July/August 1997 Medicare Part B Update! Publication
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HCFA
Health Care Financing Administration
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FIRST COAST SERVICE OPTIONS, INC.
A HCFA Contracted Carrier and Intermediary
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## CLIA Requirements for Physician Office Lab Services

Beginning July 1, 1997, the Health Care Financing Administration (HCFA) has advised Medicare carriers to begin denying claims for diagnostic clinical laboratory tests performed in physician office laboratories if a physician office laboratory has an expired CLIA certification or a laboratory bills for tests which are not approved for the laboratory's current CLIA certificate. Presently these situations result in claim alerts to the Medicare carriers who will work with the laboratory to correct the problem. This change, which is in keeping with CLIA requirements, will automatically deny claims which presently are subject to an alert. This means that all laboratories participating in Medicare must have current, appropriate CLIA certificates and may perform only those tests which are covered by the certificate. Presently, independent laboratories and other providers have their claims denied if they fail those two criteria of certification.

Physicians who might have inadvertently let their CLIA certificates lapse, or have questions regarding their CLIA certification must contact the Agency for Health Care Administration at the following address:

Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

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## G0095-G0098: New Temporary Lab Panel Codes Will Not Be Implemented

Because of the extensive changes needed to Medicare's processing system to accept the temporary lab panel codes (G0095-G0098)

described on the cover of the May/June 1997 issue of the Medicare B Update!, it has been decided not to implement them. As a result, providers should not bill the temporary codes (G0095-G0098). If these codes are billed, they will be rejected as invalid. Permanent codes for lab panels will be defined at a later date for use in 1998.

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What's New

Changes in HPSA Classification for Lee, Jefferson, Sumter, and Putnam Counties

Effective for services rendered on or after June 1, 1997, census tracts 5.01-5.02 and 6 in the Dunbar area of Lee county are eligible for Health Professional Shortage Area (HPSA) incentive payments. Services rendered in these census tracts may be billed with the QU (Urban HPSA) modifier.

Effective for services rendered on or after May 1, 1997, Jefferson and Sumter counties are no longer HPSAs. Effective for services rendered on or after August 1, 1997, Putnam county is no longer a HPSA. Incentive payments will not be made for services rendered in Jefferson, Sumter, or Putnam counties after the effective dates noted.

New Beneficiary Education Course at Medifest

Medifest now includes a new course on how to address questions posed by patients regarding their health insurance questions. See page 6 for more information.

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For Physicians

A Closer Look

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A Physician's Focus

Payment for Diagnostic Tests and Related Consultations

Diagnostic tests such as x-rays, clinical laboratory tests, and electrocardiograms are covered by Medicare Part B when they are ordered by a physician and considered to be medically necessary for the treatment of a patient's illness or injury (or symptom or complaint). To determine whether medical necessity for a diagnostic test exists, the patient's diagnosis reported on the claim is reviewed to ensure that condition warrants the specific test being performed. Medical necessity requirements for diagnostic tests can be found in Update! publications or in the Medical Policy section of our B LINE bulletin board system (BBS).

In certain situations, the results of diagnostic tests may require the input of a second physician to determine the best method of treatment for the patient. A clinical pathology consultation is a request from the patient's attending physician for assistance in interpreting the results of diagnostic tests and advice on the proper plan of care based on these results and the patient's condition. The consultation must require the pathologist's medical judgment. A written report, which is furnished to the attending physician, must be included in the patient's permanent medical record. Claims for consultations filed to Medicare Part B must contain the diagnosis which led to the request for the consultation. Please note that the ordering of a consultation by the patient's attending physician in and of itself does not establish medical necessity for the service.

Regardless of who orders or performs the test or consultation, the entity who submits the claim to and is paid for the service by Medicare Part B is responsible for providing documentation that demonstrates the medical necessity for that test. Providers of diagnostic tests (clinical laboratories, independent physiological laboratories, portable x-ray suppliers, etc.) should make arrangements with the ordering physician to ensure

they can obtain copies of the information necessary to establish medical necessity for the tests ordered. As the provider of the test, you are required to maintain documentation related to the medical necessity for the services provided. Requesting this information from the ordering physician does not violate the patient's right to privacy; by enrolling as a Medicare beneficiary, patients authorize the release of information needed to substantiate medical necessity for services rendered. If documentation is required for a given test, Medicare Part B will request this information from the entity who billed the test - NOT the physician who ordered the test. Your payments may be delayed or denied if this information is not provided.

I hope this information helps clarify the guidelines for payment of diagnostic tests and clinical pathology consultations and the need for providers of such tests to have access to documentation related to the medical necessity for those services. Remember, the entity who bills the service to Medicare Part B for payment is ultimately responsible to provide any information needed to facilitate processing of the claim.

Sincerely,

Sidney Sewell, M.D.

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Advance Notice Requirement

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

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

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

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

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

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

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

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

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

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

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

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General Information About the Medicare B Update!

Articles included in each Update! represent formal notice that specific coverage policies either have or will take effect on the date given. Providers who receive each issue are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines. Medicare Part B of Florida maintains copies of the mailing lists for each issue, and inclusion on these mailing lists implies that the issue was received by the provider in the event there is a dispute over whether a provider received advance notice regarding coverage of a specific service and the financial liability for it.

The Coverage/Reimbursement section includes information on general and specific Part B coverage guidelines. A General Information section includes the latest information on topics which apply to all providers such as limiting charge, correct coding initiative, etc. The remainder of this section includes information for specific procedure codes and is structured in the

same format as the Physician's CPT book (i.e., in procedure code order) using the following categories: HCPCS Codes (A0000-Z9999), Anesthesia/Surgery (00100-69999), Diagnostic Tests (70000-89999), and Medicine (90000-99999).

Distribution of the Update! is limited to individual providers and PA groups who bill at least one claim to Medicare Part B of Florida for processing during the six months prior to the release of each issue. Providers who meet this criteria are sent one complimentary copy of that issue. Production, distribution, and postage costs prohibit us from distributing a copy of each issue to each provider's practice settings. This primarily affects members of PA groups; one copy of each issue is sent to the group. The group is responsible for dissemination of each copy to its members. If additional copies are needed, there are two options: purchase a separate annual subscription for $125 (order form on page 54), or download the text version from our on-line service, the B LINE BBS (see page 55 for more information).

Medicare Part B of Florida uses the same mailing address for all correspondence, and cannot designate that each issue of the Update! be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, a Change of Address form must be completed in the event of relocation. See page 53 for a copy of this form.

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General Information

Coverage Guidelines for Limited CLIA Certificates

Under the Clinical Laboratory Improvement Amendments (CLIA) of 1988, all providers of clinical laboratory, nuclear medicine and arterial blood gas procedures require certification under the CLIA program to receive Part B payment for these services. Providers may either obtain a certificate to cover all services subject to CLIA regulations or one which limits the holder to coverage for specific laboratory tests. Claims for laboratory services submitted to Medicare Part B should accurately reflect only those services authorized by the provider's certificate. Two types of certificates (Waiver and Physician Performed Microscopy Procedures [PPMP]) limit holders to only certain test procedures. The tests that may be performed by holders of each certificate are outlined below.

Tests Granted Waived Status Under CLIA (Revised 4/23/97)

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 component 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 discontinued 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): 82465QW 83718QW 84478QW 82947QW 80061QW
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

TEST NAME: Binax NOW Strep A Test
MANUFACTURER: Binax
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: Delta West CLOtest
MANUFACTURER: Delta West Tri-Med Specialties
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: *Wampole STAT-CRIT Hct
MANUFACTURER: Wampole Laboratories
CPT-CODE(S): Pending information from the manufacturer
USE: Pending information from the manufacturer

TEST NAME: *SmithKline Diagnostics FlexSure HP Test for IgG Antibodies to H. pylori in Whole Blood
MANUFACTURER: SmithKline Diagnostics, Inc.
CPT-CODE(S): 86318QW
USE: Immunoassay for rapid, qualitative detection of IgG antibodies specific to Helicobacter pylori in whole blood

TEST NAME: *Wyntek Diagnostics OSOM Strep A Test
MANUFACTURER: Wyntek Diagnostics,
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: *GI Supply HP-FAST
MANUFACTURER: Mycoscience Labs, Inc.
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: *Abbott FlexPak HP Test for whole blood
MANUFACTURER:  Abbott Laboratories
CPT-CODE(S): 86318QW
USE:Immunoassay for rapid, qualitative detection of IgG antibodies specific to Helicobacter pylori in whole blood

* Newly-added waived test system

** Newly-added CPT code for waived test system

Physician Performed Microscopy Procedures (PPMP)

Holders of PPMP certificates are authorized to perform all of the procedures covered under the Waiver certificate, in addition to the following tests:

81000 Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; with microscopy.

81015 Urinalysis; microscopic only

89190 Nasal smear for granulocytes

G0026 Fecal leukocyte examination

G0027 Semen analysis; presence and/or motility of sperm excluding Huhner test

Q0111 Wet mount, including preparations of vaginal, cervical or skin specimens

Q0112 All potassium hydroxide (KOH) preparations

Q0113 Pinworm examinations

Q0114 Fern test

Q0115 Post-coital direct, qualitative examinations of vaginal or cervical mucous

Providers who wish to obtain CLIA certification should contact the Health Care Financing Administration at (404) 331-0083 or write to:

HCFA CLIA Program
PO Box 26689
Baltimore, MD 21307-0489

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## Ordering a National Correct Coding Policy Manual

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

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

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

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

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

## Individual Chapters of the Correct Coding Manual

A one-time individual chapter of the correct coding manual may be purchased at $40.00 plus handling for each chapter or a one year subscription (updated quarterly) for one chapter may be purchased for $160.00. Listed below are the individual chapters that are available for purchase.

| CHAP | DESCRIPTION | ORDER# |
|---|---|---|
| 2 | Anesthesia Services (00000-09999) | PB97-990202LOV |
| 3 | Surgery: Integumentary System (10000-19999) | PB97-990302LOV |
| 4 | Surgery: Musculoskeletal System (20000-29999) | PB97-990402LOV |
| 5 | Surgery: Respiratory, Cardiovascular, Hemic, and Lymphatic System (30000-39999) | PB97-990502LOV |
| 6 | Surgery: Digestive System (40000-49999) | PB97-990602LOV |
| 7 | Surgery: Urinary, Male & Female Genital, Maternity Care, and Delivery System (50000-59999) | PB97-990702LOV |
| 8 | Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, Auditory System (60000-69999) | PB97-990802LOV |
| 9 | Radiology Services (70000-79999) | PB97-990902LOV |
| 10 | Pathology and Laboratory Services (80000-89999) | PB97-991002LOV |
| 11 | Medicine, Evaluation, and Management Services (90000-99999) | PB97-991102LOV |

## Questions and Answers Regarding the Correct Coding Initiative Manual

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

A The benefit is that by using the most recent manual can you be sure of receiving full and appropriate reimbursement for the medical services you provide. A completely new manual is produced quarterly because code changes from version to version are so extensive that to "pen and ink" those changes would be too laborious to users.

Q How often will the manual be updated in 1997?

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

If filing claims in 1997 from... Then...
July 1 to Sept. 30 you should use the 3rd edition, Version 3.2 (to be released 6/1/97)
Oct. 1 to Dec. 31 you should use the 4th edition, Version 3.3 (tentatively available 9/1/97)

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Correct Coding Modifiers

Procedure code modifier 59 (Distinct procedural service) should be used only for those procedures listed in the correct coding relationships which are otherwise distinct and separately identifiable from the comprehensive procedure and for which there is no other modifier which can be used to identify the service as distinct and separate.

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

| Modifier | Description |
|---|---|
| E1-E4 | eyelids |
| F1-F9 | fingers |
| FA | left hand thumb |
| TA | left foot great toe |
| T1-T9 | toes |
| LT | left side of body |
| RT | right side of body |

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

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

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

LC left circumflex coronary artery

LD left anterior descending coronary artery

RC right coronary artery

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

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Retraction of Revised Q1 Modifier Description

Page 50 of the March/April 1997 Medicare B Update! featured revised language for procedure code modifier Q1 effective May 1, 1997.

Until further notice the following Q1 modifier description will remain in effect:

Documentation on file for ambulatory or nonambulatory patients that indicates mycosis/dystrophy of the toenail causing secondary infection and/or pain which results or would result in marked limitation of ambulation and require the professional skills of a provider.

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Covered Diagnosis Codes for Post-Operative Immunosuppressive Therapy

The following list includes all the diagnosis codes to be used when the transplant surgeon bills an evaluation and management (E/M) service for immunosuppressive therapy provided during the global surgical post-operative period.

If an E/M service for immunosuppressive therapy is provided during the global surgical post-operative period, add a 24

modifier (unrelated E/M service by the same physician during a postoperative period) to the procedure code and use one of the following ICD-9 diagnosis codes:

V420 Organ or tissue replaced by transplant, kidney

V421 Organ or tissue replaced by transplant, heart

V422 Organ or tissue replaced by transplant, heart valve

V423 Organ or tissue replaced by transplant, skin

V424 Organ or tissue replaced by transplant, bone

V425 Organ or tissue replaced by transplant, cornea

V426 Organ or tissue replaced by transplant, lung

V427 Organ or tissue replaced by transplant, liver

Electronic Filing

Providers are encouraged to file electronically any claims for E/M services for immunosuppressive therapy provided by the surgeon during the global period.

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Important Information about Utilization Parameters

Medicare Part B of Florida will no longer indicate which procedures are subject to utilization parameters. We will continue to publish information related to the type of information or documentation needed to establish medical necessity for each procedure. This information will need to be provided when the total number of services provided to the patient exceeds the accepted standards of medical practice for that procedure.

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HCPCS Codes

Documentation for Radiopharmaceuticals Not Otherwise Classified

When procedure codes A4641(Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified) or 79900 (Provision of therapeutic radiopharmaceutical[s]) are billed, certain information must be supplied.

Providers may check the August 1995 Medicare Part B Special Update: Pricing Changes for Radionuclide Materials to see if pricing has been established by the carrier.

If a Price has not Been Established

If a price has not been established, submit a paper claim with the following information so Medicare Part B may determine the appropriate allowance:

the name of the product,

a copy of the dated invoice with the product identified ,

the number of millicuries (mCi) or microcuries (uCi) provided to the patient, and

the charge to Medicare Part B.

If an invoice is submitted, it should not be dated more than 45 days prior to the patient's test.

Your charge to Medicare Part B should not be more than your acquisition cost.

If a Price has Been Established

If a price has been established, supply the following information in block 19 of the HCFA-1500 claim form:

the name of the product, and

the number of millicuries (mCi) or microcuries (uCi) provided to the patient.

For electronic claims, enter the information in the appropriate HA0 record. One record must be used for each "not otherwise classified" code.

Coverage for Radiopharmaceuticals

Payment for all radiopharmaceuticals is allowed only in addition to covered nuclear medicine procedures (procedure codes 78000 through 78999).

Note: Copies of all radiopharmaceutical invoices should be retained in your office in case of a review.

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Billing for Acupuncture

The March/April 1997 issue of the Medicare B Update! featured an article (p. 25) that stated acupuncture treatments are not covered by Medicare Part B. If a provider does submit a claim for acupuncture to Medicare, he/she should use one of the following procedure codes:

A9170 Non-covered service by chiropractor.

A9270 Non-covered service.

Advance Notice Requirement

Applies to the procedure's investigational status (see p. 4).

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Antigens Prepared for Sublingual Administration

Page 47 of the March/April 1997 Medicare B Update! indicated that antigens prepared for sublingual administration is not covered by Medicare Part B because such treatment has not been proven to be safe and effective. When billing claims for this service, providers are asked to report this service using procedure code A9270 (noncovered service or item).

Advance Notice Requirement

Applies as this type of therapy has not been proven to be safe and effective (see p. 4).

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Coverage of Indirect Calorimetry as a Respiratory Service

A chain of rehabilitation hospitals that provides respiratory therapy services to skilled nursing facilities across the country is attempting to bill indirect calorimetry as a respiratory therapy service. This chain is promoting the use of indirect calorimetry as an aid for proper nutritional assessment.

Respiratory therapy is defined in Section 230.10 of the Medicare Skilled Nursing Facility Manual as those services that are prescribed by the attending physician, to assess, treat, manage, and monitor patients with deficiencies and abnormalities of cardiopulmonary function. The use of indirect calorimetry is not a covered respiratory therapy service when used to assess nutritional status.

In addition, Medicare normally does not cover screening procedures for asymptomatic patients, based on Medicare law found in Section 1862(a)(1)(A) of the Social Security Act (the Act). This section generally permits coverage only for those services that are considered reasonable and necessary for diagnosing or

treating an illness, injury, or other impairment that has already manifested itself. The only exceptions under existing law with regard to screening procedures are those specifically authorized by the law itself, such as screening mammographiesand pap smears (see Section 1862(a)(1)(F) of the Act). Therefore, claims forindirect calorimetry used to assess nutritional status as a respiratory therapy should be billed with procedure code A9270 (noncovered service or item).

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Jurisdiction for DME, Prosthetics, Orthotics and Supplies

A comprehensive listing outlining the claims jurisdiction for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) was published on page 28 of the January/February 1997 Medicare B Update! Since that publication, the following jurisdiction determinations have been made. These jurisdiction determinations are effective for claims with service dates on or after January 1, 1997, with the exception of procedure codes E1700-E1702. Claims for procedure code E1700-E1702 received on or after June 30, 1997, will be processed by the local carrier.

Required documentation for procedure codes E1700-E1702 is a history and physicial and office progress notes to show the medical necessity. In addition, a complete description of the service must be provided.

The following table outlines the revised claims jurisdiction for certain 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 submitted to the DME Regional Carrier (Palmetto GBA)

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

Procedure Code(s): A6020
Description: Surgical Dressing
Jurisdiction: Joint: Local Carrier if incident to a physician s service (not separately payable); if other, DMERC

Procedure Code(s): E1700-E1702
Description: TMJ Device and Supplies
Jurisdiction: Local Carrier

Procedure Code(s): J7310
Description: Ganciclouir (Vitrasert)

Jurisdiction: Joint:  Local Carrier if incident to a physician s service (not separately payable);  if other, DMERC

Procedure Code(s): J7500-J7599
Description: Immunosuppressive Drugs
Jurisdiction: Joint:  Local Carrier if incident to a physician s service (not separately payable);  if other, DMERC

Procedure code(s):J7610-J7699
Description: Inhalation Solutions
Jurisdiction: Joint:  Local Carrier if incident to a physician s service (not separately payable);  if other, DMERC

Procedure Code(s):K0277-K0281
Description: Ostomy and Urological Supplies
Jurisdiction: Joint:  Local Carrier if incident to a physician s service (not separately payable);  if other, DMERC

Procedure Code(s): K0418
Description: Cyclosporin
Jurisdiction: Joint:  Local Carrier if incident to a physician s service (not separately payable);  if other, DMERC

Procedure Code(s): K0419-K0439
Description: Ostomy Supplies
Jurisdiction: Joint:  Local Carrier if incident to a physician s service (not separately payable);  if other, DMERC

Procedure Code(s): L7520
Description:  Repair of Prosthetic Device
Jurisdiction: Joint:  Local Carrier if incident to a physician s service (not separately payable);  if other, DMERC

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G0050: Coding Guidelines for Bladder Scans

Analysis of medical record documentation indicates that some providers are performing bladder scans and incorrectly billing procedure codes 76700, 76705 (Echography, abdominal, B-scan and/or real time with image documentation) or 76857 (Echography, pelvic B-scan and/or real time with image documentation; limited or follow-up) . A bladder scan should be reported with procedure code G0050 (Measurement of post-voiding residual urine and/or bladder capacity by ultrasound).

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Revised Fees for Injectable Drugs

Reimbursement amounts for most drugs are updated quarterly, except for chemotherapy drugs, which are updated as needed. Payment for drugs is made at the median of the average wholesale

price (AWP) for generic drugs, which is based on the Drug Topics Red Book.

The medians of the AWPs have changed for the following injectable drugs effective for claims processed April 21, 1997 and after. Their revised fees are listed as follows:

Note: Procedure codes that are designated as "N.C." are non-covered for Medicare Part B.

Procedure Code: J0270 4/21/97 Maximum Med B Par Allowance: N.C.
4/21/97 Maximum Med B Non-Par Allowance: N.C.
Maximum Limiting Charge: N.C.

Procedure Code: J0295 4/21/97 Maximum Med B Par Allowance: 7.47
4/21/97 Maximum Med B Non-Par Allowance: 7.10
Maximum Limiting Charge: 8.17

Procedure Code: J0300 4/21/97 Maximum Med B Par Allowance: 2.33
4/21/97 Maximum Med B Non-Par Allowance: 2.21
Maximum Limiting Charge: 2.54

Procedure Code: J0390 4/21/97 Maximum Med B Par Allowance: 15.32
4/21/97 Maximum Med B Non-Par Allowance: 14.55
Maximum Limiting Charge: 16.73

Procedure Code: J0515 4/21/97 Maximum Med B Par Allowance: 3.70
4/21/97 Maximum Med B Non-Par Allowance: 3.52
Maximum Limiting Charge: 4.05

Procedure Code: J0585 4/21/97 Maximum Med B Par Allowance: 4.19
4/21/97 Maximum Med B Non-Par Allowance: 3.98
Maximum Limiting Charge: 4.58

Procedure Code: J0620 4/21/97 Maximum Med B Par Allowance: 3.35
4/21/97 Maximum Med B Non-Par Allowance: 3.18
Maximum Limiting Charge: 3.66

Procedure Code: J0696 4/21/97 Maximum Med B Par Allowance: 12.35
4/21/97 Maximum Med B Non-Par Allowance: 11.73
Maximum Limiting Charge: 13.49

Procedure Code: J0702 4/21/97 Maximum Med B Par Allowance: 4.45
4/21/97 Maximum Med B Non-Par Allowance: 4.23
Maximum Limiting Charge: 4.86

Procedure Code: J0725 4/21/97 Maximum Med B Par Allowance: 3.50

4/21/97 Maximum Med B Non-Par Allowance: 3.33
Maximum Limiting Charge: 3.83

Procedure Code: J0900 4/21/97 Maximum Med B Par Allowance: 1.74
4/21/97 Maximum Med B Non-Par Allowance: 1.65
Maximum Limiting Charge: 1.90

Procedure Code: J0970 4/21/97 Maximum Med B Par Allowance: 1.49
4/21/97 Maximum Med B Non-Par Allowance: 1.42
Maximum Limiting Charge: 1.63

Procedure Code: J1000 4/21/97 Maximum Med B Par Allowance: 3.27
4/21/97 Maximum Med B Non-Par Allowance: 3.11
Maximum Limiting Charge: 3.58

Procedure Code: J1030 4/21/97 Maximum Med B Par Allowance: 2.12
4/21/97 Maximum Med B Non-Par Allowance: 2.01
Maximum Limiting Charge: 2.31

Procedure Code: J1050 4/21/97 Maximum Med B Par Allowance: 10.13
4/21/97 Maximum Med B Non-Par Allowance: 9.62
Maximum Limiting Charge: 11.06

Procedure Code: J1080 4/21/97 Maximum Med B Par Allowance: 2.16
4/21/97 Maximum Med B Non-Par Allowance: 2.05
Maximum Limiting Charge: 2.36

Procedure Code: J1110 4/21/97 Maximum Med B Par Allowance: 11.83
4/21/97 Maximum Med B Non-Par Allowance: 11.24
Maximum Limiting Charge: 12.93

Procedure Code: J1160 4/21/97 Maximum Med B Par Allowance: 2.46
4/21/97 Maximum Med B Non-Par Allowance: 2.34
Maximum Limiting Charge: 2.69

Procedure Code: J1180 4/21/97 Maximum Med B Par Allowance: 4.84
4/21/97 Maximum Med B Non-Par Allowance: 4.60
Maximum Limiting Charge: 5.29

Procedure Code: J1190 4/21/97 Maximum Med B Par Allowance: 141.10
4/21/97 Maximum Med B Non-Par Allowance: 134.05
Maximum Limiting Charge: 154.16

Procedure Code: J1362 4/21/97 Maximum Med B Par Allowance: 6.27
4/21/97 Maximum Med B Non-Par Allowance: 5.96
Maximum Limiting Charge: 6.85

Procedure Code: J1390 4/21/97 Maximum Med B Par Allowance: 1.63
4/21/97 Maximum Med B Non-Par Allowance: 1.55
Maximum Limiting Charge: 1.78

Procedure Code: J1440 4/21/97 Maximum Med B Par Allowance: 161.30

4/21/97 Maximum Med B Non-Par Allowance: 153.24
Maximum Limiting Charge: 176.23

Procedure Code: J1441 4/21/97 Maximum Med B Par Allowance: 256.90
4/21/97 Maximum Med B Non-Par Allowance: 244.06
Maximum Limiting Charge: 280.67

Procedure Code: J1580 4/21/97 Maximum Med B Par Allowance: 3.13
4/21/97 Maximum Med B Non-Par Allowance: 2.97
Maximum Limiting Charge: 3.42

Procedure Code: J1630 4/21/97 Maximum Med B Par Allowance: 6.30
4/21/97 Maximum Med B Non-Par Allowance: 5.99
Maximum Limiting Charge: 6.89

Procedure Code: J1650 4/21/97 Maximum Med B Par Allowance: 16.80
4/21/97 Maximum Med B Non-Par Allowance: 15.96
Maximum Limiting Charge: 18.35

Procedure Code: J1730 4/21/97 Maximum Med B Par Allowance: 102.89
4/21/97 Maximum Med B Non-Par Allowance: 97.75
Maximum Limiting Charge: 112.41

Procedure Code: J1741 4/21/97 Maximum Med B Par Allowance: 3.15
4/21/97 Maximum Med B Non-Par Allowance: 2.99
Maximum Limiting Charge: 3.44

Procedure Code: J1790 4/21/97 Maximum Med B Par Allowance: 3.84
4/21/97 Maximum Med B Non-Par Allowance: 3.65
Maximum Limiting Charge: 4.20

Procedure Code: J1810 4/21/97 Maximum Med B Par Allowance: 8.67
4/21/97 Maximum Med B Non-Par Allowance: 8.24
Maximum Limiting Charge: 9.48

Procedure Code: J1820 4/21/97 Maximum Med B Par Allowance: 1.98
4/21/97 Maximum Med B Non-Par Allowance: 1.88
Maximum Limiting Charge: 2.16

Procedure Code: J1910 4/21/97 Maximum Med B Par Allowance: 12.08
4/21/97 Maximum Med B Non-Par Allowance: 11.48
Maximum Limiting Charge: 13.20

Procedure Code: J1940 4/21/97 Maximum Med B Par Allowance: 1.00
4/21/97 Maximum Med B Non-Par Allowance: 0.95
Maximum Limiting Charge: 1.09

Procedure Code: J1980 4/21/97 Maximum Med B Par Allowance: 4.40
4/21/97 Maximum Med B Non-Par Allowance: 4.18
Maximum Limiting Charge: 4.81

Procedure Code: J2010 4/21/97 Maximum Med B Par Allowance: 1.76
4/21/97 Maximum Med B Non-Par Allowance: 1.67

Maximum Limiting Charge: 1.92

Procedure Code:  J2175 4/21/97 Maximum Med B Par Allowance: 1.02
4/21/97 Maximum Med B Non-Par Allowance:  0.97
Maximum Limiting Charge: 1.12

Procedure Code:  J2210 4/21/97 Maximum Med B Par Allowance: 3.17
4/21/97 Maximum Med B Non-Par Allowance:  3.01
Maximum Limiting Charge: 3.46

Procedure Code:  J2240   4/21/97 Maximum Med B Par Allowance:
1.35
4/21/97 Maximum Med B Non-Par Allowance:  1.28
Maximum Limiting Charge: 1.47

Procedure Code:  J2321  4/21/97 Maximum Med B Par Allowance: 5.99
4/21/97 Maximum Med B Non-Par Allowance:  5.69
Maximum Limiting Charge: 6.54

Procedure Code:  J2322 4/21/97 Maximum Med B Par Allowance: 11.31
4/21/97 Maximum Med B Non-Par Allowance:  10.74
Maximum Limiting Charge: 12.35

Procedure Code:  J2360  4/21/97 Maximum Med B Par Allowance: 2.38
4/21/97 Maximum Med B Non-Par Allowance:  2.26
Maximum Limiting Charge: 2.60

Procedure Code:  J2430 4/21/97 Maximum Med B Par Allowance:
199.28
4/21/97 Maximum Med B Non-Par Allowance:  189.32
Maximum Limiting Charge: 217.72

Procedure Code:  J2515 4/21/97 Maximum Med B Par Allowance: 1.32
4/21/97 Maximum Med B Non-Par Allowance:  1.25
Maximum Limiting Charge: 1.44

Procedure Code:  J2550  4/21/97 Maximum Med B Par Allowance: 1.11
4/21/97 Maximum Med B Non-Par Allowance:  1.05
Maximum Limiting Charge: 1.21

Procedure Code:  J2560  4/21/97 Maximum Med B Par Allowance: 4.99
4/21/97 Maximum Med B Non-Par Allowance:  4.74
Maximum Limiting Charge: 5.45

Procedure Code:  J2675 4/21/97 Maximum Med B Par Allowance:  1.77
4/21/97 Maximum Med B Non-Par Allowance:  1.68
Maximum Limiting Charge: 1.93

Procedure Code:  J2765 4/21/97 Maximum Med B Par Allowance: 2.40
4/21/97 Maximum Med B Non-Par Allowance:  2.28
Maximum Limiting Charge: 2.62

Procedure Code:  J2800 4/21/97 Maximum Med B Par Allowance: 5.18
4/21/97 Maximum Med B Non-Par Allowance:  4.92
Maximum Limiting Charge: 5.66

Procedure Code:  J2860 4/21/97 Maximum Med B Par Allowance:  8.05

4/21/97 Maximum Med B Non-Par Allowance:  7.65
Maximum Limiting Charge: 8.80

Procedure Code:  J2910 4/21/97 Maximum Med B Par Allowance: 12.99
4/21/97 Maximum Med B Non-Par Allowance:  12.34
Maximum Limiting Charge:  14.19

Procedure Code:  J2970 4/21/97 Maximum Med B Par Allowance: 6.40
4/21/97 Maximum Med B Non-Par Allowance:  6.08
Maximum Limiting Charge:  6.99

Procedure Code:  J3030 4/21/97 Maximum Med B Par Allowance: 38.00
4/21/97 Maximum Med B Non-Par Allowance:  36.10
Maximum Limiting Charge: 41.52

Procedure Code:  J3070  4/21/97 Maximum Med B Par Allowance: 4.19
4/21/97 Maximum Med B Non-Par Allowance:  3.98
Maximum Limiting Charge:  4.58

Procedure Code:  J3130  4/21/97 Maximum Med B Par Allowance: 1.66
4/21/97 Maximum Med B Non-Par Allowance:  1.58
Maximum Limiting Charge: 1.82

Procedure Code:  J3150  4/21/97 Maximum Med B Par Allowance: 1.60
4/21/97 Maximum Med B Non-Par Allowance:  1.52
Maximum Limiting Charge: 1.75

Procedure Code:  J3230 4/21/97 Maximum Med B Par Allowance:  2.15
4/21/97 Maximum Med B Non-Par Allowance:  2.04
Maximum Limiting Charge: 2.35

Procedure Code:  J3265 4/21/97 Maximum Med B Par Allowance: 1.93
4/21/97 Maximum Med B Non-Par Allowance:  1.83
Maximum Limiting Charge: 2.10

Procedure Code:  J3310 4/21/97 Maximum Med B Par Allowance: 5.96
4/21/97 Maximum Med B Non-Par Allowance:  5.66
Maximum Limiting Charge: 6.51

Procedure Code:  J3320  4/21/97 Maximum Med B Par Allowance:
19.25
4/21/97 Maximum Med B Non-Par Allowance:  18.29
Maximum Limiting Charge: 21.03

Procedure Code:  J3370 4/21/97 Maximum Med B Par Allowance: 11.89
4/21/97 Maximum Med B Non-Par Allowance:  11.30
Maximum Limiting Charge:  13.00

Procedure Code:  J9015 4/21/97 Maximum Med B Par Allowance:
442.00
4/21/97 Maximum Med B Non-Par Allowance:  419.90
Maximum Limiting Charge: 482.89

Procedure Code:  J9020 4/21/97 Maximum Med B Par Allowance: 56.80
4/21/97 Maximum Med B Non-Par Allowance:  53.96
Maximum Limiting Charge: 62.05

Procedure Code:  J9031 4/21/97 Maximum Med B Par Allowance:
158.85
4/21/97 Maximum Med B Non-Par Allowance:  150.91
Maximum Limiting Charge: 173.55

Procedure Code:  J9165  4/21/97 Maximum Med B Par Allowance:
14.18
4/21/97 Maximum Med B Non-Par Allowance:  13.47
Maximum Limiting Charge:  15.49

Procedure Code:  J9200  4/21/97 Maximum Med B Par Allowance:
133.05
4/21/97 Maximum Med B Non-Par Allowance:  126.40
Maximum Limiting Charge: 145.36

Procedure Code:  J9211 4/21/97 Maximum Med B Par Allowance:
274.31
4/21/97 Maximum Med B Non-Par Allowance:  260.59
Maximum Limiting Charge: 299.68

Procedure Code:  J9214 4/21/97 Maximum Med B Par Allowance: 11.31
4/21/97 Maximum Med B Non-Par Allowance:  10.74
Maximum Limiting Charge: 12.35

Procedure Code:  J9218 4/21/97 Maximum Med B Par Allowance: 61.25
4/21/97 Maximum Med B Non-Par Allowance:  58.19
Maximum Limiting Charge: 66.92

Procedure Code:  J9266 4/21/97 Maximum Med B Par Allowance:
1337.70
4/21/97 Maximum Med B Non-Par Allowance:  1270.82
Maximum Limiting Charge: 1461.44

Procedure Code:  J9270 4/21/97 Maximum Med B Par Allowance: 88.73
4/21/97 Maximum Med B Non-Par Allowance:  84.29
Maximum Limiting Charge: 96.93

Procedure Code:  J9320  4/21/97 Maximum Med B Par Allowance:
74.35
4/21/97 Maximum Med B Non-Par Allowance:  70.63
Maximum Limiting Charge: 81.22

Procedure Code:  J9340 4/21/97 Maximum Med B Par Allowance: 83.94
4/21/97 Maximum Med B Non-Par Allowance:  79.74
Maximum Limiting Charge: 91.70

Procedure Code:  J9390 4/21/97 Maximum Med B Par Allowance: 64.71
4/21/97 Maximum Med B Non-Par Allowance:  61.47
Maximum Limiting Charge: 70.69

Procedure Code:  90726  4/21/97 Maximum Med B Par Allowance:
145.50
4/21/97 Maximum Med B Non-Par Allowance:  138.23
Maximum Limiting Charge: 158.96

Procedure Code:  90732 4/21/97 Maximum Med B Par Allowance: 14.20
4/21/97 Maximum Med B Non-Par Allowance:  Not Applicable

Maximum Limiting Charge: Not Applicable

Procedure Code: 90745 4/21/97 Maximum Med B Par Allowance: 42.15
4/21/97 Maximum Med B Non-Par Allowance: Not Applicable
Maximum Limiting Charge: Not Applicable

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Use of Locally-Assigned Procedure Codes (Level III)

Level III codes and modifiers include alpha-numeric codes assigned locally by Medicare Part B of Florida. Level III codes describe procedures not included in Level I (numeric codes - CPT) or Level II (alpha-numeric - HCFA-assigned) and begin with an alpha prefix of W-Z (e.g., W4150). Most Level III or locally assigned, codes have been deleted as part of the standardization of the Medicare program.

The only locally-assigned procedure codes currently recognized by Medicare Part B of Florida are the following radionuclide procedures:

| Procedure Code | Description | Allowed Amount |
|---|---|---|
| W4125 | Tc-99m Technetium, Pertechnetate, up to 30 mCi | 26.53 |
| W4128 | I-131 Iodohippurate Sodium, per uCi (HIPPURAN) | 0.33 |
| W4130 | Tc-99m Technetium, Mebrofenin, up to 10 mCi (CHOLETEC) | 29.85 |
| W4131 | Tc-99m Technetium, Mertiatide, up to 20 mCi (MAG 3, TECHNESCAN MAG3) | 107.25 |
| W4132 | Tc-99m Technetium, Labeled Red Blood Cells (RBCs), up to 30 mCi (LABELED RBCs) | 63.87 |
| W4133 | Co-57 Cobalt Cyanocobalamin, Phase 1 -OR- 2 (SCHILLING TEST KIT, COBATOPE-57, RUBRATOPE-57) | 121.69 |
| W4134 | Tc-99m Technetium, Pyrophosphate, up to 30 mCi (PYP, PHOSPHOTEC, PYROLITE, SODIUM PYROPHOSPHATE) | 22.57 |
| W4136 | Xe-133, Xenon, per 10 mCi | 13.97 |
| W4139 | Tc-99m Technetium Pentetate, up to 30 mCi (PENTETATE DTPA, AN-DTPA, TECHNEPLEX, DTPA, TECHNESCAN DTPA) | 19.80 |
| W4140 | I-123 Sodium Iodide capsule, per 100 uCi (SODIUM IODINE capsules) | 21.81 |
| W4141 | I-131 Sodium Iodide capsule (diagnostic), up to 100 uCi (IODOTOPE, Diagnostic) | 12.90 |

W4142 I-131 Sodium Iodide capsule (therapeutic), up to 6 mCi (IODOTOPE, Therapeutic) 121.44

W4143 I-131 Sodium Iodide capsule (therapeutic), each additional mCi (IODOTOPE, Therapeutic) 17.86

W4144 Ga-67, Gallium Citrate, per mCi (NEOSCAN) 13.75

W4147 I-131 Sodium Iodide solution (therapeutic), up to 6 mCi (IODOTOPE, Therapeutic solution) 115.56

W4149 Tc-99m Technetium, Gluceptate, up to 30 mCi (GLUCO, GLUCOSCAN) 13.86

W4150 Tc-99m Technetium, Macroaggregated Albumin, up to 10 mCi (PULMONITE, MAA) 19.80

W4153 Tc-99m Technetium, Sulfur Colloid, up to 10 mCi (AN-SULFUR COLLOID, SC, TESULOID) 20.35

W4156 Tc-99m Technetium, Disofenin, up to 10 mCi (HEPATOLITE, HIDA) 28.60

W4158 Tc-99m Technetium, Exametazime, up to 30 mCi (CERETEC, HMPAO) 275.00

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Diagnostic Tests

86880, 86885, 86886, 86900, 86903-86906, 86910-86911: Transfusion Medicine Type of Service Change

Effective July 1, 1997, transfusion medicine codes may be considered either "medicine" (type of service 1) or "diagnostic laboratory" (type of service 5).

When transfusion medicine codes are billed on a claim with blood product codes (P9012-P9022), the transfusion medicine codes are paid under reasonable charge, as type of service 1 (medicine). If the transfusion codes are billed alone (i.e., no blood products), they are processed as a type of service 5 (diagnostic laboratory), and will be paid under the clinical lab fee schedule at 100%. This change affects the following codes:

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

86885 indirect, qualitative, each antiserum

86886 indirect, titer, each antiserum

86900 Blood typing; ABO

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

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

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

86906  Rh phenotyping, complete

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

86911*  each additional antigen system

*Non-covered by Medicare.

Providers are reminded that it is not appropriate to fragment codes. When medicine codes and blood product codes are provided during the same service, they should be billed on the same claim.

Reimbursement

Transfusion medicine codes billed with blood product codes are payable under reasonable charge. Reasonable charge allowances are determined by taking the lower of the customary, area prevailing or billed amount, reduced by 80 percent. The reasonable charge allowances are:

| Code | Loc 01 | Loc 02 | Loc 03 | Loc 04 |
|---|---|---|---|---|
| 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 |
| 86900 | 9.05 11.23 | 6.78 10.59 | | |
| 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 | | | |

Transfusion medicine codes billed without blood products are paid under the clinical lab fee schedule. Clinical lab fees are determined by taking the lower of the fee or the billed amount. They are reimbursed at 100 percent of that amount.

| Code: | Fee: |
|---|---|
| 86880 | 7.62 |
| 86885 | 8.12 |
| 86886 | 7.32 |
| 86900 | 4.23 |
| 86903 | 8.37 |

| | |
|---|---|
| 86904 | 13.49 |
| 86905 | 5.43 |
| 86906 | 11.00 |
| 86910 | NC |
| 86911 | NC |

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92499: Correction to Computerized Corneal Topography

An article was published on page 30 of the May/June Medicare B Update! which outlined the covered diagnoses for computerized corneal topography (procedure code 92499). The diagnosis code 371.41 was published in error. The correct diagnosis code is 371.71. See the May/June article for a complete list of covered diagnoses.

Advance Notice Requirement

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

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93015-93018: Additions to Cardiovascular Stress Test Coverage

Since the implementation of the Cardiovascular Stress Test policy published in the October 1996 Medicare B Update! Special Issue: New Local Medical Review and Focused Medical Review Policies, the following additions to the indications and covered diagnosis list has occurred:

The stress test is covered when it is performed to assess for the presence or absence of coronary disease, appropriate heart rate and/or blood pressure response for cardiac transplant patients. For optimal management of these patients, annual testing is recommended. When the stress test is performed for a cardiac transplant patient, diagnosis code V42.1 (Organ or tissue replaced by transplant, heart) can be submitted.

Please see the October 1996 Medicare B Update! Special Issue for a complete list of indications and covered diagnoses for Cardiovascular Stress Test.

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92978-92979: Intravascular Ultrasound Type of Service Change

Effective for claims processed on or after July 1, 1997, the following codes will be considered type of service 4 (diagnostic x-ray) and will require the referring/ordering provider's Unique Physician Identification Number (UPIN):

92978 Intravascular ultrasound (coronary vessel or graft) during therapeutic intervention including imaging supervision, interpretation and report; initial vessel

92979 each additional vessel.

As a result of this change, the referring/ordering provider's name must appear in block 17 and the referring/ordering provider's UPIN must appear in block 17a of the HCFA-1500 claim form. For electronic claims, supply this information in the appropriate record.

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93975, 93976: Diagnosis Requirements for Duplex Scans

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

HCPCS Codes

93975 Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, and/or retroperitoneal organs; complete study

93976 limited study

Indications and Limitations of Coverage and/or Medical Necessity

Medicare may provide coverage for duplex scanning of arterial inflow and venous outflow of abdominal, pelvic, and/or retroperitoneal organs when performed as part of the evaluation of conditions described by the covered ICD-9 codes.

ICD-9 Codes That Support Medical Necessity

442.1
442.84
452
453.3
557.0
557.1
572.3
593.81
902.20
902.25
902.27
902.31
902.32
902.39
902.41
902.42
902.87

902.9

Advance Notice Requirement

Applies to diagnosis requirement (see page 4).

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This section of the Medicare B Update! features new and revised medical policies developed as a result of either the Local Medical Review (LMR) or Focused Medical Review (FMR) initiatives. Both the LMR and FMR initiatives are designed to ensure the appropriateness of medical care and that the Carrier's medical policies and review guidelines are consistent with the accepted standards of medical practice.

Effective Dates

The policies contained in section are effective for claims processed August 18, 1997, and after.

Sources of Information

The sources of information used in the development of these policies may be obtained by accessing the B LINE BBS. For additional information on the B LINE BBS, refer to page 55 of the July/August 1997 Medicare B Update!

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J9217: Luteinizing Hormone-Releasing Hormone Analogs For Diagnosed Malignant Neoplasm Of The Prostate

Goserlin acetate (HCPCS code J9202) and leuprolide acetate (HCPCS code J9217) are synthetic hormone-releasing hormone (LHRH) analogs indicated in the palliative treatment of advanced carcinoma of the prostate. Both drugs offer an alternative treatment of prostate cancer when orchiectomy or estrogen administration are either not indicated or are unacceptable to the patient. Medicare Part B of Florida has developed medical policy explaining the methodology used in pricing luteinizing hormone-releasing hormone analogs. This policy is effective for services rendered August 18, 1997, and after.

In order to be covered by Medicare, drugs and biologicals must be safe, effective, and medically reasonable and necessary. FDA approval determines safety and efficacy, but medical necessity is determined by the Carrier. S1862(a)(1)(A) of the Social Security Act states that Medicare excludes coverage for "items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a

malformed body member." The underlying issue in this statute, as it applies to this policy, is that if two services are clinically comparable, Medicare does not cover the additional expense of the more costly one, because this additional expense is not attributable to an item or service that is medically reasonable and necessary.

According to the medical literature, there is no demonstrable difference in clinical efficacy between goserlin acetate (J9202) and leuprolide acetate (J9217) in the treatment of malignant neoplasm of the prostate (ICD-9 code 185). Medicare Part B of Florida will deny payment for the additional expense of the more costly agent as not medically reasonable and necessary. As with any submitted charge that is not considered medically reasonable or 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 each injection. The beneficiary's liability, however, must not exceed the difference in the Medicare allowance between the two medications.

If there are medical indications requiring the use of leuprolide acetate instead of goserlin acetate, such as cachexia, infection or allergy to goserlin acetate, Medicare will consider payment for the difference in cost if documentation of medical necessity accompanies the claim.

## Diagnosis Requirements

A complete list of diagnoses for which procedure code J9217 is covered is listed below:

185*
198.82
233.4
239.5
280.0
285.1
617.0-617.9

* When billing for procedure code J9217 with ICD-9 code 185, documentation substantiating the medical necessity of the service must be submitted with the claim.

## Coding Guidelines

Bill for leuprolide acetate (for depot suspension) using HCPCS code J9217. This code represents 7.5 mg.; and the number of services should be adjusted to indicate the amount of the drug being billed. Provide the correct ICD-9 code to indicate the medical condition being treated.

Bill for goserlin acetate implant 3.6 mg. using HCPCS code J9202. Adjust the number of services to indicate the amount of the drug

being billed. Provide the appropriate ICD-9 code to indicate the condition being treated.

Use the -GA modifier to indicate that the Advance Notice to Beneficiary statement is on file for the difference in cost of the two drugs.

Chemotherapy administration codes 96400 through 96450, 96542, 96545, and 96579 are used only in reporting chemotherapy administration when the drug being administered is an antineoplastic agent, and the diagnosis is cancer. The administration of other drugs, such as growth factors, hormones, saline, and diuretics to patients with cancer, or the administration of antineoplastic drugs to patients with a diagnosis other than cancer, must be reported with codes 90780 through 90784, as appropriate.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4 ).

Documentation Requirements

Additional documentation must be submitted when billing for J9217 with the diagnosis of malignant neoplasm of the prostate (ICD-9 code 185). This information must document the medical necessity for using leuprolide instead of the less costly teatment with goserlin acetate. The documentation could include:

history and physical

office/progress notes

letter of medical necessity from the physician

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J9000: Doxorubicin

Doxorubicin is a cytotoxic anthracycline antibiotic that selectively kills malignant cells and produces regression in a variety of human cancers. Local medical review policy was developed in 1996, defining this service and the circumstances under which it would be considered to be reasonable, necessary, and therefore covered by Medicare Part B of Florida. Due to recent studies which provide evidence that Doxorubicin is useful in the treatment of cancers in addition to those cited in the original policy, this policy is being enhanced to expand the indications and limitations of coverage. It is now known that Doxorubicin HCl 10 mg has been used successfully in the treatment of disseminated neoplasms including the following: adrenocortical, biliary tract, transitional cell bladder, breast, carcinoid, endometrial, esophageal, Ewing's sarcoma, gastric,

hepatoblastoma, islet cell, Kaposi's sarcoma, , primary central nervous system lymphoma, acute lymphocytic leukemia, chronic lymphocytic leukemia, blast phase chronic myelogenous leukemia, liver, small cell lung, Hodgkin's lymphoma, Burkitt's lymphoma, diffuse large cell lymphoma, follicular lymphoma, lymphoblastic lymphoma, multiple myeloma, neuroblastoma, osteosarcoma, epithelial cell ovarian, prostate, retinoblastoma, soft tissue sarcoma, thyroid, and Wilm's tumor.

Coding Guidelines

When billing for Doxorubicin HCl 10mg, use HCPCS code J9000 and the ICD-9 diagnosis code which shows the medical condition being treated.

When billing for Doxorubicin HCL Liposome 20mg (Doxil), use HCPCS code J9999 and the name, strength and dosage of the drug in Item 19 of the HCFA-1500 claim form. EMC senders should report this information in HA0 field 05.0

Reasons for Denial

Clinical scenarios which deviate from outlined indications and limitations of coverage. Lack of documentation to support medical necessity.

Documentation Requirements

In the event of a pre- or postpayment medical review, a narrative statement of medical necessity clearly documenting why the physician feels the service(s) was medically necessary must be maintained in the patient's records.

**********

17260-17286: Destruction of Malignant Lesions

Destruction of malignant lesions, procedure codes 17262, 17281, and 17282, were identified as aberrancies and selected as part of the 1995 Focused Medical Review Process. Follow-up data for the time period of January 1, 1996, through June 30, 1996 revealed that these procedure codes continued to be aberrant. Analysis of the data revealed that some of the diagnoses submitted did not substantiate medical necessity. As a result, the local medical review policy has been revised and a covered diagnosis list has been developed.

Medicare will consider the destruction of malignant skin lesions medically necessary in the following circumstances:

When a pathology report confirms the diagnosis of a skin malignancy, and or

When the description of the lesion is consistent with that of a skin malignancy.

Policy enhancements have been developed for the following procedure codes:

17260 Destruction, malignant lesion, any method, trunk, arms or legs; diameter 0.5 cm or less

17261 Lesion diameter 0.6 to 1.0 cm

17262 lesion diameter 1.1 to 2.0 cm

17263 lesion diameter 2.1 to 3.0 cm

17264 lesion diameter 3.1 to 4.0 cm

17266 lesion diameter over 4.0 cm

17270 Destruction, malignant lesion, any method, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less

17271 lesion diameter 0.6 to 1.0 cm

17272 lesion diameter 1.1 to 2.0 cm

17273 lesion diameter 2.1 to 3.0 cm

17274 lesion diameter 3.1 to 4.0 cm

17276 lesion diameter over 4.0 cm

17280 Destruction, malignant lesion, any method, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less

17281 lesion diameter 0.6 to 1.0 cm

17282 lesion diameter 1.1 to 2.0 cm

17283 lesion diameter 2.1 to 3.0 cm

17284 lesion diameter 3.1 to 4.0 cm

17286 lesion diameter over 4.0 cm

Diagnosis Requirements

To ensure that payment is made only for medically necessary services, these procedures will be covered only when performed for the following diagnoses:

145.0-145.9

171.0
171.2
171.3
171.4
171.5
171.6
171.7
171.8
172.0 - 172.8
173.0 - 173.8
195.0 - 195.8
232.0 - 232.8
234.0

If the pathology report or the clinical description of the lesion does not indicate a malignancy, these codes should not be used when the lesion is destroyed.

Coding Guidelines

Procedure codes 17260 through 17286 are strictly for use when destroying malignant skin lesions. They are grouped by area and then by size. The size should reflect the size of the lesion at time of destruction and not the size on the pathology report.

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

Modifier -25 is used to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable evaluation and management service.

Reasons for Denial

These codes are not to be used for non-malignant lesions; therefore, the services will be denied when billed for diagnoses other than those listed in the covered ICD-9 code(s) that support medical necessity.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4 ).

Documentation Requirements

The medical record/progress note should indicate the removal of a malignant lesion with a corresponding pathology report or a clinical description consistent with a skin malignancy.

The size and location of the lesion must be included in the documentation.

**********
page 26

80162: Digoxin Assay

Therapeutic drug assays are performed on blood to determine the levels of drugs systemically. Medicare Part B of Florida has had medical policy in place for digoxin assay since 1996. As part of the Carrier's process of periodic review of finalized policies, it has been determined that revisions should be made to this policy in order to ensure that only medically reasonable and necessary services are covered.

Diagnosis Requirements
Medicare Part B will consider Digoxin Assay to be medically necessary when performed for the following conditions/diagnoses:

368.16
368.9
402.00-402.91
413.0
425.3-425.9
426.0
426.10
426.4
426.50-426.54
426.6
426.7
426.81-426.9
427.0-427.9
428.0-428.9
514
783.0
787.01-787.03
972.1
V72.84

Reasons for Denial

Diagnoses other than those listed as covered ICD-9 codes are considered not reasonable and necessary and will result in denial of coverage.

Coverage is not provided for this test when it is performed for screening purposes.

Advance Notice Requirement

Applies to diagnosis requirements (see p. 4 ).

Documentation Requirements

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

**********

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

Effective for claims processed on or after August 18, 1997, all claims for comparison x-rays submitted by portable x-ray suppliers (specialty 63) must be accompanied with the original x-ray report, along with the indication and report of the comparison x-ray. This information should be included in the office/progress notes. The provider must document the reason for the comparison x-ray.

If the comparison x-ray is performed for screening purposes, it should be reported with ICD-9-CM diagnosis code V72.5 (Radiological examination, not elsewhere classified). The patient may be held financially liable for x-rays performed for screening purposes.

For more information on comparison x-rays, refer to page 23 of the May/June 1997 Medicare B Update!

**********



80061, 82172, 82465, 83715-83721 and 84478: Coverage for Lipid Profile/Cholesterol Testing

Analysis of 1995 claims data indicates that LDL cholesterol, direct measurement and HDL cholesterol, direct measurement (Procedure codes 83721 and 83718) have been billed substantially more in Florida than at the national level for multiple specialties. Further analysis of the data indicates that these procedure codes and those listed below (which are included in the Lipid Profile/Cholesterol Testing policy) are being billed with diagnoses that do not support medical necessity. Therefore, this policy was created to establish the conditions/illnesses for which Medicare Part B of Florida will consider the service to be medically reasonable and necessary. The Lipid Profile/Cholesterol Testing medical policy includes the following procedure codes: 80061, 82172, 82465, 83715, 83717, 83718, 83719, 83721, and 84478.

To ensure that payment is being made only for medically reasonable and necessary services, Lipid Profile/Cholesterol Testing is covered for the following diagnoses:

240.0-246.9

272.0-272.9
401.0-405.99
410.00-410.92
411.0-411.89
412
413.0-413.9
414.00-414.05
414.10-414.9
414.8
414.9
429.2
431-437.9
438
440.0-440.9
441.00-441.9
443.9
444.0-444.89
786.50
E942.2

Note: Once lipid profile testing is performed to rule out the cause of a condition and/or symptom (i.e., chest pain, thyroid disorder, etc.) it is not considered medically necessary to repeat the test(s) unless the results indicate a lipid disorder or the patient exhibits new symptomology.

Medicare will consider Lipid/Cholesterol testing to be medically reasonable and necessary for the current treatment of the following list which are clearly documented in the patient's office/progress notes. The goal of diet and drug therapy is most often to lower LDL cholesterol.

Dietary Treatment

Some patients may be able to be managed during diet therapy on the basis of their total cholesterol levels. If the total cholesterol monitoring goal is met, the LDL cholesterol should be measured to confirm the desired LDL cholesterol level has been achieved.

Monitoring for adherence to dietary therapy would be expected at approximately 4 to 6 weeks from initiation and at 3 months. If the desired LDL and cholesterol levels have been achieved, quarterly monitoring for the first year and twice yearly thereafter would be expected. In addition, triglyceride levels at the same frequency may also require monitoring to assess that desired levels have been achieved.

Drug Treatment

After drug therapy is initiated the serum cholesterol, serum triglyceride, LDL, VLDL and HDL level(as applicable to the drug

therapy) would be expected to be measured at approximately 4 to 6 weeks and again at 3 months. If the drug therapy response is adequate (i.e., the LDL, serum cholesterol and triglyceride goal has been achieved) it would be expected that every 4 months or more frequently when drugs requiring closer follow-up are used to monitor the cholesterol response and possible side effects of therapy, would be required.

Those with desirable blood cholesterol, HDL, and LDL levels would expect to be tested within 5 years however, this is considered screening and not payable by Medicare.

Coding Guidelines

When billing procedure code 83721 only those done by direct measurement are appropriate to bill for Medicare. Those tests done by the calculated method are not appropriate when billed for LDL cholesterol levels.

Reasons for Denial

Apolipoprotein (82172) is considered to be a screening test and therefore, non-covered by Medicare.

Advance Notice Requirement

Applies to diagnosis requirements (see p. 4).

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the test, including:

- office/progress notes
- laboratory results

If the provider of the service is other than the ordering/referring physician, that provider must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies. The physician must state the clinical indication/medical necessity for the study in his order for the test.

**********



80091-80092, 84436-84439, 84443, and 84479-84482: Coverage for Thyroid Function Tests and Panels

Procedure codes 80092, 84436 and 84479 were identified as aberrancies and selected as part of the 1995 Focused Medical Review Process. A local medical review policy including procedure codes 80091-80092, 84436-84439, 84443, and 84479-84482 was developed and published in the March/April 1996 Medicare Update! Follow-up data for the time period of January 1, 1996 through June 30, 1996 revealed that these procedure codes continued to be aberrant. Analysis of the diagnosis submitted revealed that some of the thyroid tests and/or panels were being performed for conditions that do not substantiate medical necessity. As a result, a revision to the policy was performed. Thyroid Function Tests and Panels will be considered medically necessary and reasonable if performed for one of the following diagnoses:

193
226
237.4
239.7
240.0-240.9
241.0-241.9
242.00-242.91
243
244.0-244.9
245.0-245.9
246.0-246.9
253.2
253.3-253.4
253.7
255.4
272.0
272.1
273.2
275.4
276.1
278.01
293.1
300.00-300.02
310.1
311
333.1
356.9
358.0
359.5
368.2
374.41
376.21
376.30-376.31
376.33-376.34
427.0
427.1
427.2
427.31
427.32
427.81-427.9
560.1
564.0
564.7

625.3
626.0-626.2

626.4
648.10-648.14
701.1
703.8
704.00
729.1
729.82
733.09
759.2
775.3
780.09
780.50
780.7
780.8
781.3
782.3
783.1
783.2
783.4
784.1
784.49
785.0
785.1
786.09
794.5
799.2

Once thyroid testing is performed to rule out the cause of a condition and/or symptom (i.e., malaise, hyperlipidemia, etc.) it is not considered medically necessary to repeat the test(s) unless the results indicate a thyroid disorder or the patient exhibits new symptomotology.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4 ).

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing a thyroid function panel. Initially a comprehensive history and physical examination should be performed and documented that includes the following:

cardiovascular examination

neuromuscular examination

patient's complaints or symptoms

pulse rate

thyroid palpation

weight and blood pressure

During follow-up visits, an appropriate interim history and physical examination should be performed in conjunction with appropriate laboratory tests. An interim history should assess response to therapy, changes in medication or therapy, and evaluation of the clinical improvement in symptoms, as well as possible side effects of the medication or therapy.

**********

82105, 84702, 84703, 86316: Tumor Antigens

Radioimmunoassay and immunohistochemical determination of the serum levels of certain proteins or carbohydrates have been developed as markers for various cancers. When elevated, serum concentration of these markers may reflect tumor size and grade and may be helpful in monitoring response to treatment. However, tumor markers are not useful for making a differential diagnosis of cancer since the sensitivity and specificity of these tests make it unreliable.

Indications and Limitations of Coverage and/or Medical Necessity

Alpha - fetoprotein; serum

Medicare Part B of Florida will consider Alpha-fetoprotein; serum (CPT code 82105) to be medically reasonable and necessary for:

evaluating the extent of involvement of hepatocellular carcinoma and germ cell tumors of the testis, ovary and extragonadal sites

choosing therapy and predicting tumor behavior (prognosis).

predicting effects of therapy and detecting recurrent cancer of hepatocellular carcinoma and germ cell tumors of the testis, ovary, and extragonadal sites.

Diagnosis Requirements

To ensure that payment is made only for medically necessary services, Alpha-fetoprotein (CPT code 82105) is covered when it is performed for the following diagnoses:

155.0-155.2
183.0
186.0
186.9

197.7

198.6

198.82

V10.43

V10.47

Gonadotropin, Chorionic (hCg)

Gonadotropin is a glycoprotein hormone which is normally produced by the developing placenta and aberrantly produced by gestational trophoblastic tumors, seminomatous and nonseminomatous testis cancer and ovarian tumors.

CPT codes 84702, 84703 (hCg) are considered medically reasonable and necessary for:

evaluating the extent of involvement of specific types of cancer (see covered ICD-9 list);

monitoring therapy response and evaluating the patient's prognosis.

Diagnosis Requirements

To ensure that payment is made only for medically necessary services, Gonadotropin, chorionic (hCG) is covered when it is performed for the following diagnoses:

181
183.0

186.0
186.9
198.6
198.82
V10.43
V10.47
CA 125

The cancer antigen CA 125 is recognized by a monoclonal antibody OC-125. It is increased in most patients with advanced, nonmucinous (serous) ovarian cancer.

CA 125 is a covered service for patients with ovarian cancer (see covered ICD-9 list). CA 125 is considered investigational for diagnoses other than ovarian cancer.

CA 125 is not covered for making a differential diagnosis of pelvic masses since the sensitivity and specificity of the test makes it unreliable.

CA 125 is advocated for prognostic information. When measured serially, it may also be useful in the detection of relapse and as a monitor of patient response to chemotherapeutic agents.

Diagnosis Requirements

To ensure that payment is made only for medically necessary services, CA 125 (CPT code 86316) is covered when it is performed for the following diagnoses:

183.0
198.6
V10.43

Reasons for Denial

If coverage is provided for indications other than those listed in this policy.

Routine screening services are not covered by Medicare Part B of Florida.

All other tumor markers including those listed below are considered investigational and therefore, ineligible for payment.

| | |
|---|---|
| A2-PAG | pregnancy-associated alpha2 glycoprotein |
| BCM | breast cancer mucin |
| CA15-3 | Cancer antigen 15-3 |
| CA19-9 | Cancer antigen 19-9 |
| CA27.29 | Cancer antigen 27.29 |
| CA50 | Cancer antigen 50 |
| CA72-4 | Cancer antigen 72-4 |
| CA195 | Cancer antigen 195 |
| CA242 | Cancer antigen 242 |
| CA549 | Cancer antigen 549 |
| CA-SCC | Squamous cell carcinoma |
| CAM17-1 | Monoclonal antimucin antibody 17-1 |
| CAM26 | Monoclonal antimucin antibody 26 |

| | |
|---|---|
| CAM29 | Monoclonal antimucin antibody 29 |
| CAR3 | Antigenic determinant recognized by monoclonal antibody AR3 |
| DU-PAN-2 | Sialylated carbohydrate antigen DU-PAN-2 |
| MCA | Mucin-like carcinoma associated antigen |
| NSE | Neuron-specific enolase |
| P-LAP | Placental alkaline phosphatase |
| PNA-ELLA | Peanut lectin bonding assay |
| SLEX | Sialylated Lewis X-antigen |
| SLX | Sialylated SSEA-1 antigen |
| SPAN-1 | Sialylated carbonated antigen SPAN-1 |
| ST-439 | Sialylated carbonated antigen ST-439 |
| TAG12 | Tumor-associated glycoprotein 12 |
| TAG72 | Tumor-associated glycoprotein 72 |
| TAG72.3 | Tumor-associated glycoprotein 72.3 |
| TATI | Tumor-associated trypsin inhibitor |
| TNF-a | Tumor necrosis factor alpha |
| TPA | tissue polypeptide antigen |

Documentation Requirements

The medical record must indicate the medical indications for performing these tumor antigen tests.

Required documentation supporting medical necessity would include:

- History and physical
- Office/progress notes
- Test results

Advance Notice Requirements

Applies to diagnosis requirements (see page 4).

**********

# 82108: Coverage for Aluminum Testing

Aluminum is the third most prevalent element in the earth's crust. The gastrointestinal tract is virtually impervious to aluminum, absorption being around 2percent. Factors regulating aluminum's crossing of the blood-brain barrier are not well understood. Serum aluminum correlates with encephalopathy. Aluminum toxicity has been recognized in many settings where exposure is heavy or prolonged and/or where renal function is limited. To ensure that Medicare only pays for services that are considered medically reasonable and necessary, Aluminum testing (procedure code 82108) is covered for signs and symptoms of aluminum toxicity associated with:

infants on parenteral fluids, particularly parenteral nutrition

burn patients through administration of intravenous albumin, particularly with coexisting renal failure

adult and pediatric patients with chronic renal failure who accumulate aluminum readily from medications and dialysate

adult parental nutrition patients

patients with industrial exposure

patients with prolonged exposure to or excessive doses of such medications as antacids, salicylates, antilipemics, antiatherosclerosis medications, and antipruritics, etc.

Except for patients with chronic renal failure, one or more of the following signs and symptoms of aluminum toxicity must be present for aluminum testing to be considered medically necessary for the above patients:

encephalopathy (stuttering, gait disturbance, myoclonic jerks, seizures, coma, abnormal EEG)

osteomalacia or aplastic bone disease (associated with painful spontaneous fractures, tumorous calcinosis)

proximal myopathy

increased left ventricular mass and decreased myocardial function; and/or,

microcytic anemia

## Diagnosis Requirements

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

68.2
280.9
284.9
284.8
285.1

294.8
348.3
359.4*
428.1
585
965.1
972.2
973.0
976.1
976.2
976.3
E858.3
E858.4
E858.7
E935.3
E942.2
E943.0
E946.2
E946.3
E950.0
E950.4

*This code must be accompanied by the appropriate E diagnosis code.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4 ).

Documentation Requirements

The reason the test was performed and the test result must be included in the patient's medical record.

**********

82728: Coverage for Serum Ferritin

Serum ferritin (procedure code 82728) was reviewed as part of the periodical evaluation of finalized policies. The review concluded that revisions to the covered diagnosis list were needed to ensure that all services covered by Medicare are medically reasonable and necessary.

Indications and Limitations of Coverage

Medicare can provide coverage for a ferritin level when it is performed for any of the following conditions:

The patient has anemia with possible iron deficiency. (This includes necessary monitoring of serum ferritin during the course of treatment for anemia: e.g., periodic determination of serum ferritin in patient under treatment with epoetin alpha or with anemia due to chronic renal failure),

The patient has unexplained microcytic and/or hypochromic red blood cell indices,

The patient has hemochromatosis or iron overload or based on clinical findings (i.e., skin coloration, hepatomegaly hyperglycemia, multiple transfusions, polyarthropathy, hemochromatosis) iron overload is suspected,

The patient has suspected deficiency of iron due to factors identified in the patient's history, e.g., prior gastrectomy, intestinal malabsorption, a history of gastrointestinal hemorrhage.

Diagnosis Requirements

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

275.0
280.0-280.9
281.0-281.9
282.0-282.9
283.0-283.9
285.0-285.9
585
789.1
999.8

Reasons for Denial

Ferritin determinations are not a covered service when performed as a routine screening procedure or in the absence of documentation of clinical findings in the patient's medical record indicating a confirmed or suspected iron deficient or overload condition.

**********



82784: Gammaglobulin; IgA, IgD, IgG, IgM, each

Gammaglobulin policy (82784) was recently published in the March/April 1997 Medicare B Update! Since that time there have been enhancements to the "Indications and Limitations of Coverage and/or Medical Necessity" and there is the addition of a "Noncovered ICD-9 Code(s)" list. Analysis of the January through June 1995 claims data indicated that this procedure was being billed with nonspecific diagnoses and/or diagnoses that do not substantiate medical necessity.

Medicare Part B will consider the test for one or more of the gammaglobulins medically necessary when used in the following circumstances:

When the patient has had repeated infections, a serum IgA, an IgG and an IgM could be performed to determine whether a Immunodeficiency disorder exists.

When the patient presents with signs and symptoms of multiple myeloma which include, but are not limited to, the following:

anemia,

hypercalcemia,

increased susceptibility to infection, and/or

bone pain.

Serum IgA, IgG, or IgD levels are performed to monitor myeloma therapy after initially diagnosing and determining the gammaglobulin which is increased.

When the patient presents with signs and symptoms of suspected, unusual autoimmune disorders, serum gammaglobulin levels could be performed to assist with diagnosis.

When the patient presents with signs and symptoms of Lyme's Disease.

When the patient is suspected of having hypogammaglobulinemia or agammaglobulinemia.

The following patient conditions/circumstances may lead to either of these conditions:

Long-term and or high-dose steroid use,

Nephrotic syndrome,

Patients with overwhelming infections,

Chronic lymphocytic leukemia,

Lymphocytic lymphoma,

Multiple myeloma, or

Protein-losing enteropathy.

Patients who are hypogammaglobulinemic and are receiving intravenous (IV) Immune Globulin could have serum gammaglobulin (IgG) levels performed as medically appropriate to monitor their response to this therapy. This test could be performed 3-4 weeks after IV Immune Globulin depending upon a patient's clinical response to the therapy.

When the patient is suspected of having Waldenstrom's macroglobulinemia (a small-cell lymphocytic lymphoma that produces monoclonal IgM). This disease characteristically occurs in the elderly. Signs and symptoms may include, but are not limited to, the following:

Retinal hemorrhages, visual impairment and transient neurologic deficits (usually associated with the high viscosity serum);

Bleeding diatheses or hemolytic anemia (associated with the macroglobulin complexes with coagulation factors or binds to the surface of red blood cells);

Raynaud's phenomenon and peripheral vascular occlusions (associated with cold-insoluble proteins [cryoglobulins]);

Splenomegaly on examination.

Note: This disease is differentiated from chronic lymphocytic leukemia and multiple myeloma by bone marrow morphology and the finding of the IgM spike in macroglobulinemia. Serum IgM levels are useful in diagnosing and monitoring therapy for this disorder.

When the patient presents with signs and symptoms of inflammatory bowel disease; gastrointestinal or hepatobiliary tract carcinoma; or cirrhosis, an IgA could be performed to assist with diagnosis (an elevation is usually seen with these disease processes).

When the patient is at high risk of infection related to an ineffective immune response such as that associated with chronic lymphocytic leukemia, malignant lymphomas, other bone marrow

disorders, corticosteroid treatments, chemotherapy, or radiation therapy, the gammaglobulins may be markedly reduced or absent, therefore, periodic monitoring of the gammaglobulins could be performed.

When the patient presents with frequent and recurrent infections of the paranasal sinuses, bronchi and/or lungs, a serum IgA could be performed to determine whether Selective IgA Defiency exists.

Gammaglobulins could be performed to assist in determining how extensive tissue necrosis is with myocardial infarctions or in severe burn cases.

When the patient is suspected of having Subacute Bacterial Endocarditis (SBE), serum gammaglobulin levels may be performed to assist with diagnosis.

When the patient is suspected of having polyarteritis nodosa, serum gammaglobulins could be performed to assist in diagnosis.

When the patient is suspected of having a paraproteinemia, serum gammaglobulin levels could be performed to assist with diagnosis.

When the patient is suspected of having biliary cirrhosis, a serum IgA, an IgG, and an IgM may assist with diagnosis. Typically, serum IgAs and IgGs are decreased while serum IgMs are increased.

When patients are receiving plasmapheresis therapy, more than one IgM could be performed per day.

Generally, the following disorders may result in abnormalities in at least one or more of the serum gammaglobulins:

Liver dysfunctions,

Acute or chronic infections,

Severe malnutrition,

Lymphoproliferative disorders,

Myelomas (polyclonal or monoclonal),

Autoimmune disorders/collagen disorders,

Lyme's Disease,

Waldenstrom's macroglobulinemia,

Tissue necrosis,

Leukemia and other cancers,* and

Immune deficiency disorders (congenital and/or acquired).

However, after diagnosis, performing serum gammaglobulin tests may not be medically necessary or reasonable, except in cases of monitoring a patient's propensity to infection; monitoring therapy such as is done with myelomas (particularly IgG or IgA myeloma) or Immune Globulin Therapy; monitoring the advancement of a disease.

After diagnosis of IgA or IgG myelomas, it would only be considered medically necessary to perform one serum gammaglobulin test, i.e., IgA or IgG, to determine the effectiveness of therapy. Periodically, two or more of the gammaglobulin tests may be performed on the same day when the patient has myeloma for purposes of monitoring therapy and/or propensity to infection.

IgDs have questionable clinical significance except in the rare instance of IgD myeloma. It would be expected that this test only be performed to assist with diagnosis of that condition and, therefore, would only be rarely performed. Routinely performing a serum IgD level when performing the other tests would generally not be medically necessary or reasonable.

* Generally, in Hodgkin's Disease, B cell function is intact. Therefore, serum immunoglobulins are normal and generally not performed for diagnostic purposes when this condition is suspected.

The ICD-9 code(s) that will be considered as "Noncovered ICD-9 Code(s) are as follows:

102
306.3

413.9
414.0
414.9
477.0
585
586
600
693.1
789.00-789.09
796.4
799.9
V745

For additional information on this policy, please refer to the March/April 1997 Medicare B Update (p.59-61).

Advance Notice Requirement

Applies to diagnosis requirements (see page 4 ).

**********

82947, 82948, 82962: Blood Glucose Testing

Blood glucose testing is used to aid in the diagnosis, treatment, and follow-up of carbohydrate metabolism disorders. When it is used as a screening tool, or with diagnoses which do not support medical necessity, it is not covered by Medicare. Local medical review policy has been developed for CPT codes 82947 (Glucose; quantitative), 82948 (Blood, reagent strip) and 82962 (Glucose, blood by glucose monitoring device[s] cleared by the FDA specifically for home use). The policy defines the service and to identify the circumstances under which Medicare Part B of Florida will consider it to be medically reasonable, necessary and, therefore, covered.

Medicare Part B of Florida will consider blood glucose testing to be medically necessary when performed for the following conditions/diagnoses:

112.0
112.1
112.2
157.0-157.8

194.0
211.6
211.7
227.0
250.00-250.93
251.0
251.1
251.3
251.4
251.8
252.0
253.0
253.2
253.7
255.0
255.4
276.5
356.8
357.8
571.0
571.2
571.49

571.5
571.6

571.8
577.0
577.1
648.80-648.84
780.01
780.1
780.2
780.3
780.4
780.8
783.2
783.5
783.6
788.41
788.42
790.2
791.5
V67.51

## Coding Guidelines

Bill the service with CPT procedure code 82947 for glucose; quantitative, and CPT procedure code 82948 for blood glucose, reagent strip. Include the appropriate ICD-9 code which describes the symptom or condition. CPT code 82947 should not be billed on the same date as an automated profile (80002-80019, G0058-G0060), unless the blood is obtained at different encounters.

Separate payment will be made to physicians or independent clinical laboratories for drawing a blood sample through venipuncture (G0001).

## Advance Notice Requirement

Applies to diagnosis requirements (see page 4 ).

## Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the test, including:

office/progress notes

laboratory results

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

copies of the ordering/referring physician's order for the studies. The physician must state the clinical indication/medical necessity for the study in his order for the test.

**********



82985: Glycated Protein

Glycated protein measures concentration of nonlabile glycated serum proteins, giving a reliable estimate of mean blood glucose levels during the preceding 2-3 weeks. This test is most useful in monitoring the treatment of diabetics. Medicare Part B of Florida has had medical policy in place for glycated protein since 1996. As part of the process of periodic policy review, it has been determined that revisions should be made to covered ICD-9 list in order to ensure that only those services which are medically reasonable and necessary are covered.

Diagnosis Requirements

Medicare Part B of Florida will consider glycated protein to be medically necessary when performed for the following conditions/diagnoses:

250.00-250.03
250.40-250.43
250.50-250.53
250.60-250.63
250.70-250.73
250.80-250.83
648.00-648.04

Reasons for Denial

Glycated protein testing performed for indications other than those listed above will be considered not medically necessary or reasonable and will result in denial of coverage.

Glycated protein testing has not been proven reliable as a long term indicator of hypoglycemia.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4 ).

Documentation Requirements

Office medical records must contain sufficicient information to substantiate the service rendered.

**********

83036: Glycated Hemoglobin

Glucose combines with hemoglobin continuously and nearly irreversibly during the life span of normal red blood cells, making glycosylated hemoglobin proportional to the mean plasma glucose level during the previous 4-8 weeks. Thus, the chief use of the glycated hemoglobin test is to monitor the diabetic's compliance with treatment regimen, as well as long term blood glucose level control. Medicare Part B of Florida has had medical policy in place for glycated hemoglobin testing since 1996. As part of the process of periodic policy review, it has been determined that revisions should be made to the covered ICD-9 list in order to ensure that only those services which are medically reasonable and necessary are covered.

Diagnosis Requirements

Medicare Part B of Florida will consider glycated hemoglobin to be medically necessary when performed for the following conditions/diagnoses:

250.00-250.03
250.40-250.43
250.50-250.53
250.60-250.63
250.70-250.73
250.80-250.83
648.00-648.0

Reasons for Denial

Glycated hemoglobin testing performed for indications other than those listed above will be considered not medically necessary or reasonable and will result in denial of coverage.

Glycated hemoglobin testing has not been proven reliable as a long term indicator of hypoglycemia.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4 ).

Documentation Requirements

Office medical records must contain sufficient information to substantiate the service rendered.

**********



83735: Magnesium

Magnesium is an important activator ion, participating in the function of many enzymes involved in phosphate transfer

reactions. This electrolyte is critical in nearly all metabolic processes and most organ functions. When a magnesium test is used for screening or with diagnoses which do not support medical necessity, it is not covered by Medicare. Local medical review policy has been developed to define this service and to identify the circumstances under which Medicare Part B of Florida will consider it to be medically reasonable, necessary and, therefore, covered.

Medicare Part B of Florida will consider magnesium testing (83735) to be medically necessary when performed for the following conditions/diagnoses:

242.00-242.91

250.10-250.13
250.20-250.23
250.30-250.33
250.40-250.43
250.50-250.53
250.60-250.63
250.70-250.73
250.80-250.83
252.0
252.1
252.8
255.1
259.3
260
261
262
263.0
263.8
275.2
275.4
276.2
276.4
276.5
276.7

276.8
293.0-293.1
303.90-303.93
307.1
307.51
307.52
333.2
333.3
410.00-410.92
427.0-427.89
458.0-458.2
536.2
579.3
579.8
584.5-584.9
585
588.8

593.81
646.80-646.84
763.8
780.01-780.02
780.09
780.2
780.3

781.0
781.7
783.0
785.0
785.50-785.59
787.01
787.02
787.03
787.91
790.6
794.31
794.4
799.4
958.4
995.2
997.1
998.0
V56.0
V56.8
V58.1
V58.69

Coding Guidelines

Separate payment will be made to physicians or independent clinical laboratories for drawing a blood sample through venipuncture (G0001).

Advance Notice Requirement

Applies to diagnosis requirements (see page 4 ).

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the test, including:

office/progress notes

laboratory test results

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

copies of the ordering/referring physician's order for the study. The physician must state the clinical indication/medical necessity for the study in his order for the test.

**********

84066 Phosphatase, Acid; Prostatic

Acid Phosphatase (84066) was evaluated as part of the carrier's process to periodically evaluate finalized policies. Analysis of the January through June 1996 claims data indicated that this test was being billed with nonspecific diagnoses and/or diagnoses that do not substantiate medical necessity. The review concluded that a medical policy revision with a covered diagnosis list was needed to ensure that all services covered by Medicare are medically necessary and reasonable.

Medicare Part B will consider Acid Phosphatase (84066) to be medically necessary when used in the following circumstances:

To aid in the diagnosis and staging of metastatic cancer of the prostate and to monitor the effectiveness of treatment.

Diagnosis Requirements

To ensure that payment is made only for medically necessary services, Acid Phosphatase (84066) test is covered only when performed for the following diagnoses:

185
198.5
199.0
199.1
222.2
233.4
236.5
239.5
790.93
V10.46

Coding Guidelines

V70.0-V70.9 (General medical examination) should be used in the absence of any signs or symptoms to indicate screening.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4 ).

Documentation Requirements

Medical record documentation (i.e., office/progress notes) maintained by the ordering/referring physician must indicate the medical necessity for performing the test. Additionally, a copy of the test results should be maintained in the medical records.

If the provider of the service is other than the ordering/referring physician, that provider must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies. The physician must state the clinical indication/medical necessity for the study in his order for the test.

**********



85007-85031: Complete Blood Count

As part of the 1996 Focused Medical Review (FMR) process, procedure code 85024 was selected as an aberrancy. Originally, a local medical review policy was developed which included procedure codes 85007-85027, and 85031. This policy was published in the October 1996 Special Issue. Continual enhancements and additions have occurred since the policy was implemented in November 1996, therefore, the affected sections of the policy are being published.

Two additional procedure codes (85029 and 85030) have been added to the policy. Both procedure code 85029 and 85030 are not reimbursable as they are computerized calculations. This policy change is effective for services rendered August 18, 1997. Medicare does not pay for manual or automated percentage, ratios, or calculations.

Medicare Part B will consider a complete blood count medically reasonable and necessary for the following conditions:

Presence of abnormal signs or symptoms (such as pallor, weakness, significant tiredness, abnormal bleeding, etc.) which may suggest an anemic condition

Monitoring of patients with previously diagnosed anemias (i.e., iron deficiency, aplastic, hemolytic, etc.)

Evaluation of patients on medications or treatments that affect blood components (i.e., chemotherapy, radiation therapy, antibiotics, aspirin, etc.) [Note: there are certain medications especially Gold Salt and pencillamine used in the rheumatology field that require CBC'S every 2-4 weeks during therapy.]

Patients with known acute or chronic diseases (i.e., acute or recurrent peptic disease, renal failure, systemic lupus erythematosus, liver disease, rheumatoid arthritis, eating disorders, etc.), injury, leukemia, infections, reaction to

inflammation, dehydration if the results can be expected to contribute to the management of the patient.

Patients with acute or chronic blood loss

Patients with splenomegaly (includes post splenectomy)

Patients undergoing a major surgical procedure (i.e., abdominal thoracic, carotid, cranial or femoral/poplitial surgery) in which significant blood loss may result.

Platelet counts with a hemogram would be clinically indicated when a condition falls into one of the following categories:

When signs and symptoms suggest a possible hemorrhagic condition

To assess the effects of chemotherapy or radiation therapy on platelet formation

To aid in the diagnosis of thrombocytopenia and thrombocytosis

To confirm a visual estimate of platelet number and morphology from a previous stained blood film.

A complete blood count can be ordered initially if indications for testing are met. Repeat testing for a CBC or portions thereof will be allowed if it can be expected to provide information for further management or to evaluate a response to therapy (e.g., several days after iron therapy for an iron deficiency anemia). Frequent testing is not expected except under unusual circumstances (i.e., acute bleeding, etc.).

To ensure that complete blood counts (procedure codes 85007-85027 and 85031) are medically necessary, services billed with the following diagnoses codes are noncovered and will be denied:
V01.9
V07.8-V07.9
V40.0-V40.9
V58.9
V64.0-V64.3
V67.59
V67.6
V67.9
272.0-272.9
278.00
278.1
290.0-290.9

295.00-295.95
298.0-298.9
307.80-307.9
331.0
331.1
331.2
332.0-332.1
366.00-366.9
369.00-369.9
380.4
401.0-401.9
455.0

455.3
455.6
627.3
700
701.0-701.9
702.0-702.9
724.00-724.09
735.00-735.9
736.00-736.9
737.0-737.9
739.0-739.9
743.30-743.39
780.3
780.50-780.59
780.8
780.9
796.2
799.0-799.9
840.0-848.9

Coding Guidelines

CBC's performed for rheumatoid arthritis patients being treated with the following medications should submit the indicated diagnosis on the claim:

Diagnosis code E933.1 for patients on antineoplastic and immunosuppressive drugs such as Methotrexate and Imuran;

Diagnosis code E935.6 (Artirheumatics) for patients on Gold Salts; or

Diagnosis code E933.8 (Other systemic agents not elsewhere classified) for patients on a penicillamine.

Documentation Requirements

Documentation to support the medical necessity of the laboratory service is the responsibility of the billing entity whether physician or independent laboratory. Documentation may include History and Physical, progress notes with presenting symptoms, laboratory results and active treatment protocol. Office/progress notes must contain the date of service and the signature of the physician.

Advance Notice Requirement

Applies to diagnosis requirement (see page 4).

**********



85610: Prothrombin Time

A prothrombin time is utilized to determine the time required for a particular specimen of prothrombin to induce blood plasma clotting under standardized conditions, in comparison with a time of between 11.5-12 seconds for normal human blood. Medicare Part B of Florida has had a policy in place for prothrombin time since 1996. In the Carrier's process of periodic review of finalized policies, it was determined that revisions were necessary to ensure that only reasonable and necessary services were covered.

Diagnosis Requirements

Medicare Part B will consider prothrombin time testing to be medically necessary when performed for the following diagnoses/conditions:

070.0-070.9
285.1
286.0-286.9
287.0-287.9
325
362.30-362.37
394.0-394.9
395.0
395.2
396.0-396.9
410.00-410.92
411.1
411.81-411.89
413.0-413.9
414.8
414.9
415.0-415.19
416.9
424.0
425.0-425.9
427.0-427.9
428.0-428.9

429.1-429.4
432.0-432.9
433.00-433.91
434.00-434.91
435.0-435.9
437.0
437.1
437.6
444.0-444.9
447.1
451.0-451.9
452
453.0-453.9
459.0
459.1
459.81
514
569.3
571.0-571.9
572.2
572.4
572.8
573.9
577.0
578.0-578.9
579.2
599.7
671.90-671.94
673.00-673.84
719.15-719.19
746.00-746.9
782.7
784.7
784.8
786.3
789.1
789.5
790.92
852.00-852.59
964.2
995.2
V12.3
V15.1
V42.2
V42.7
V43.2
V43.3
V43.4
V43.61-V43.69
V58.61
V72.84

Reasons for Denial

Screening for congenital deficiencies of factors II, V, VII, and X is not covered. In addition, prothrombin time testing performed

for indications other than those listed above will be considered not medically necessary or reasonable and will result in denial of coverage.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing a prothrombin time.

**********

86781: Fluorescent Treponemal Antibody Absorption (FTA-abs)

The fluorescent treponemal antibody absorption (FTA-abs) test is the most widely employed treponemal test. It is a specific test for the diagnosis of syphilis. The FTA-abs test includes a serum specimen which is absorbed and then tested with immunofluorescence for the antibody to Treponema pallidum, the causative agent of syphilis.

FTA-abs is the most sensitive test in all stages of syphilis. The FTA-abs test is of value principally in determining whether a positive nontreponemal antigen test (i.e., RPR or VDRL) is "false positive' or is indicative of syphilis. Because of its great sensitivity, particularly in the late stages of the disease, the FTA-abs test is also of value when there is clinical evidence of syphilis but the nontreponemal serologic test for syphilis is negative. The test is positive in most patients with primary syphilis and in virtually all with secondary syphilis.

Medicare Part B of Florida will consider FTA-abs testing (CPT code 86781) to be medically reasonable and necessary when performed under the following circumstances:

Confirmation of a positive RPR or VDRL test

A patient with suspected primary syphilis who has a negative RPR or VDRL

A patient with suspected latent syphilis or neurosyphilis who has a negative RPR or VDRL

Diagnosis Requirements

To ensure that payment is made only for medically necessary services, FTA-abs testing is covered when it is performed for the following diagnoses:
090.0-090.9
091.0-091.9
092.0
092.9
093.0
093.1
093.20
093.24
093.81-093.89
093.9
094.0-094.3
095.0-095.9
096
097.0-097.9
386.10-386.19
386.2
386.9

Documentation Requirements

The medical record must indicate the medical nesessity for performing the FTA-abs test. Required documentation in support of medical necessity would include office/progress notes and test results.

Reasons For Denial

FTA-abs tests performed in the absence of those instances listed under the "Diagnosis Requirements" section of this policy will be denied as not medically reasonable and necessary. Additionally, services performed as routine screening are not covered by Medicare Part B of Florida.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

**********



87086-87088: Culture, Bacterial, Urine

Bacterial urine culture testing is done when the patient exhibits clinical symptoms indicative of a urinary tract infection. Medicare Part B of Florida has had medical policy in place for bacterial urine culture since 1996. In the periodic process of policy review, it has been determined that revisions to the covered ICD-9 list should be made in order to ensure that Medicare pays only for those services which are medically reasonable and necessary.

The following codes are used to report bacterial urine culture tests:

87086 Culture, bacterial, urine; quantitative colony count

87087 Culture, bacterial, urine; commercial kit

87088 Culture, bacterial urine; identification, in addition to quantitative and commercial kit

## Indications and Limitations of Coverage

Medicare will consider these laboratory procedures to be medically reasonable and necessary in the following circumstances:

An abnormal urinalysis suggestive of a urinary tract infection, e.g., hematuria, pyuria, or proteinuria.

Clinical symptoms suggestive of a urinary tract infection, e.g., burning and/or pain on urination.

Fever of unknown origin or septicemia.

In follow-up of a previously treated urinary tract infection to confirm effectiveness of therapy.

## Diagnosis Requirements

To ensure that payment is made only for medically necessary services, these tests are covered only for the following diagnoses/conditions:
038.0
038.1
038.2
038.3
038.40
038.41
038.42
038.43
038.44
038.49
038.8
038.9
580.0
580.4
580.81
580.89
580.9
590.00
590.01
590.10
590.11

590.2
590.3
590.80
590.81
590.9
591
592.0
592.1
592.9
593.0
593.1
593.2
593.3
593.4
593.5
593.6
593.70-593.73
593.81
593.82
593.9
594.0-594.9
595.0-595.9
596.0-596.9
597.0-597.89
598.00-598.9
599.0-599.9
601.0
608.0
608.2
608.4
608.81
608.84
608.85
608.86
608.89
608.9
780.6
788.0
788.1
788.20
788.21
788.30
788.31
788.32
788.33
788.34
788.35
788.36
788.37
788.39
788.41
788.42
788.43
788.61
788.62
788.7
788.8

790.7
791.0
791.7

Reasons for Denial

Bacterial urine culture will not be covered by Medicare when performed for routine screening. Services billed with ICD-9 codes other than those listed will not be covered.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Documentation Requirements

Patient records maintained by the ordering/referring physician should document the medical necessity for this test.

**********

88150-88157: Diagnostic Pap Smears

Pap Smear (Papanicolaou Smear/Test) is a cytologic examination of a vaginal smear for early detection of cancer, especially of the cervix and uterus. The test employs exfoliated cells and a special staining technique which differentiates diseased tissue. Medicare Part B of Florida has had a local medical review policy for Pap smears in place since 1996. As part of the Carrier's process of periodic evaluation of finalized policy, it has been determined that revisions need to be made in order to ensure that only those services which are medically reasonable and necessary are covered.

Diagnosis Requirements

Medicare Part B will consider a diagnostic pap smear to be medically necessary when performed for the following diagnoses/conditions:

16.70-016.76
054.10
054.11
054.12
078.0
078.10-078.19
090.0-099.9
112.1
112.2
131.00-131.9
170.6
171.6
179

180.0-180.9
181
182.0-182.8
183.0-183.8
184.0-184.9
198.6
198.82
218.0-218.9
219.0-219.9
220
221.0-221.9
233.0-233.3
233.9
236.0-236.3
239.5
256.0-256.9
616.0
616.10-616.11
616.2
616.50-616.51
616.8
616.9
617.0
617.9
620.0
620.1
620.2
620.8
621.0
621.1
621.2
621.8
622.0
622.1
622.7
622.8
623.0
623.5
623.7
623.8
624.6
624.8
626.2
626.6
626.7
626.8
626.9
627.1
627.2
627.3
627.8
627.9
628.0-628.9
654.10-654.14
795.0

Coding Guidelines

Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies to codes 88151-26, 88157-26, and 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate.

No payment is recognized for codes 88151-26, 88157-26, or 85060 furnished to hospital outpatients or nonhospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.

Separate payment is not made for ThinPrep Pap Test. Medicare reimbursement is made primarily by service, rather than by methodology.

Reasons for Denial

Payment will not be allowed for 88150-88157 on the same date of service. Services billed with ICD-9 codes other than those listed will not be covered.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Documentation Requirements

History, physical, progress notes and the pathology report should be maintained in the patient's permanent record, to be made available upon request.

**********



90845: Medical Psychoanalysis

Psychoanalysis uses investigative techniques to gain insight into a person's unconscious motivations, conflicts and symbols and thus to effect a change in maladaptive behavior.

The primary goal of psychoanalysis is the establishment of the transference relationship and its subsequent analysis. It is this primary focus that distinguishes psychoanalysis from psychodynamic psychotherapy. The specific treatment effects of psychoanalysis grow from the experience and analysis of the transference, reawakened affects, cognitions, and behaviors linked with significant individuals in the patient's past. In the context of the arousal associated with these figures and the simultaneous understanding of the experience, behavior change can occur.

The analyst uses a number of techniques in his or her interventions, including free association, therapeutic alliance, neutrality, abstinence, defense analysis and Interpretation of transference.

## Indications and Limitations of Coverage

Medicare Part B of Florida will consider Medical Psychoanalysis (CPT code 90845) to be medically reasonable and necessary under the following circumstances:

Psychoanalysis is useful in the treatment of obsessional disorders, anxiety disorders, dysthymic disorders and moderately severe personality disorders.

Individuals with substantial preoedipal pathology, usually indicated by chaotic life setting and an inability to establish a supportive dyadic relationship, as is often seen in patients with narcissistic, borderline, schizoid, paranoid, and schizotypal personality disorders, are generally not indicated for psychoanalysis.

Psychoanalysis is generally considered unsuitable for psychoses.

The provider performing psychoanalysis must be trained and credentialed in its use.

## Diagnosis Requirements

To ensure that payment is made only for medically necessary services, Medical Psychoanalysis (CPT code 90845) is covered when it is performed for the following diagnoses:

296.20-296.25
296.30-296.35
300.01
300.02
300.11-300.13
300.20-300.29
300.3
300.4
309.1
309.21
309.22
309.23

## Reasons for Denial

Medical Psychoanalysis performed in the absence of those conditions listed under the "Diagnosis Requirements" section of

this policy will be denied as not medically reasonable and necessary.

Services will also be denied if they are not provided by a qualified provider (as defined by Medicare).

Coding Guidelines

CPT code 90845 is not time - related, but the code is billed once for each daily session regardless of the time involved (usually 45 to 60 minutes).

Documentation Requirements

The medical record must document the indications for psychoanalysis, description of the transference, and that psychoanalytic techniques were used.

Medical record documentation in support of medical necessity should include:

history and physical

office/progress notes

treatment plan

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

**********



90880: Medical Hypnotherapy

Hypnosis is an artificially induced alteration of consciousness in which the patient is in a state of increased suggestibility.

Hypnosis can be used in intensive psychotherapy as a means of gaining access to repressed memories that have not emerged using other techniques, for example, when both the patient and the psychotherapist have worked on resistance issues and feel that some additional leverage is necessary. Such a use of hypnosis comes up particularly in regard to traumatic events that may have occurred during childhood and have been dissociated.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare Part B of Florida will consider Medical Hypnotherapy (CPT code 90880) to be medically reasonable and necessary under the following circumstances:

Hypnosis can be indicated in the treatment of dissociative disorders, for example, in identifying and controlling dissociative fugue, amnesia, and identity disorder, and in treating posttraumatic stress disorder and conversion disorder.

Hypnosis can also be used in the treatment of anxiety disorders, phobias and psychogenic pain.

Consideration should be given to the use of hypnosis if the patient has the requisite hypnotizability, is cooperative with the procedure, and has a problem for which hypnosis has been shown to be of adjunctive use.

## Diagnosis Requirements

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

300.11
300.12
300.13
300.14
300.15
300.20-300.29
307.80
308.3-309.81

## Reasons for Denial

Medical Hypnotherapy performed in the absence of those conditions listed under the "Diagnosis Requirements" section of this policy will be denied as not medically necessary.

## Coding Guidelines

When hypnosis is used therapeutically to enhance psychotherapy or provided in conjunction with psychotherapy in the same session, only CPT code 90880 or the psychotherapy code should be reported.

## Documentation Requirements

The medical record documentation must document the indications for medical hypnotherapy (CPT code 90880) that support medical necessity.

Medical documentation in support of medical necessity should include:

History and Physical

Office/Progress notes

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

**********

95937: Neuromuscular Junction Testing (repetitive stimulation, paired stimuli), each nerve, any one method

Neuromuscular junction testing involves the stimulation of an individual motor nerve by means of repetitive electrical impulses with measurement of muscle electrical activity. Supramaximal electrical stimuli are delivered to the skin overlying a motor nerve. A percutaneous electrode, placed over the corresponding muscle records the evoked muscle action potentials using standard EMG technique. This procedure is unique in that the electrical stimuli are delivered in a repetitive train (1-4 Hz). In diseases of the neuromuscular junction, characteristic changes in the compound action potential may be seen upon repetitive stimulation.

Analysis of 1995 Medicare claims data for the state of Florida indicates that the Carrier has allowed significantly more reimbursement per 1,000 Medicare beneficiaries than Medicare has paid nationally for procedure code 95937 for specialties 01 (General Practice), 02 (General Surgery), 08 (Family Practice), 13 (Neurology), 29 (Pulmonary Disease), 83 (Hematology/Oncology), and 95 (Independent Physiological Laboratories). In addition, analysis of data indicated that this procedure was being billed using nonspecific diagnoses and/or diagnoses that do not substantiate medical necessity. Analysis of place of service data for aberrant specialties demonstrated that 22 percent of the services were being performed in the home (place of service 12). Local medical review policy was developed, defining the service and the circumstances under which Medicare will consider it to be medically necessary and reasonable, and to establish guidelines for medical review, as well as a diagnosis to procedure code edit.

Medicare will consider neuromuscular junction testing to be medically necessary when used in the following circumstances:

Evaluation of the patient with a disorder of the neuromuscular junction suspected on clinical grounds. This includes both postsynaptic disorders such as myasthenia gravis and presynaptic disorders such as Eaton-Lambert syndrome (myasthenic paraneoplastic syndrome associated with small cell carcinoma of

the lung), botulism and disorders associated with use of aminoglycosides.

Myasthenia gravis usually affects the muscles to the eyes, face, jaws, throat, and neck first; however, as the disease advances if often spreads to other muscles. Signs and symptoms may include, but are not limited to, the following: ptosis, diplopia, difficulty in chewing and swallowing, dysarthria, respiratory difficulties, limb weakness, or some combination of these problems. Weakness may remain localized to a few muscle groups, especially the ocular muscles, or may become generalized. Sensory modalities and deep tendon reflexes are normal. Symptoms often fluctuate in intensity during the day. Muscle weakness tends to increase with continued activity and rest restores strength at least partially.

Myasthenic syndrome (Eaton-Lambert Syndrome) usually affects muscles of the trunk, shoulder girdle, pelvic girdle, and lower extremities. Often the first symptoms are difficulty in arising from a chair, climbing stairs, and walking; the shoulder muscles are usually affected later. Other signs and symptoms may include ptosis, diplopia, dysarthria, and dysphagia. Tendon reflexes are often diminished. There may be a temporary increase in muscle power with sustained contractions.

Botulism results from ingestion of toxin and symptoms usually begin within 72 hours and may progress for several days. Typically, there is diplopia, ptosis, facial weakness, dysphagia, and nasal speech, followed by respiratory difficulty, and finally weakness in the limbs. Other signs and symptoms may include blurring of vision (with unreactive dilated pupils), dryness of the mouth, constipation, and postural hypotension. Sensory modalities and deep tendon reflexes are normal.

Aminoglycoside antibiotics may produce clinical disturbance similar to botulism, but symptoms subside rapidly as the responsible drug is eliminated from the body. These antibiotics are particularly dangerous in patients with pre-existing disturbances of neuromuscular transmission and are therefore best avoided in patients with myasthenia gravis. You would not expect to see this procedure performed for this reason due to the fact that the symptomatology subsides with removal of drug. If signs and symptoms persist after removal of the medication, then this should be billed per signs and symptoms that exist.

Diagnosis Requirements

To ensure that payment is made only for medically necessary services, Neuromuscular Junction Testing (95937) is covered only when performed for the following conditions/diagnoses:

199.1

358.0
358.1
368.2
368.8
374.30
378.73
723.1
728.9
780.7

781.2
781.9
784.5
786.09
787.2

Coding Guidelines

Based on review of this service, it has been determined that this service should be carried out in a fully equipped electrodiagnostic testing room. Therefore, this service should not be performed in the home (POS 12) or in a custodial care facility (POS 33).

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the test. Medical record documentation in support of medical necessity could include:

History and physical (including a neurologic history, examination, and documentation of neurologic symptomatology)

Office/progress notes

Repetitive neuromuscular junction test(s) results

If the provider of the service is other than the ordering/referring physician, that provider must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies. The physician must state the clinical indication/medical necessity for the study in his order for the test.

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## A Closer Look

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

### Important Information About the Appeals Process

This information is being provided to assist you in the processing of your appeal requests by providing you with an overview of the appropriate steps which should be followed if you should disagree with Medicare's initial decision on your claims. The following information will be addressed:

Which types of appeals are available and the appropriate procedures to be followed when requesting a specific type of appeal,

Who can file for a review,

Which types of reviews should be requested over the telephone,

Which types of reviews should be requested in writing,

How much time you have to request a review,

How you will be notified of the review decision,

What the next steps are to be followed if you still disagree with review decision, and

How to file a request for a hearing.

We hope this information will prove helpful, and encourage you to reference it whenever appealing an initial claim determination.

### Appropriate Procedures to Follow When You Disagree With the Initial Claim Determination

When you are notified a claim has been denied, the first step in determining appropriate action to take is to review your Provider Remittance Notice (PRN) for the claims denial reason. If your claimwas denied with no appeal rights afforded, then you would need to make the appropriate changes on the claim form and resubmit it for processing. If the claim denied and appeal rights were extended then the first level of appeal would be a review.

Before submitting the claim to review, always ensure that the following steps are followed:

1. If it has been more than six months since the service were originally processed by Medicare, the time limit for requesting a review has passed. Refer to the section "How Long do I Have to File for a Review?" for further information when this situation exists.

2. If the detail information (e.g., service date, procedure, location of service) on your PRN is different than what you originally filed, refer to the section "To Request a Telephone Review."

3. If you normally receive payment for this service(s), but received a denial, refer to the section, "What Types of Reviews are Available and Which Type Should I Request?" to determine your next steps.

4. If you have additional documentation to submit which can support the medical necessity for the service(s), refer to the section, "Procedure to Follow When Filing for a Written Review." Be sure to include the additional documentation when filing for the review.

What Types of Reviews are Available and Which Type Should I Request?

There are two types of review which may be available to you. You may request a review in writing, or, in certain situations, by telephone. The following information will help you decide which type of review request will be helpful for you to get the most timely response.

Telephone Reviews

Request a telephone review if the claim requires corrections and/or changes to the items listed below:

Date of service (except for change in year, such as 1996 to 1997; year of service changes must be made via a written request.),

Billed amount,

Procedure code,

Add, change, or delete a modifier (except modifiers 22, 24, 62, 64, and 66; changes to these modifiers require a written review request),

Place of service,

ICD-9-CM diagnosis code, and/or

Number/quantity billed.

When requesting telephone reviews on non-assigned claims where the beneficiary is held financially liable, the beneficiary must remain on the phone with the provider throughout the entire conversation (i.e., a three-way call or a conference call). If the beneficiary is not present, only the following information may be released over the telephone:

The date the claim was received;

The date the claim processed; and

The date the beneficiary can expect a Medicare Summary Notice.

If, in reviewing a Limiting Charge Exception Report (LCER), an error on the original claim is detected, the error can be corrected over the telephone by the Customer Review Representative.

If the service was denied or payment reduced because it was considered not reasonable and necessary under Medicare guidelines, the provider has liability for the claim, unless an appropriate written advance notice was provided to the patient before the service was furnished.

To request a telephone review, call the Medicare Part B Customer Service Department at (904) 634-4994. Be prepared to indicate the provider's license number or tax identification number, and have available the Medicare Part B Provider Remittance Notice (PRN) that identifies the claim(s) to be reviewed. The Customer Service Representative will ask for this information and the full name of the caller to verify the identity of the provider and the claim in question.

The Customer Service Representative will review up to five claims at each call. If there are more than five claims to be reviewed, the representative will give you a confirmation number and instructions for faxing the review request. If you prefer to fax your requests, no matter the number, simply tell the representative of this preference instead of waiting for the

representative to complete the review. A "Request for Telephone Review" form has been created for use when faxing reviews. The form includes all necessary information for a telephone review. A copy of the "Request for Telephone Review' form can be found on page 45. You may also fax a PRN, but you must be sure to circle the claim in question and state clearly the reason for the review request.

NOTE: A new confirmation number must be obtained each time you fax a request or the request will be rejected.

Written Reviews

A written review can be filed in two ways:

1.

Highlight on your Provider Remittance Notice (PRN) the services you would like reviewed. Send us a detailed letter telling us specifically why you feel the initial decision was not correct. Please include a copy of the claim and any supporting documentation relating to the service at issue. Please be very specific regarding the service you would like reviewed to ensure a more timely and accurate reply to your request.

2.

You may also file your request for review by utilizing the HCFA-1964 form (see page 46). Please denote clearly in section five (5) your reason for the review request. A supply of the HCFA-1964 forms can be ordered by writing to:

Superintendent of Documents

United States Government Printing Office

Washington D.C. 20402

Where Do I Mail My Review Request?

Mail your review request with the appropriate documentation to:

Medicare Part B Reviews

P. O. Box 2360

Jacksonville, Florida 32231-0048

How Long Do I Have To File For A Review?

A review request must be filed within six months from the date the services initially processed. This date can be found on your Provider Remittance Notice (PRN). We can consider review requests filed late only for reasons of a "good cause" nature. Good cause reasons are generally limited to:

Incorrect or incomplete information from the Medicare B Carrier, Social Security Administration or the Health Care Financing Administration (HCFA),

or

Damage to your records as a result of a fire, theft, etc.

How Will I Be Notified of the Review Decision?

Once a review request is processed, the provider will receive a written response. The response varies depending upon the action taken.

1.If the original decision on the claim is upheld, a detailed letter will be sent advising why additional payment cannot be allowed.

2.If the original decision on the claim can be changed and payment is due, a new PRN and check will be issued.

3.If the original decision on the claim is changed, but no further payment is due, a letter will be sent which explains why no payment is forthcoming. A new PRN will be issued indicating that a correction was made to the previously processed claim.

4.If a portion of the claim can be allowed, a check with a corrected PRN will be issued for the services allowed. A separate explanatory letter will be sent advising that an adjustment has been made. It will include an explanation of why the other service(s) on the claims were not allowed or why additional reimbursement was not made.

In any review decision letter, providers are advised of their rights to a Medicare Part B hearing, should they choose to request one.

What Are the Next Steps After a Review?

If after a review decision, you are still dissatisfied and the amount in controversy is $100 or more, you may request a hearing. The amount in controversy is 80 percent of the difference between the billed charge and the approved amount less any deductible remaining. For example: You billed $1,000 for a surgical

procedure. Medicare Part B allowed $600 and the patient's deductible was met previously. The amount in controversy is determined by:

Subtracting the allowed amount from the billed amount $1,000 - $600 = $400

Subtracting the deductible remaining from the difference $400 - $0 = $400

Multiplying the balance by 80 % $400 X 80 % = $320

You may combine claims which have been previously reviewed or reviews that have been reopened within the past six months to meet the $100 requirement.

## Who Can Request a Hearing?

### Assigned Claims

Either the provider, the patient, or an authorized representative may request a hearing on an unassigned claim. The hearing request must be in writing. You may represent yourself or appoint someone to represent you.

### Nonassigned Claims

For nonassigned claims, you may request a hearing only if the payment was denied or reduced due to medical necessity guidelines and you are liable for the denied payment or payment reduction. You may also request a hearing if the beneficiary gives you written authorization to submit the hearing request. As with assigned claims, the request must be in writing.

## Types of Hearings

There are three different types of hearings. They differ only in the speed with which the hearing can be conducted and the method of presenting testimony. The purpose of any type of hearing is to arrive at the correct determination. The three types of hearings are:

On-The-Record (OTR) Decisions: This type is the easiest and most convenient and can save time. A decision can be made quickly based on the facts in the file and any additional information sent to the Hearing Officer.

Telephone Hearing: This type offers a convenient and less costly alternative to the "in-person" hearing since the need to appear

is eliminated. Oral testimony and oral challenge may be conducted via the telephone.

In-Person Hearing: You are given the opportunity to appear and present oral testimony (as with telephone hearings) supporting your claim and refuting or challenging the information used to deny the claim.

NOTE: The same benefits derived from in-person hearings are also available during telephone hearings.

Regardless of the type hearing requested, the Hearing Officer may first perform an On-The-Record (OTR) decision. If you do not agree with the outcome of the OTR decision, you may pursue the formal type hearing you initially requested by completing the post card sent with the OTR decision and returning it to Medicare Part B. The hearing will be held on the date and time noted on the post card.

Hearings are conducted by a Hearing Officer appointed by Medicare Part B. The Hearing Officer's role is to determine whether the carrier has followed Medicare guidelines in making the determination in question. The hearing process should be reserved for those unusual or unique situations permitting to a certain procedure or course of treatment requiring in-depth medical or administrative review.

How to File a Request for a Hearing

Submit your request in writing, explaining clearly why you are dissatisfied with the review determination, and indicate the type of hearing you are requesting. You may use the HCFA-1965 form to file your request.

Send the request, a copy of the review notice and any additional evidence you may wish to include to:

Medicare Part B Fair Hearings

P.O. Box 45156

Jacksonville, FL 32232-5156

How Long Do I Have to File a Hearing Request?

A hearing request must be filed within six months from the date of the previous notification (review letter or corrected PRN). Requests filed after this time period cannot be considered.

Is the Decision Rendered by the Hearing Officer Final?

The decision made by the Hearing Officer, in many cases, is final and binding. If at least $500 remains in controversy following the Hearing Officer's decision, further consideration may be made by an Administrative Law Judge (ALJ). The hearing determination will include instructions for obtaining an ALJ hearing. The request must be made within 60 days of receipts of the hearing determination. The ALJ will advise you of hearing preparation procedures.

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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. Please report the following activities, or any fraudulent and abusive practices, to the Medicare Fraud Branch (MFB) by phone, facsimile, or by mail at one of the following:

Medicare Part A Provider Customer Service Department (904) 355-8899 Medicare Part B Provider Customer Service Department (904) 634-4994 MFB Fax Line (904) 791-6716

Medicare Fraud Branch

P.O. Box 45087

Jacksonville, FL 32231-0048

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

## Seminar Advisory

Multiple Medicare contractors have been contacted regarding a company which is advertising/promoting Medicare seminars aimed at providers throughout the United States. This company uses "Medicare" in their company name and acts as if they represent a federal contractor. Actual Medicare contractors will identify themselves as such and do sponsor/provide multiple seminars throughout the year.

However, we do not advertise that we will show a provider how to circumvent reimbursement guidelines and/or how to maximize reimbursement. The company at issue in this scam is located in California and has been advised, by HCFA and the OIG, that they

may not use the term "Medicare" in their company name and must clearly state that they are a private corporation not associated with any federal contract. If there is any doubt about who sponsors a seminar, contact your local contractor or HCFA.

## Kickbacks

Under federal law, Section 1128 (b)(7) of the Social Security Act (42 USC 1320a-7), it is a felony for anyone to knowingly and willfully offer, pay, solicit or receive any payment in return for the furnishing of any item or service that may be paid by the Medicare or Medicaid programs. Individuals convicted under this law may be fined up to $25,000 or imprisoned up to five years or both.

Anyone who accepts or solicits any payment or other remuneration for referring patients to any practitioner, durable medical equipment supplier, home health agency, laboratory, or any other health provider or facility which furnishes items or services that may be paid by a federal program, may be subject to prosecution. The criminal statute applies regardless of whether the payment for a referral is made directly or indirectly, overtly or covertly, in cash or in kind.

The following arrangements are just a few examples of potential violations of federal law if the services are covered under the Medicare or Medicaid programs:

Respiratory, physical or other therapists working in the hospital are paid a "finder's fee" for patients they refer to DME suppliers.

Hospital social workers or discharge planners receive payment from home health agencies or DME suppliers for referring hospital patients.

Physicians working in outpatient departments are offered percentages of prescription payments if they refer patients to local pharmacies.

In the preceding examples, the unlawful activity is the referral by the solicitation/offer or receipt/payment of the kickback. A referral of a patient that does not involve the solicitation or exchange of payment/remuneration would not be considered a violation of the statute. These are but a few examples of situations which may be considered inappropriate. Providers are encouraged to seek legal council before engaging in any financial transaction involving patient referrals, federal and state funds, etc.

## Routine Foot Care Alert

Section 1862(a)(13)(C) of the Social Security Act prohibits payment for routine foot care, including the cutting or removal of corns and calluses, the trimming of toenails and other routine hygienic care. The only circumstances in which the coverage of these otherwise excluded services is permitted under the Medicare program are described in section 2323B of the Medicare Carrier's Manual. That is, services that are a necessary and integral part of otherwise medically necessary services, such as warts, the presence of a systemic condition and mycotic nails.

Recently the OIG released a report, describing their findings resulting from an audit of claims submitted for toenail trimmings performed by multiple podiatrists. This report noted the following findings:

The podiatrists contracted with numerous SNF's to perform routine foot care to their residents.

The podiatrists visited the facilities every two months and performed nail trimming on every resident.

They submitted claims to Medicare as covered services using systemic diagnoses such as asthma, dementia, or organic brain syndrome.

In addition to nail trimmings, the podiatrists billed an evaluation and management
procedure code.

The diagnoses submitted are not consistent with the systemic conditions set forth in MCM section 2323C. This list specifies underlying conditions that might justify coverage of routine foot care and includes diabetes, peripheral neuropathies, arteriosclerosis, and chronic thrombophlebitis. Also, to qualify for routine foot care, the patient, with few exceptions, must be under the active care of an MD or DO who documents the condition. There must also be convincing evidence that a non-professional could not perform the services as it would be considered hazardous to the beneficiary. The mere statement of a diagnosis, such as those listed above, does not of itself indicate the severity of the condition nor does it completely document the need for a physician's level of care.

Medicare & Medicaid Fraud Actions

Indictments

A Miami psychiatrist and a St. Petersburg business associate were indicted for using Adult Living Facilities in the Tampa Bay

area to defraud the Medicare program of about $1 million. If convicted, each could be sentenced to a maximum of 90 years in prison and a fine of $4.5 million. The basis of their operation was to provide recreational services in the ALF and nursing home environment.

## Plea Agreements

On April 15, 1997, a Florida man pled guilty to six of a seven count indictment for violation of the Medicare anti-kickback statute and one count of filing a false tax return. The man was involved with a Florida impotence clinic set up, who was billing Medicare for medically unnecessary services or services not ordered by a physician. Numerous mobile diagnostic labs were paying kickbacks which were disguised as rental fees or marketing fees.

A Florida dentist pled guilty on March 12, 1997, to mail fraud charges. The provider was billing non-covered routine dental services as covered by altering the procedure code and submitted diagnosis. Sentencing is scheduled for mid-June. The dentist is currently serving time for federal bank fraud and embezzlement.

## In The News/FYI

A Hialeah pharmacy, Cueto Pharmacy, defrauded Medicare out of more than $25 million by watering down inhalation prescriptions for nebulizer treatments. This case was the result of a crackdown on durable medical equipment and pharmacies by the DMERC fraud unit and the FDA.

OIG Counsel cautions against routine waivers of Medicare co-payments. The chief counsel cautioned providers that the new health insurance portability law expressly makes it illegal for hospitals or other providers to routinely waive Medicare A or B co-payments to induce seniors to sign up for their plan or obtain services. The action is considered illegal under the new statute's Section 231, which provides for penalties for offering inducements to purchase Medicare or Medicaid services from particular provider.

The Florida Attorney General's statewide grand jury has indicted more than 67 people and three corporations accused of defrauding the state of more than $24 million.

Florida Medicaid suspended payments to a financially troubled counseling and drug treatment facility in Del Ray Beach, Florida. Total Recovery, Inc. has been plagued with complaints from patients, the landlord and the state.

Two fraud and abuse provisions in HR 3103 will directly affect the managed care industry in its efforts to contract with the government to provide Medicare services; Section 215, which creates new intermediate sanctions for Medicare risk plans; and Section 216, which creates a new exception to the Medicare and Medicaid anti-kickback law.

A justice suit alleges that Florida's Charter Hospital of St. Louis, Inc. submitted fraudulent billings to Medicare and Medicaid after improperly admitting 200 elderly, disoriented patients brought from area nursing homes.

U.S. files $1.1 million suit against Royal Geropsychiatric Services Inc., alleging they submitted false claims to the government for various psychiatric services provided to nursing home patients, between 1993-1995.

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## Payment Suspension Regulations Revised

The Health Care Financing Administration (HCFA) has revised the federal regulations that govern the suspension of Medicare payments to a provider. The cite for these regulations is 42CFR405.370ff. As a result of this revision HCFA, not Medicare contractors, has the authority to suspend Medicare payments to providers for whom evidence of fraud or misrepresentation exists. In such cases, HCFA would direct us to suspend payments. We continue to have the authority to suspend payment to a provider for other reasons, including when we believe an overpayment exists or that payments to be made may not be correct.

Additionally, HCFA has advised us that it is considering expanding the scope of its suspension actions. Presently, if a medical group is suspected of fraud or misrepresentation, payment is suspended for services rendered by the group's physicians. HCFA is considering, in such cases, extending the payment suspension to other entities billing for that group's physicians and to claims filed directly by those physicians. Medical groups need to be careful, therefore, before entering into reassignment agreements with new physicians who have had their Medicare payments suspended, at least until the issue that necessitated the suspension action has been satisfactorily addressed.

## Requests for Medical Records

Federal law requires physicians and suppliers to maintain and make available information, including medical records, that the Medicare program may need to make a determination on a Medicare claim. Additionally, Florida law requires physicians to keep detailed records of every patient encounter including referrals for laboratory work and test results related to the encounter. For these reasons and because we plan to conduct more on-site

visits to collect and review medical records, it is critically important that you comply with these laws. Some of our on-site visits will be conducted in conjunction with representatives from HCFA. Failure to make available requested information during such a visit could result in suspension of your Medicare payments and/or referral to the Florida Medical Quality Assurance Division for licensure revocation. Finally, when we or HCFA requests medical records, you do not need to obtain the beneficiary's authorization to release them because all beneficiaries have authorized us to make such requests as part of their application for Medicare eligibility.

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Providers May Correct and Resubmit Claims Denied for Certain Reasons

Not all denied claims require a review! Providers who have had a claim denied can often make the necessary corrections to the claim and simply resubmit it either electronically or on paper. Some common examples of when it would be appropriate to resubmit a claim include:

Improper completion of block 24E of the HCFA-1500 claim form,

Diagnosis not billed to the highest level of specificity,

Improper completion of block 11 of the HCFA-1500 claim form,

Modifier 59 (needed to indicate a separate service), and

Improper completion of block 32 of the HCFA-1500 claim form.

Resubmitting the claim could result in receipt of payment (when applicable) faster, since the provider will only be bound by the 14-day (EMC) or 27-day (paper) payment floor. This is substantially less time than the review process, which can take up to 45 days.

Do not make any notations on the resubmitted claim such as "Please Review" or "Review Request". This will cause your claim to be routed to the Medicare Part B Review Department, thus defeating your purpose.

Be sure that you only submit the denied detail lines, not the entire claim. Duplicate submissions may be considered a form of program abuse.

Resubmitting Electronic Claims

If you are unable or unsure if you are able to resubmit denied or rejected claims electronically, contact your vendor.

If you are resubmitting a service that has been rejected on EMC Error Reports, after correction, resubmit the entire claim. If you don't resubmit the entire claim, the other details/lines without errors (not printed on EMC Error Report) won't be processed for payment.

When resubmitting an entire batch of electronic claims, be sure to add or delete a claim from that batch. This allows the batch to bypass the duplicate batch transmission edit.

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Updates To The Medigap Insurer Listing

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

Medigap Insurer Address Changes

| Number | Insurer Name |
|---|---|
| 30020 | FELRA & UFCW 10626 YORK ROAD COCKEYSVILLE MD 21030 |
| 48008 | PENNSYLVANIA BLUE SHIELD PO BOX 898845 CAMPHILL PA 17089 |
| 53005 | TRANSPORT LIFE222 MERCHANDISE MART CHICAGO IL 60654 |

Medigap Insurer Name/Address Change

| Number | Former Name | Changed To |
|---|---|---|
| 45004 | BCBS MUTUAL OF OHIO | MEDICAL MUTUAL OF OHIO 2060 E NINTH STREET CLEVELAND OH 44115 |
| 45154 | BCBS MUTUAL OF N REGION | MEDICAL MUTUAL OF OHIO 2060 E NINTH STREET CLEVELAND OH 44115 |
| 31051 | CUSTOM BENEFIT PLAN IBA HEALTH & LIFE ASSURANCE PO BOX 51100 KALAMAZOO MI 49005 | |

Medigap Insurer Numbers Changed to Exempt

The following Medigap Insurer Numbers have been changed to an Exempt status. We will not crossover Medicare payment data to these Medigap insurer numbers. Please change the N to an Y in your update.

| Number | Insurer Name |
|---|---|
| 28021 | ASSOCIATED HEALTH PLANS |
| 19566 | CAC HEALTH PLAN HMO |
| 48372 | FIDELITY LIFE |
| 40068 | GP BENEFIT ADMINS |
| 24011 | GRACE BUSINESS GROUP |
| 40056 | HEALTH WAYS |

| | |
|---|---|
| 19223 | HMO HEALTH PLAN CAC |
| 53130 | INLAND FINANCIAL MUTUAL |
| 19597 | JEFFERSON PILOT LIFE |
| 19397 | STATE MUTUAL LIFE |
| 40077 | STATE MUTUAL LIFE |
| 28019 | SOUTHEAST MEDICAL PLAN |
| 42231 | THE ELDER PLAN CARD |

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## Ensure Your Software Supports Most Current National Standard Formats

Medicare Part B of Florida supports electronic claims submitted in one of the two national standard formats: The American National Standard Institute (ANSI) and the National Standard Format (NSF). We are required by the Health Care Financing Administration to support the current version and the most recent prior version.

When selecting your software for electronic claims submission make sure that it supports the most current version of one of the national standard formats:

| Version | NSF | ANSI |
|---|---|---|
| Prior: | 001.04 | 3032, 2B |
| Current: | 002.00 | 3051, 3B |

Upgrades to the current version are as follows:

Descriptor of Change: Version Code - NationalPrior: The version code must be
00104.Current:  The version code must be 00200.
(NSF) 00104: AA0/19/244-24800104
(NSF) 00200: AA0/19/244-24800200
(ANSI) 3032,2B: 1/01/REF/02/2B
(ANSI) 30351,3B: 1/01/REF/02/3B

Descriptor of Change: Billing ProviderNSF Only: Prior: Billing provider is housed in record BA0, field 02. Current:  Billing provider is housed in record BA0, field 09.
(NSF) 00104: BA0/02/04-18
(NSF) 00200: BA0/09/48-62
(ANSI) 3032,2B: No Change

(ANSI) 30351,3B: No Change

Descriptor of Change: Claims Editing IndicatorCurrent: Added two new indicators.
(NSF) 00104: No change
(NSF) 00200: CA0/23/183
(ANSI) 3032,2B: No Change
(ANSI) 30351,3B: 2/130/CLM/03

Descriptor of Change: Source of PaymentCurrent: Added four new indicators.
(NSF) 00104: No change
(NSF) 00200: DA0/05/24
(ANSI) 3032,2B: No change
(ANSI) 30351,3B: 2/130/CIM/03

Descriptor of Change:Medigap IndicatorCurrent: must have the "MG" indicator for Medigap crossover.
(NSF) 00104: No Change
(NSF) 00200: DA002/06/25-26
(ANSI) 3032,2B: No Change
(ANSI) 30351,3B: 2/290/SBR/05

Descriptor of Change: Provider Assignment IndicatorCurrent : Added new indicator "P: for "Patient refuses to assign benefits".
(NSF) 00104: No change
(NSF) 00200: EA0/34/199
(ANSI) 3032,2B: No change
(ANSI) 30351,3B: 2/130/CLM/07

Descriptor of Change: Homebound IndicatorCurrent: New field.
(NSF) 00104:N/A
(NSF) 00200: EA0/48/283
(ANSI) 3032,2B: N/A
(ANSI) 30351,3B:2/130/CLM/13

Descriptor of Change:Facility Provider NumberChange the way you enter the facility number:Prior: Add the "10" state code and drop the first alpha prefix (i.e., 10NNNN).Current: Dropped the "10" prefix and enter the number as assigned by the Medicare carrier (i.e., ANNNN).
(NSF) 00104: NO CHANGE
(NSF) 00200: EA1/04/23-27The prefix "10" is no longer required.
(ANSI) 3032,2B: NO CHANGE
(ANSI) 30351,3B:NO CHANGE

Descriptor of Change: Service From Date/Service To Date Current versions support the century positions: CCYYMMDD.
(NSF) 00104: No change
(NSF) 00200: All dates of service fields
(ANSI) 3032,2B: No change
(ANSI) 30351,3B: 2/455.A/DTP/03

Descriptor of Change: Units of Service Prior: Supports two whole numbers. Exception logic to bring in three whole numbers for specific procedure code (i.e., ambulance mileage).Current: Supports three whole numbers for all procedure codes.
(NSF) 00104: NO CHANGE
(NSF) 00200: FA0/18/82-85
(ANSI) 3032,2B: NO CHANGE
(ANSI) 30351,3B: 2/370/SV/04

Descriptor of Change: Drug Discount AmountCurrent: New field.

(NSF) 00104: NO CHANGE
(NSF) 00200: FA0/49/231-237
(ANSI) 3032,2B: NO CHANGE
(ANSI) 30351,3B: NO CHANGE\
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Not available in this format
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Physicians Should Provide Laboratories with ICD-9-CM Diagnosis Codes and/or Advance Beneficiary Notice

Medicare Part B of Florida is asking physicians to provide the ICD-9-CM diagnosis code to laboratories when ordering tests. Clinical laboratory tests outlined in our local medical review policies submitted without a diagnosis to substantiate the medical necessity of the service may be denied.

Although Medicare Part B does not require physicians to provide the ICD-9-CM diagnosis codes to the laboratories, we strongly encourage you to do so to help expedite payment of claims submitted by clinical laboratories. Again, without a diagnosis to substantiate medical necessity, the laboratory may not be paid for its service.

If you believe the test may be denied because it does not meet Medicare Part B of Florida's medical necessity criteria, please obtain a signed advance beneficiary notice and forward it to the laboratory along with your specimen. The laboratory needs this notice in order to bill the beneficiary for tests denied due to medical necessity. If you are not sure about the medical necessity criteria for a specific test, contact our Provider Customer Service representatives at (904) 634-4994.

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Revised Customer Service Hours of Operation

Medicare Part B of Florida's provider and beneficiary telephone Customer Service Representatives can be reached from 9 a.m. until 4:30 p.m., Monday through Thursday, and from 8 a.m. - noon on Friday. The Automated Response Unit (ARU) systems are available from 7:30 a.m. until 5:30 p.m. on Monday, and from 7:30 a.m. until 6:30 p.m. Tuesday through Friday.

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