner

How Do I Get Electronic Remittance?

There are two requirements to receive electronic remittance:

You must be sending your Medicare B claims to us electronically since the ability to send and pick up claims information must be done utilizing a computer.

The software you are using to send claims to us electronically must also have the capability to retrieve the remittance information. The vendor from whom you purchased your software from will know if that application is available to you. Contact them if you are interested. We can make the specifications available to any interested vendor who would like to develop this application.

By using both direct deposit (EFT) and electronic remittance (ERN), you are receiving the identical information as on the paper Medicare Remittance Notice. If you find that you no longer have a need for this paper copy, notify our office and we will discontinue sending the paper copies to you. This can be done on a trial basis which will allow you to analyze whether you actually need the paper copy or not. Why not become totally paperless? Call the Provider Electronic Services area at (904) 791-8767 if you are interested in trying this option.

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Be Aware of Fraud

Billions of taxpayer dollars are lost annually to health care fraud and abuse, money which should be paid to legitimate providers and suppliers for actual services provided to keep our seniors in good health. The Medicare Fraud Branch is aggressively dealing with these issues along with the Health Care Financing Administration, the Federal Bureau of Investigation, the Office of the Inspector General, the Medicaid Fraud Control Unit, the Durable Medical Equipment Regional Carrier, and the United States Attorney s Office just to name a few. We have also joined forces with the Florida Medical Association, the Florida Hospital Association, the Florida Chiropractic Association, and many other provider and beneficiary advocacy associations. Outreach education is one of the various methods utilized to reach our physician and suppliercommunities. Stay abreast of these issues to avoid becoming a victim yourself. Please report suspected fraud and abuse, be a part of the solution rather than the problem. Remember, it is difficult to compete with someone who has more to offer illegitimately and who is actually harming our seniors in this state. Any providers who suspects fraud and abuse may call the Medicare Provider Customer Service line at (904) 634-4994, or they may write to:

Medicare Fraud Branch

P.O. Box 45087

Jacksonville, Florida 32231-0048

All reports are held in the strictest confidence, and the concerned individual will not be exposed. We at the Fraud Branch are indebted to our providers and suppliers who have identified scams in the community and reported them to us.

Providers please be advised, should any of your patients report that they may have lost or had their Medicare card/number utilized by someone else, please advise them to report this to their local Social Security Office and to the Medicare Fraud Branch.

Civil Monetary Penalties Now Applied To Limiting Charge Violations

Recent legislation changed the civil monetary penalties applicable to limiting charge violations.

The Social Security Act Amendments of 1994 state that physicians, other practitioners or suppliers are liable for charges which exceed the federal limiting charge on services to which they apply. If a physician, other practitioner, or supplier willfully, knowingly and repeatedly exceeds the limiting charge, then they are subject to sanctions.

The Health Insurance Portability and Accountability Act of 1996 amends the civil monetary provisions of Section 1128A(a) of the Social Security Act by increasing the amount of the penalty from $2,000 to $10,000 for each item or service involved. It also increases the assessment which a person may be subject to from not more than twice the amount to not more than three times the amount claimed for such item or service in lieu of damages sustained by the United States or a State agency because of such a claim. In addition, the physician, other practitioner, or supplier may still be excluded from the Medicare program for up to five years. This amendment is effective for only those services rendered on or after January 1, 1997.

Indictments

Impotence Clinics Under Investigation: An indictment was returned against a New Port Richey woman, who was the owner of one of these operations. The indictment is based upon the receipt of kickbacks in return for referring Medicare and Champus patients for diagnostic and psychiatric testing.

DPM Indictment: A federal grand jury returned a twenty count indictment against a local podiatrist, who was charged with multiple violations, such as: committing mail fraud; failing to disclose a prior federal conviction and program exclusion; falsifying a provider application; and causing payment for services for which he was ineligible for payment, secondary to the prior exclusion. Each count carries a maximum sentence of five years imprisonment, and a $250,000.00 fine.

Plea Agreements & Settlements:

The Bull Dog Medical company s owner pled guilty to fraud charges related to urinary incontinence supplies. The owner agreed to pay $2,500,000.00 in restitution to the federal government; to liquidate all assets with the proceeds to be provided to the government; and the forfeiture of the currently seized $32,000,000.00, which cannot be utilized to pay the agreed-upon restitution. The owner has also agreed to assist law enforcement agencies in other investigations.

Fletcher s Medical Supply, Inc.: A settlement was signed by the owners of this Jacksonville-based medical supply company in which the owners agreed to pay the United States a lump sum amount of $200,000.00. This settlement prohibits the U.S. Attorney s office from pursuing any further civil or criminal action for the period of time at issue in this case. This does not prohibit the U.S. Attorney from pursuing these same actions, if warranted by the company s behavior, for any other time frame not at issue in this case. Immediate notification of the DMERC Anti-Fraud Unit has taken place, to make them aware of this settlement so that they may pursue any further issues that may have arisen since this case was pursued by the Florida carrier.

Ambulance Services, Inc.: A Jacksonville ambulance company owner recently pled guilty to the filing of false claims as well as aiding and abetting the filing of false claims. The owner was altering claims for the routine transport of dialysis patients as emergency services, in an attempt to gain payment for services which would not be covered under the Medicare program. Sentencing is scheduled for February, 1997.

Sentencing/Convictions

A St Petersburg acupuncturist was sentenced to 36 months probation and ordered to make restitution of $927,636.93 to the HCFA. Another individual involved, a family member of the acupuncturist, is reported to be a fugitive. This case involved the submission of false claims for reimbursement for acupuncture.

National Medicare Fraud Alert

Please report any information about the following activities to the Medicare Fraud Branch at the phone number or address listed in the introduction of the fraud section, or to your Durable Medical Equipment Regional Carrier.

A provider has been submitting claims for hip abduction devices when it was actually providing the Hipguard , which is a protective pad unit which would not be a covered benefit under the Medicare program.

The carrier is aware of situations where there is an agreement between ESRD facilities and outside laboratories are billing separately for lab studies already paid under the ESRD composite rate. Be advised that the Florida carrier is actively pursuing this issue.

Clinical Laboratory Reminder

Be advised that laboratories in Florida must allow physicians to specify which particular tests/studies are medically necessary and ordered when the laboratory has special panels and profiles on their request forms. ONLY those laboratory studies which are medically necessary will be covered under the Medicare program, REGARDLESS of the other test results which may be a part of the panel. ALSO, laboratories must maintain the exact information which indicates the medical necessity and which tests in particular were ordered by the requesting physician.

New Trends for Dealing With Health Care Fraud In Florida

Beneficiary Flag & the Florida Guardianship Project: The Florida Medicare carrier has been in the process of placing all

beneficiaries who report that their Medicare cards are lost or stolen on a pre-payment flag. The carrier will pre-identify those providers who have rendered services to the flagged beneficiary, and will routinely deny all services not previously indicated as legitimate.

Beneficiaries who are incapable of managing their own affairs are at higher risk for being victimized. Therefore, we intend to implement a new flag process, similar in action, for those beneficiaries whose affairs are being managed by a guardian. We will identify the legitimate providers through direct contact with the beneficiary s guardian. This will lessen the instances where false and fraudulent claims could be paid.

New Medicare Fraud Information Specialist Report: the HCFA has created a new position with carrier fraud units called the Medicare Fraud Information Specialist or MFIS. A part of the role of each MFIS will be to develop, coordinate and share information related to fraud schemes, specific providers identified, etc with other carriers throughout the US. This shared information will be released, as applicable, into the provider, supplier, and beneficiary communites in each state.

Be Aware/Advised

Be advised that the carrier fraud unit has been made aware of the following issues and are researching, via data analysis, these to identify potential fraudulent and/or abusive providers:

Billing Medicare Part B for non-covered pulmonary services provided in a skilled nursing facility.

Outpatient claims for non-covered services filed on custodial care SNF residents, by utilizing an acute hospital provider number.

Billing for evaluation and management services on ESRD patients, where the services have been previously paid under the ESRD composite rate.

Billing for individual ambulance services where multiple patients are being
grouped and transported together.

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Revision to the Timely Filing Limits Related to OBRA 1993

Before the enactment of the Omnibus Budget Reconciliation Act of 1993 (OBRA), Medicare was the secondary payer for services furnished to disabled beneficiaries who had large group health plan coverage and who qualified as active individuals. OBRA abolished the concept of active individuals and made Medicare secondary payer for services furnished to disabled beneficiaries who had large group health plan coverage based on their own or a family member s current employment status. In November 1993, the Health Care Financing Administration (HCFA) established procedures which would allow for employers to elect a specific date for their group health plans.

The purpose of this date was to establish an entitlement date for beneficiaries who had not previously enrolled in Medicare Part B. Once an employer has selected an effective date, the employer must abide by that date. (All claims which have met the timely filing criteria must be submitted to Medicare for primary processing.)

All services rendered to disabled beneficiaries affected by the OBRA 1993 Disability Act must be submitted with the expiration date of the timely filing limits. Claims and reviews submitted for the following situations will be denied payment:

The beneficiary was eligible for Medicare at the time the services were rendered, but chose not to enroll.

The beneficiary elected a special enrollment period pursuant to the transition rules.

If you have any questions or review requests related to OBRA 1993, please send them to the following address:

Medicare Secondary Payer Unit

OBRA 93 Disability
P.O. Box 44078
Jacksonville, FL 32231-4078

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Reminder to Anesthesiologists: Bill Correctly

Medicare has received a number of claims from anesthesiologists where a surgical code has been billed. Using the surgical codes will cause delays in the payment of your claim, as well as reviews and requests for additional information. Anesthesiologists should bill the appropriate anesthesia code (procedure codes 00100-01999) from the 1997 CPT book.

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

Period	Interest Rate
October 4, 1994 to January 5, 1995	13.375%
January 6, 1995 to April 3, 1995	13.625%
April 4, 1995 to July 10, 1995	14.125%
July 11, 1995 to October 23, 1995	14.000%
October 24, 1995 to January 29, 1996	13.875%
January 30, 1996 to April 29, 1996	13.75%
April 30, 1996 to July 18, 1996	13.625%
July 19, 1996 to October 23, 1996	13.50%
October 24, 1996 to present	13.375%

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Medicare Introduces a New Look to Beneficiaries Benefits Notice

Medicare beneficiaries will see a change in the look of their statements beginning January 1, 1997. These changes will affect both the Part B Explanation of Medicare Benefits (EOMB) statements and the Part A Medicare Benefits Notice.

The new Medicare Summary Notice (MSN) will replace the current notices. The MSN will be a customer-friendly, easy to read, summarized notice.

A brochure has been designed to help beneficiaries understand the new MSN. Called How to Read Your Medicare Summary Notice, it will accompany every MSN mailed between January 1, 1997, and January 31, 1997.

Providers who would like to receive a supply of the brochures for their office may call Provider Customer Service at (904) 634-4994.

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Sanctioned and Reinstated Provider Lists

The Office of the Inspector General (OIG) has notified Medicare that individuals/entities identified in this article are excluded from reimbursement under Medicare (title XVIII of the Social Security Act). In addition to identifying information pertaining to the sanctioned party, the list shows the specialty, notice date, sanction period, and reason for sanction being imposed, or

the sections of the Social Security Act used in arriving at the determination to impose a sanction. The sections of the Act used to impose the sanction are defined. In addition, individuals/entities reinstated under Medicare are identified. The provisions of exclusion are:

Denial of Payment to an Excluded Party

(1) Medicare payment will not be made to an excluded party (who has accepted assignment or for the beneficiary s claim) for items and services furnished on or after the effective date of the sanction.

(2) An assignment of a beneficiary s claim that is made to an individual or supplier on or after the effective date of the sanction is not valid.

Denial of Payment to a supplier

(1) Medicare payment will not be made to a supplier (e.g., durable medical equipment supplier or laboratory) that is wholly owned by an excluded party for items and services furnished on or after the effective date of the sanction if the supplier has accepted assignment for the beneficiary s claim.

(2) An assignment of a beneficiary s claim that is made on or after the effective date of the sanction to a supplier that is wholly owned by an excluded party is not valid.

Denial of Payment to a Provider of Service

(1) Medicare payment will not be made to a provider for services performed or items received, including services performed under contract, by an excluded party or by a supplier which is wholly owned by an excluded party on or after the effective date of the sanction.

Denial of Payment to Beneficiaries

If a beneficiary submits claims for items or services furnished by an excluded party or by a supplier which is wholly owned by an excluded party, on or after the effective date of the sanction:

(1) Medicare payment may be made for the first claim submitted by the beneficiary and the Medicare program will immediately give the beneficiary notice of the sanction; and

(2) The Medicare program will not pay the beneficiary for items of services furnished more that 15 days after the date on the notice to the beneficiary.

Exceptions: Payment is available for services or items provided up to 30 days after the effective date of the sanction for:

(1) Inpatient hospital services or post hospital skilled nursing facility services or items furnished to a beneficiary who was admitted to a hospital or skilled nursing facility before the effective date of the sanction; and

(2) Home health services or items furnished under a plan of treatment established before the effective date of the sanction.

The Medicare and Medicaid Patient and Program Protection Act of 1987" (P.L. 100-93) does permit payment for an emergency item or service furnished by an excluded individual or entity.

At the conclusion of the designated period of sanction, an individual and/or entity may be eligible for reinstatement to the Medicare program. The sanction, which has national effect, is in addition to any sanction an individual state may impose under the authority of state law.

SECTIONS OF SOCIAL SECURITY ACT UNDER WHICH SANCTIONS WERE IMPOSED

Section Definition

1128(a)(1) Program-related conviction

1128(a)(2) Conviction for patient abuse or neglect

1128(b)(1) Conviction relating to fraud

1128(b)(2) Conviction relating to obstruction of an investigation

1128(b)(3) Conviction relating to controlled substances

1128(b)(4) License revocation or suspension

1128(b)(5) Suspension or exclusion under a Federal or State healthcare program

1128(b)(6) [Formerly 11862(d)(1)(B) and (C)] Excessive claims or furnishings of unnecessary to substandard items or services

1128(b)(7) Fraud, kickbacks and other prohibited activities

1128(b)(8) Formerly 118(b)] Entities owned or controlled by a sanctioned individual

1128(b)(9) Failure to disclose required information

1128(b)(10) Failure to supply requested information on subcontractors and suppliers

1128(b)(11) Failure to provide payment information

1128(b)(12) Failure to grant immediate access

1128(b)(13) Failure to take corrective action

1128(b)(14) Default on health education loan or scholarship obligations

1128Aa [Formerly 1128(c)] Imposition of a civil money penalty or assessment

1156(b) [Formerly 1160] Peer Review Organization (PRO) recommendation

Daumy, Ileana DME/General
DATE OF BIRTH: 10/3/59
3130 S W 76 Avenue Miami, FL 33155
TYPE OF ACTION: 1128(a)(1)
DATE OF NOTICE: 11/17/96
TERM/SANCTION: 10 YRS

Lanza, Ramon DME/General
DATE OF BIRTH: 12/21/47
101 NW 59TH ST, #47278-004Miami, FL 33127
TYPE OF ACTION: 1128(a)(1)
DATE OF NOTICE: 11/17/96
TERM/SANCTION: 15 YRS

Mateus, Luise DME/General
DATE OF BIRTH: 4/27/38
1300 W 37TH Street Hialeah, FL 33012
TYPE OF ACTION: 1128(a)(1)
DATE OF NOTICE: 11/17/96
TERM/SANCTION: 10 YRS

Mompo, Vicente Family Physician/General Practice
DATE OF BIRTH: 8/8/17
1653 S W 17TH Street Miami, FL 33145
TYPE OF ACTION: 1128(a)(1)
DATE OF NOTICE: 11/17/96
TERM/SANCTION: 10 YRS

Ouimette, Ray Jr Business Manager
DATE OF BIRTH: 11/16/45
6413 Walton Way Tampa, FL 33610
TYPE OF ACTION: 1128(b)(1)
DATE OF NOTICE: 10/31/96
TERM/SANCTION: 3 YRS

Padron, JohnFamily Physician/General Practice
DATE OF BIRTH: 12/27/51
85 Grand Canal Dr, Suite 107 Miami, FL 33144-2566
TYPE OF ACTION: 1128(a)(1)
DATE OF NOTICE: 11/17/96
TERM/SANCTION: 10 YRS

Perez-Miranda, Azucena Private Citizen

DATE OF BIRTH: 7/16/53
3186 West 71 Place Hialeah, FL 33016
TYPE OF ACTION: 1128(a)(1)
DATE OF NOTICE: 10/31/96
TERM/SANCTION: 10 YRS

Soberon, Gladys Employee (Non-Gov t)
DATE OF BIRTH: 7/14/32
1740 S W 87TH Avenue Miami, FL 33165
TYPE OF ACTION: 1128(a)(1)
DATE OF NOTICE: 10/31/96
TERM/SANCTION: 3 YRS

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Attendance at Educational Seminars NOT Required

Medicare Part B of Florida has been made aware of cases where office staff have been instructed that attendance at educational seminars is required to maintain Medicare certification. While there are several outside entities that conduct seminars on the Medicare program, attendance is NOT REQUIRED to maintain your status as a Medicare provider. This also applies to the specialty and Medifest sessions offered by Medicare Part B. While we encourage providers to attend any educational session they feel best meets their needs, there is not requirement to participate in any of these sessions. As the saying goes, Let the buyer beware.

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end of file