September/October 1998 Medicare Part B Update! Publication
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Health Care Financing Administration
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Changes are on the Horizon for 1999!

Several administrative changes will take place to the Medicare Part B program for 1999. These changes will affect how providers receive participation agreements, the MEDPARD (Medicare's directory of participating providers), and the fee schedule. These have potentially large impacts to your office, so read the following information carefully!

Participation Agreements Will Not Be Mailed Separately

There will be no special mailing of the participation enrollment packages for 1999. Instead, the November/December edition of the Medicare B Update! will include all participation agreement information, including the agreement form itself. Providers are reminded that the open enrollment period from November 15 through December 31 is the only time that they can change their participation status, unless they are newly-practicing providers, or have set up a new location. Providers who do not want to change their status do not need to complete a participation agreement. Providers who want to change their status should be sure to look for the participation information in the next edition of the Update!

Hardcopy MEDPARDs Will Not Be Produced

The MEDPARD, Medicare's directory of participating providers, will not be produced in hardcopy version for 1999, but will be loaded on the Medicare Online Bulletin Board System (BBS). Information about how to access the BBS can be found on page 63.

Fee Schedules Will Not Be Routinely Mailed to Providers

The Medicare Fee Schedule will not be automatically mailed to providers for 1999. Providers who want a hardcopy fee schedule can purchase one at cost (see page 66 for an order form), or they can access the information on the Medicare Online BBS (see page 63). All orders for hardcopy fee schedules must be pre-paid and mailed no sooner than October 1, 1998.

The November/December edition of the Medicare B Update! will include more information on these and other changes to the Medicare program, so watch for it!

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What's New

Diabetes Outpatient Self-Management

The Balanced Budget Act of 1997 includes a provision for the coverage of diabetes outpatient self-management training services. The implementation of the provision is scheduled for October 1, 1998, and is retroactive for dates of service on or after July 1, 1998. Details about outpatient diabetes self-management and training programs are published on page 24.

Travel Allowance for Specimen Collection

Medicare Part B will reimburse for specimen collection and travel allowance when the collection is performed for a medically necessary reason and the patient is either in a nursing home or is homebound. Information about coding and payment guidelines can be found on page 27.

Medicare Part B Crossovers

Everything you ever wanted to know about crossovers, including information about automatic crossovers, Medicaid crossovers, and Medigap crossovers, is found on page 42.

Year 2000

Is your office ready for the millennium? Read our information about the possible impacts of Year 2000. See page 51 for details.

New Provider Applications

Medicare Part B of Florida has received the new provider enrollment applications. The previous version of the applications will not be accepted after September 30, 1998. See page 54 for more information.

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Highlights

Volume 11, Number 5September/October 1998

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The Medicare B Update! is published by the Medicare Part B Provider Education Department to provide timely and useful information to Medicare Part B providers in Florida. Questions concerning this publication or its contents may be directed in writing to:

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Are You Millennium (Y2K) Ready?

Imagine, if you will, your first day at the office in year 2000 (Y2K). Your 1995 auto sputtered all the way to work because one of the chips in the pollution control equipment was not Y2K ready. When you arrived at the office, your employees were all milling around the parking lot because no one could get the time lock on the door to work. After you paid the locksmith hundreds of dollars for an emergency call to unlock the doors, you discovered that none of your appointments showed up because your computer failed to mail out the reminder notices. (The computer thought the appointments were a hundred years ago.) A few Medicare patients did walk in, but when your staff tried to submit the claims electronically, they kept getting the "reject" message. When they tried to call Medicare, they found that the telephone system you purchased in 1995 could not dial out of the office. Alarmist fiction? Don't be too sure.

The Year 2000 computer problem, also known as the millennium bug, arises because most computer chips and software until recently, were programmed to use only two digits rather than four digits to represent the year. Therefore, "97" is recognized as the year 1997. On January 1, 2000, computer systems which are not Y2K ready will consider the date to be January 1, 1900. This failure may cause computer systems to shut down (hard crash). Some systems may attempt to generate calculations (such as interest calculations) based on the year 1900 rather than the leap year 2000, resulting in incorrect calculations (soft crash).

Now is the time to take aggressive action to insure that all of your office equipment, devices and processes are Y2K ready. Y2K readiness is HCFA's number one priority, but it won't work for you if your office is not ready.

As of October 1, 1998, all Medicare providers must submit HCFA-1500 claim forms following the specific changes required to accommodate the millennium. Failure to adhere to these requirements will result in the claims being returned as

unprocessable. For information on these changes, refer to page 53 of this issue of the Medicare B Update!

We will continue to provide information about the Year 2000 changes impacting your practice on an on-going basis through the Medicare B Update!

Sincerely,

Sidney R. Sewell, M.D.

Medical Director

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Advance Notice Requirement

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

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

Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.

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

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

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

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

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

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

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

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

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General Information About the Medicare B Update!

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

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

Distribution of the Update! is limited to individual providers and PA groups who bill at least one claim to Medicare Part B of Florida for processing during the six months prior to the release of each issue. Providers who meet this criteria are sent one

complimentary copy of that issue. Production, distribution, and postage costs prohibit us from distributing a copy of each issue to each provider's practice settings. This primarily affects members of PA groups; one copy of each issue is sent to the group. The group is responsible for dissemination of each copy to its members. For additional copies, providers may purchase a separate annual subscription for $75 (order form in FYI section), or download the text version from our on-line service, the Medicare Online BBS (see this issue for more information).

Medicare Part B of Florida uses the same mailing address for all correspondence, and cannot designate that each issue of the Update! be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their mailing addresses current with the Medicare Provider Registration Department.

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MEDIFEST
Medicare Part A and B Seminars for 1998

REFER TO "EDUCATIONAL EVENTS" at Main Menu

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Page 13

Additional Commercial Edits

Effective October 1, 1998, the Medicare Part B claims processing system will be modified to detect inappropriate billing code combinations (i.e., procedure to procedure code combinations), including those considered mutually exclusive and those considered incidental procedures.

Mutually exclusive procedures are two or more procedures that are usually not performed during the same patient encounter on the same date of service. An incidental procedure is performed at the same time as a more complex primary procedure. The incidental procedure requires little additional physician work and/or is clinically integral to the performance of the primary procedure.

Medicare considers all the services necessary to accomplish a given procedure to be included in the description of that procedure by CPT (copyright by the American Medical Association).

Note that these additional edits are not part of the Correct Coding Initiative (CCI). These edits will not be available to the public in a mass publication like CCI because they are proprietary. The new commercial edits will not be published by the National Technical Information Service (NTIS). However, these edits have been reviewed for consistency with Medicare policy and approved by HCFA for Medicare implementation.

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Waiver of Liability: Providing Patients with Acceptable Advance Notice

Information concerning Advance Notice Requirements was published in the November/December 1992 and July/August 1993 editions of the Medicare Part B Update! Providers have asked us to revisit what constitutes acceptable advance beneficiary notice for services likely to be reduced or denied as "not reasonable and necessary." The following information will help clarify the requirements of the provisions of law that mandate advance beneficiary notice and provide examples of "acceptable statements" of reasons why Medicare Part B is likely to deny payment.

Reason for the Law

Beneficiary Protection: The beneficiary should be told before the service is performed that Medicare may not pay for the service and why. The patient can then decide if he wants the service and if he is willing to pay for it.

Provider Protection: The provider is not held liable if he did not know or could not reasonably have been expected to know that Medicare would not pay for a particular service. The provider is not liable if he provides proper advance notice to the patient that Medicare might not pay. A provider will be considered informed if the information has been published in the Medicare Part B Update! or Specialty Update!, or if he has received a previous Provider Remittance Notice (PRN) explaining the reason for denial of payment, or if he has received a letter resulting from a review request explaining the reason for denial.

To What Services Does Advance Notice Apply?

Services Usually Covered: Advance notice applies to those services which usually are covered by Medicare but may not be covered in a particular case because of Medicare program standards (e.g., the utilization limits have been exceeded or the service is not covered for a particular diagnosis).

Noncovered Services: Advance notice does not have to be given for those services that fall into the category of "noncovered services". These are services that are never covered by Medicare (e.g., routine physicals, dentures, etc.).

When is Advance Notice Required?

Assigned Claims: When assignment is accepted, all physicians and suppliers must inform beneficiaries about any services they believe may be denied as "not reasonable and necessary" if they do not want to assume financial responsibility for the services rendered. This advance notice is required by the Waiver of Liability provisions of the Amendments to the Social Security Act passed in 1972.

Unassigned Claims: When a nonassigned claim is filed for physician services which the physician believes may be denied as "not reasonable and necessary," advance notice must be provided to the beneficiary if the physician does not want to assume financial responsibility for the services rendered. This advance notice is required by the "medically unnecessary services" provision of the Omnibus Budget Reconciliation Act (OBRA) of 1986.

What About Services That Are Reduced, Not Denied?

Both the Waiver of Liability and "medically unnecessary services" policies apply when a procedure is reduced to a lesser procedure during claims processing because the lesser procedure was considered reasonable and necessary. For example, a comprehensive office visit may be reduced to an intermediate office visit because the more extensive visit was considered "not reasonable and necessary."

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In these situations, nonparticipating physicians may not bill the patient more than the limiting charge for the lesser service and other providers may not bill the patient more than the allowable charge for the lesser service unless acceptable advance notice was provided or the provider had no way of knowing the service would be reduced during processing.

Examples of Acceptable Statements

The following are some examples of acceptable statements of reasons why Medicare is likely to deny payment. You are free to use these or similar statements as appropriate to a particular case:

- Medicare usually does not pay for this many visits or treatments.

- Medicare usually does not pay for this service for this diagnosis/condition.

- Medicare usually does not pay for this many services within this period of time.

- Medicare usually does not pay for like services by more than one doctor of the same specialty.

Unacceptable Advance Notice Language

Many providers are submitting advance notices that are merely vague statements used on a blanket basis. Medicare considers such non-specific statements as unacceptable advance notice. Examples of unacceptable language are found below:

- Medicare or any other insurance may or may not pay for this service.

- Based on new Medicare Part B guidelines, some services may be denied as not medically necessary. I, therefore, acknowledge and accept liability for payment of these service.

- I acknowledge and accept responsibility for payment of noncovered services.

- Patient is aware that Medicare will not pay on any charges.

- Patient signed statement: "I acknowledge and accept responsibility for payment of noncovered services" on file in our office.

- These services may not be medically necessary.

Failure to provide acceptable advance notice could result in the provider being held financially liable for denied services.

How Do I Inform Medicare That Advance Notice Was Provided?

For Paper Claims:

- Include a copy of the advance notice with the claim

- In Block 24 of the HCFA-1500 claim form, write "Proper advance notice given"

- Give a copy of the advance notice form to the patient

- Keep a copy in the patient's file

For Electronic Claims:

- Use GA modifier

- Give a copy of the advance notice form to the patient and retain a copy in the patient's file for future data verification.

How Often Should Advance Notice Be Given?

Advance notice should be given to the patient when a service is provided that Medicare Part B may deem not medically necessary.

A written notice covering an extended course of treatment/services is acceptable as long as the notice identifies all the services and the dates of services that the provider believes Medicare Part B may not pay.

If additional services are furnished which the provider believes Medicare Part B may not pay, the provider must provide another advance notice and obtain the patient's signature and agreement to pay for the services.

Failure to provide acceptable advance notice for services which may not be medically necessary could result in the provider being held financially responsible for the denied services.

What Happens if a Service Is Not Reasonable and Necessary?

Once the beneficiary receives an explanation of benefits which indicates the service was not covered because it was not reasonable and necessary, the beneficiary may request indemnification (security against loss) from Medicare Part B.

If the provider gave advance notice to the beneficiary that the services may not be covered and provides proof that the appropriate advance notice was given, then the provider would not be held financially liable for the services.

If the provider is found liable for the services, Medicare Part B sends a letter to the provider requesting that a refund is made to the beneficiary within 15 days. The provider must then notify Medicare Part B when the refund was made. If the refund is not made within 15 days of the notice, Medicare Part B will pay the beneficiary and collect the refund from the provider.

To assist providers, we have provided on the following page an example of an advance notice form that fulfills the notification requirements mandated by the Health Care Financing Administration. Please note that the form makes provision for the specific reason for Medicare's probable denial or reduction.

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Provider Notice to Beneficiary Regarding Service(s) That Are Likely to Be Denied Payment by Medicare Part B as "Not Reasonable and Necessary"

Beneficiary's Name:

_____

Health Insurance Claim Number:

_____

Physicain/Supplier Notice to Beneficiary:

Medicare will pay only for services that it determines to be "reasonable and necessary under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it will otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for the following services(s) for the reason(s) noted below:

Date and Description of Service/Reason for Medicare's Denial of Payment:

Beneficiary's Acknowledgment and Agreement to Pay:

I have been notified by my physician/supplier that he believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denied payment, I agree to be personally and fully responsible for payment.

Beneficiary's Signature: _____

Date: _____

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Private Contracts Between Beneficiaries and Physicians/Practitioners

As provided in 4507 of the Balanced Budget Act of 1997 (BBA), a "private contract" is a contract between a Medicare beneficiary and a physician or other practitioner who has "opted out" of Medicare for two years for all covered items and services he/she furnishes to Medicare beneficiaries. In a private contract, the Medicare beneficiary agrees not to seek Medicare payment for services furnished by the contracted physician or practitioner and to pay that physician or practitioner without regard to any limits that would otherwise apply to what the physician or practitioner could charge.

The March/April 1998 Medicare B Update! included a list of Questions and Answers (Q's and A's), to give providers information on this provision of the BBA. The following provides additional information regarding two of these Q's and A's.

Q

What rules apply to urgent or emergency treatment?

A

Payment may be made for services furnished by an "opt out" physician or practitioner who has not signed a private contract with a Medicare beneficiary for emergency and urgent care items and services furnished to, or ordered or prescribed for such beneficiaries on or after the date the physician "opted out." In other words, where the physician or practitioner provides emergency or urgent services to the beneficiary, he/she must submit a claim to Medicare, and may collect no more than the Medicare limiting charge in the case of a physician or the deductible and coinsurance in the case of a practitioner.The law specifies that a contract may not be entered into when the beneficiary is in need of emergency or urgent care. Since the services are excluded from coverage only if they are furnished under private contract, they are not excluded in emergency or urgent situations where there is no private contract, even though they were furnished by an "opt out" physician or practitioner. Hence, they are covered services furnished by a nonparticipating physician or practitioner and the rules in effect absent the "opt out" would apply in these cases. Specifically, the physician may choose to take assignment (thereby agreeing to collect no more from the beneficiary than the Medicare deductible and coinsurance based on the allowed amount) or not to take assignment (and to collect no more than the Medicare limiting charge). However, the practitioner must take assignment In this circumstance the physician or practitioner must submit a completed Medicare claim on behalf of the beneficiary with the appropriate HCPCS code and HCPCS modifier (new modifier GJ - see below) which indicates the services furnished to the Medicare beneficiary were emergency or urgent and the beneficiary does not have a private agreement with him or her.

Definition of the new national HCPCS modifier: GJ = "OPT OUT" PHYSICIAN OR PRACTITIONER EMERGENCY OR URGENT SERVICES.

This modifier must be used on claims for services rendered by an "opt out" physician or practitioner for an emergency/urgent service. The use of this modifier indicates that the service was furnished by an "opt out" physician or practitioner who has not signed a private contract with a Medicare beneficiary for emergency or urgent care items and services furnished to, or

ordered or prescribed for such beneficiary on or after the date the physician or practitioner "opted out."

Payment for emergency or urgent care items and services to both an "opt out" physician or practitioner and the beneficiary if these parties have entered into a private contract will be denied.

Under the emergency and urgent care situation where an "opt out" physician or practitioner renders emergency or urgent service to a Medicare beneficiary who has not entered into a private agreement with him/her (i.e., reduction of a fractured leg), as stated above the physician is required to submit a claim to Medicare with the appropriate modifier and is subject to all the rules and regulations of Medicare including limiting charge. However, if the "opt out" physician or practitioner asks the beneficiary, whom he/she has no private contract with, to return for a follow-up visit (i.e., return within 5 to 6 weeks to remove the cast and examine the leg) the physician or practitioner shall ask the beneficiary to sign a private contract. In other words, once a beneficiary no longer needs emergency or urgent care (i.e., nonurgent follow-up care), Medicare cannot pay for the follow-up care and the physician or practitioner can and must, under the "opt out" affidavit agreement, ask the beneficiary to sign a private agreement as a condition of further treatment.

In the above example, the physician or practitioner would bill Medicare for the setting of the fractured leg with the emergency "opt out" modifier (GJ) and the surgical care only modifier (54). The physician or practitioner would then either have the beneficiary sign the private contract or refer the beneficiary to a Medicare physician or practitioner who would bill Medicare using the post op only modifier to be paid for the post op care in the global period.

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However, if the beneficiary continues to be in a condition that requires emergency or urgent care (i.e., unconscious or unstable after surgery for an aneurism), the follow-up care would continue to be paid under emergency or urgent care until such time as the beneficiary no longer needed such care. Such services can be billed without the 54 modifier, but still require the use of the GJ modifier.

Definition of Emergency and Urgent Care Situations._Emergency or urgent care services are defined as being services furnished to

an individual who has an emergency medical condition or who requires services to be furnished within twelve hours after the determination of need is made to avoid adverse health consequences.

An "emergency medical condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

Placing the health of the individual (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy;

Serious impairment to bodily functions; or

Serious dysfunction of any bodily organ or part; or

With respect to a pregnant woman who is having contractions:

That there is inadequate time to effect a safe transfer to another provider before delivery; or

That transfer may pose a threat to the health or safety of the woman or unborn child.

HCFA has adopted this definition of emergency medical condition since it has been a longstanding definition in Medicare with respect to when a hospital must furnish emergency care to an individual who appears at their door. However, the term "emergency or urgent care services" is not limited to emergency services since it also includes "urgent care services." An urgent care service could be any service that needs to be furnished without significant delay to avoid adverse health consequences. For purposes of the "opt out" provision, an urgent care service is one that needs to be furnished within twelve hours of the determination of need to avoid adverse consequences. For example, if a beneficiary has an ear infection with significant pain, Medicare would view that as requiring treatment to avoid the adverse consequences of continued pain and perforation of the ear drum. The patient's condition would not meet the definition of emergency medical condition since immediate care is not needed to avoid placing the health of the individual in serious jeopardy or to avoid serious impairment or dysfunction. However, although it does not meet the definition of emergency care, the beneficiary needs care within a relatively short period of time (which is defined as 12 hours) to avoid adverse consequences, and the

beneficiary may not be able to find another physician or practitioner to provide treatment within 12 hours.

Q

Are there any situations where a physician or practitioner who has not opted out of Medicare does not have to submit a claim for a covered service provided to a Medicare beneficiary?

A

Yes. A physician who has not opted out of Medicare must submit a claim to Medicare for services that may be covered by Medicare unless the beneficiary, for reasons of his or her own, declines to authorize the physician or practitioner to submit a claim or to furnish confidential medical information to Medicare that is needed to submit a proper claim. Examples would be where the beneficiary does not want information about mental illness or HIV/AIDS to be disclosed to anyone. Moreover, if the beneficiary or their legal representative later decides to authorize the submission of a claim for the service and asks the physician or practitioner to submit the claim, the physician or practitioner must do so. Once a physician or practitioner who has not opted out of Medicare has furnished a covered item or service to a beneficiary who is enrolled in Part B of Medicare, the law requires that the physician or practitioner submit a claim to Medicare for the covered services unless the beneficiary refuses to authorize the submission of the claim.

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ASC Approved Procedures

The following is an inclusive list of surgical procedures that may be reimbursed when billed by an Ambulatory Surgical Center (ASC). Facility charges for procedures other than those on the list are not covered by Medicare, although the physician's fee may be payable. The beneficiary is liable for such non-covered facility charges; waiver of liability does not apply.

The first column lists the procedure code and the second column indicates its payment group. This list is effective for services rendered on or after January 1, 1998, and is valid through December 31, 1998.

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

G0105	2	10180	2	11042	2	11043	2	11044	2
11404	1	11406	2	11424	2	11426	2	11444	1
11446	2	11450	2	11451	2	11462	2	11463	2
11470	2	11471	2	11604	2	11606	2	11624	2
11626	2	11644	2	11646	2	11770	3	11771	3
11772	3	11960	2	11970	3	11971	1	12005	2
12006	2	12007	2	12016	2	12017	2	12018	2
12020	1	12021	1	12034	2	12035	2	12036	2
12037	2	12044	2	12045	2	12046	2	12047	2
12054	2	12055	2	12056	2	12057	2	13100	2
13101	3	13120	2	13121	3	13131	2	13132	3
13150	3	13151	3	13152	3	13160	2	13300	4
14000	2	14001	3	14020	3	14021	3	14040	2
14041	3	14060	3	14061	3	14300	4	14350	3
15000	2	15050	2	15100	2	15101	3	15120	2
15121	3	15200	3	15201	2	15220	2	15221	2
15240	3	15241	3	15260	2	15261	2	15350	2
15400	2	15412	3	15414	3	15416	3	15500	3
15505	3	15510	4	15515	4	15540	1	15545	2
15550	2	15555	3	15570	3	15572	3	15574	3
15576	3	15580	3	15600	3	15610	3	15620	4
15625	3	15630	3	15650	5	15700	1	15710	2
15720	2	15732	3	15734	3	15736	3	15738	3
15740	2	15750	2	15755	3	15756	3	15757	3
15758	3	15760	2	15770	3	15840	4	15841	4
15842	4	15845	4	15920	3	15922	4	15931	3
15933	3	15934	3	15935	4	15936	4	15937	4
15940	3	15941	3	15944	3	15945	4	15946	4
15950	3	15951	4	15952	3	15953	4	15954	3
15955	4	15956	3	15958	4	15960	2	15961	4
15964	3	15965	4	15966	4	15967	4	15970	2
15971	4	15972	3	15973	4	15974	3	15975	4
15980	3	15981	4	15982	3	15983	4	16015	2
16030	1	16035	2	19020	2	19100	1	19101	2
19110	2	19112	3	19120	3	19125	3	19126	3
19140	4	19160	3	19162	7	19180	4	19182	4
19260	5	19290	1	19291	1	19318	4	19328	1
19330	1	19340	2	19342	3	19350	4	19357	5
19364	5	19366	5	19370	4	19371	4	19380	5
20005	2	20200	2	20205	3	20206	1	20220	1
20225	2	20240	2	20245	3	20250	3	20251	3
20525	3	20650	3	20660	2	20661	3	20662	3
20663	3	20665	1	20670	1	20680	3	20690	2
20694	1	20900	3	20902	4	20910	3	20912	3
20920	4	20922	3	20924	4	20926	4	20955	4
20960	4	20962	4	20969	4	20970	4	20971	4
20972	4	20973	4	20975	2	21010	2	21025	2
21026	2	21034	3	21040	2	21041	2	21044	2
21050	3	21060	2	21070	3	21100	2	21206	5
21208	7	21209	5	21210	7	21215	7	21230	7
21235	7	21240	4	21242	5	21243	5	21244	7
21245	7	21246	7	21248	7	21249	7	21267	7
21270	5	21275	7	21280	5	21282	5	21300	2
21310	2	21315	2	21320	2	21325	4	21330	5
21335	7	21337	2	21338	4	21339	5	21340	4
21343	5	21355	3	21360	4	21365	5	21385	5
21386	5	21387	5	21390	7	21395	7	21400	2

21401	3	21406	4	21407	5	21421	4	21422	5
21440	3	21445	4	21450	3	21451	4	21452	2
21453	3	21454	5	21461	4	21462	5	21465	4
21470	5	21480	1	21485	2	21490	3	21493	3
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ASC Approved Procedures

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53450	1	53460	1	53502	2	53505	2	53510	2
53515	2	53520	2	53605	2	53665	1	54001	2
54015	4	54057	1	54060	1	54065	1	54100	1
54105	1	54110	2	54115	1	54120	2	54125	2
54152	1	54161	2	54205	4	54220	1	54300	3
54360	3	54420	4	54435	4	54440	4	54450	1
54500	1	54505	1	54510	2	54520	3	54530	4
54550	4	54600	4	54620	3	54640	4	54660	2

54670	3	54680	3	54700	2	54800	1	54820	1
54830	3	54840	4	54860	3	54861	4	54900	4
54901	4	55040	3	55041	5	55060	4	55100	1
55110	2	55120	2	55150	1	55175	1	55180	2
55200	2	55400	1	55500	3	55520	4	55530	4
55535	4	55540	5	55600	1	55605	1	55650	1
55680	1	55700	2	55705	2	55720	1	56300	3
56301	3	56302	3	56303	5	56304	5	56305	4
56306	4	56307	5	56309	5	56316	4	56317	7
56343	5	56344	5	56350	1	56351	3	56352	2
56354	3	56356	4	56360	2	56361	3	56362	3
56363	3	56405	2	56440	2	56441	1	56515	3
56605	1	56620	5	56625	7	56700	1	56720	1
56740	3	56800	3	56810	5	57000	1	57010	2
57020	2	57065	1	57105	2	57130	2	57135	2
57180	1	57200	1	57210	2	57220	3	57230	3
57240	5	57250	5	57260	5	57265	7	57268	3
57300	3	57310	3	57311	4	57320	3	57400	2
57410	2	57513	2	57520	2	57522	2	57530	3
57550	3	57700	1	57720	3	57800	1	57820	3
58120	2	58145	5	58800	3	58820	3	58900	3
60000	1	60200	2	60220	2	60225	3	60280	4
60281	4	61020	1	61026	1	61050	1	61055	1
61070	1	61215	3	61790	3	61791	3	61885	2
61888	1	62194	1	62225	1	62230	2	62256	2
62268	1	62269	1	62270	1	62272	1	62273	1
62274	1	62275	1	62276	1	62277	1	62278	1
62279	1	62280	1	62282	1	62288	1	62289	1
62294	3	62350	2	62351	2	62360	2	62361	2
62362	2	62365	2	62367	2	62368	2	63600	2
63610	1	63650	2	63660	1	63685	2	63688	1
63744	3	63746	2	63750	4	63780	2	64410	1
64415	1	64417	1	64420	1	64421	1	64430	1
64442	1	64443	1	64510	1	64520	1	64530	1
64575	1	64590	2						

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64595	1	64600	1	64605	1	64610	1	64620	1
64622	1	64623	1	64630	2	64680	2	64702	1
64704	1	64708	2	64712	2	64713	2	64714	2
64716	3	64718	2	64719	2	64721	2	64722	1
64726	1	64727	1	64732	2	64734	2	64736	2
64738	2	64740	2	64742	2	64744	2	64746	2
64771	2	64772	2	64774	2	64776	3	64778	2
64782	3	64783	2	64784	3	64786	3	64787	2
64788	3	64790	3	64792	3	64795	2	64802	2
64830	5	64831	4	64832	1	64834	2	64835	3
64836	3	64837	1	64840	2	64856	2	64857	2
64858	2	64859	1	64861	3	64862	3	64864	3
64865	4	64870	4	64872	2	64874	3	64876	3
64890	2	64891	2	64892	2	64893	2	64895	3
64896	3	64897	3	64898	3	64901	2	64902	2
64905	2	64907	1	65091	3	65093	3	65101	3

65103	3	65105	4	65110	5	65112	7	65114	7
65130	3	65135	2	65140	3	65150	2	65155	3
65175	1	65235	2	65260	3	65265	4	65270	2
65272	2	65275	4	65280	4	65285	4	65290	3
65400	1	65410	2	65420	2	65426	5	65710	7
65730	7	65750	7	65755	7	65770	7	65800	1
65805	1	65810	3	65815	2	65850	4	65865	1
65870	4	65875	4	65880	4	65900	5	65920	7
65930	5	66020	1	66030	1	66130	7	66150	4
66155	4	66160	2	66165	4	66170	4	66172	4
66180	5	66185	2	66220	3	66225	4	66250	2
66500	1	66505	1	66600	3	66605	3	66625	3
66630	3	66635	3	66680	3	66682	2	66700	2
66710	2	66720	2	66740	2	66821	2	66830	4
66840	4	66850	7	66852	4	66920	4	66930	5
66940	5	66983	8	66984	8	66985	6	66986	6
67005	4	67010	4	67015	1	67025	1	67030	1
67031	2	67036	4	67038	5	67039	7	67040	7
67107	5	67108	7	67109	5	67112	7	67115	2
67120	2	67121	2	67141	2	67218	5	67227	1
67250	3	67255	3	67311	3	67312	4	67314	4
67316	4	67318	4	67320	4	67331	4	67332	4
67340	4	67350	1	67400	3	67405	4	67412	5
67413	5	67415	1	67420	5	67430	5	67440	5
67450	5	67550	4	67560	2	67715	1	67808	2
67830	2	67835	2	67880	3	67882	3	67901	5
67902	5	67903	4	67904	4	67906	5	67907	3
67908	4	67909	4	67911	3	67914	3	67916	4
67917	4	67921	3	67923	4	67924	4	67935	2
67950	2	67961	3	67966	3	67971	3	67973	3
67974	3	67975	3	68130	2	68320	4	68325	4
68326	4	68328	4	68330	4	68335	4	68340	4
68360	2	68362	2	68500	3	68505	3	68510	1
68520	3	68525	1	68540	3	68550	3	68700	2
68720	4	68745	4	68750	4	68810	1	68811	2
68815	2	68825	2	69110	1	69120	2	69140	2
69145	2	69150	3	69205	1	69310	3	69320	7
69421	3	69424	1	69436	3	69440	3	69450	1
69501	7	69502	7	69505	7	69511	7	69530	7
69550	5	69552	7	69601	7	69602	7	69603	7
69604	7	69605	7	69620	2	69631	5	69632	5
69633	5	69635	7	69636	7	69637	7	69641	7
69642	7	69643	7	69644	7	69645	7	69646	7
69650	7	69660	5	69661	5	69662	5	69666	4
69667	4	69670	3	69676	3	69700	3	69710	3
69711	1	69720	5	69725	5	69740	5	69745	5
69801	5	69802	7	69805	7	69806	7	69820	5
69840	5	69905	7	69910	7	69915	7	69930	7

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Change to Block 32 of the HCFA-1500 Form

Page 20 of the July/August 1998 issue of the Medicare Part B Update! included an article about a change to the HCFA-1500 claim form instructions for block 32 for processing physician claims under the Cardiac Artery Bypass Graft (CABG) global payment

demonstration project. The effective date for this change is January 1, 1999.
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Revisions to 1998 MPFSDB

The Medicare Physician Fee Schedule Database (MPFSDB) is updated annually with the Health Care Financing Administration's Common Procedural Coding System (HCPCS) update. The MPFSDB revisions for 1998 were outlined in the December 1997 Medicare B Update! Special Issue: 1998 HCPCS and MPFSDB Update.

Throughout the year, the MPFSDB is re-evaluated by the Health Care Financing Administration (HCFA) to ensure that services are appropriately reimbursed based on the specific payment rules to which they are subject. This re-evaluation is generally performed on a quarterly basis and, as a result, some revisions to the MPFSDB are required.

The changes outlined below are for the third quarter MPFSDB update. Unless otherwise noted, these changes are for services rendered on or after January 1, 1998.

Limited Access Cardiac Surgery

There has been some confusion noted regarding the use of limited access surgery techniques in the field of cardiothoracic surgeries. Performing a cardiothoracic procedure using limited access is a covered Medicare service. In the future, HCFA expects to do a review of the appropriate RVUs for these services. In the meantime, they will be paid at the same level as analogous open procedures.

Routine Foot Care and Modifier 25

It has been observed that in many instances, an evaluation and management service with a modifier 25 is routinely being billed in conjunction with the routine foot care codes (11055, 11056, 11057, 11719, and G0127). Medicare Part B of Florida indicated its concerns regarding this practice in the March/April 1998 issue of the Medicare B Update! (page 33). In addition, guidelines for the use of modifier 25 were published in the December 1997 Medicare B Update! Special Issue: 1998 HCPCS and MPFSDB Update.

Modifier 25, by definition, is to be used when a significant, separately identifiable evaluation and management service is provided by the same physician on the same day as a base procedure. Unless the evaluation and management service provided is clearly a significant, separately identifiable service, it is inappropriate to submit such services with modifier 25. Providers are reminded that the continued overuse of modifier 25 in

association with routine foot care services may result in such billings being considered program abuse.

Change to Billing Guidelines for Coronary Artery Bypass Codes

Before billing secondary procedure codes 33517 - 33523, one of the following procedure codes must be billed: 33533 - 33536. In other words, procedure codes 33517 through 33523 should only be billed in conjunction with one of these primary codes.

This is an additional change for the third quarter. The second quarter MPFSDB update contained changes to the way providers should bill for coronary artery bypass procedure codes 33518 - 33523. Procedure code 33517 [Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (list separately in addition to code for arterial graft)] is now added to the range of codes previously defined as secondary procedures.

Rituxan

It has been determined that Rituxan appropriately qualifies as an antineoplastic drug. Therefore, it is appropriate to bill Rituxan with one of the chemotherapy administration procedure codes (96400 through 96450, 96542, 96545, and 96549). Providers should bill using procedure code J9999 (antineoplastic drugs, not otherwise classified); be sure to specify the name, strength and dosage.

G0108, G0109: Diabetes Outpatient Self Management

Information regarding this provision of the Balanced Budget Act (BBA) of 1997 is contained in a separate article in this Update!, found on the following page.

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HCPCS Codes

G0108, G0109: Coverage of Diabetes Outpatient Self-Management Training Services

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of diabetes outpatient self-management training services when these services are furnished through a certified program that meets certain quality standards. This provision is effective July 1, 1998.

The implementation of this provision is scheduled for October 1, 1998, and is retroactive for dates of service on or after July 1, 1998. Payment for claims received prior to October 1, 1998, will be held in the Medicare system until the implementation date. The applicable interest amount will be issued with payment.

A diabetes outpatient self-management and training service is a program which educates beneficiaries in the successful self-management of diabetes. An outpatient diabetes self-management and training program includes:

education about self-monitoring of blood glucose,

education on diet and exercise,

an insulin treatment plan developed specifically for the patient who is insulin-dependent, and

motivates patients to use the skills for self-management of diabetic condition.

Outpatient self-management training services may be covered under Medicare only if the physician who is managing the beneficiary's diabetic condition certifies that such services are needed under a comprehensive plan of care. This plan of care must be related to the beneficiary's diabetic condition to ensure therapy compliance, or to provide the individual with the necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to successfully manage their condition.

Certified Training Programs

To provide diabetes outpatient self-management training services, the Health Care Financing Administration considers a certified training program to be one conduced by:

Physicians, individuals or entities that are paid under the physician-fee schedule and meet the National Diabetes Advisory Board Standards (NDAB), and

Other nonphysician practitioners whose services are paid for under the physician fee schedule and who meet the NDAB standards. These nonphysician practitioners include: physician assistants (PAs), nurse practitioners (NPs), nurse midwives (NMs), clinical psychologists (CPs) and clinical social workers (CSWs).

Note: It is the provider's responsibility to ensure that the program is NDAB-certified.

A list of the National Diabetes Advisory Board (NDAB) standards is included later in this article.

In keeping with the requirements of the legislation, services provided by individuals other than physicians are covered when the services are provided within the current coverage requirements. These services may be provided in two ways. First, the services performed by nonphysician practitioners may be incident-to a physician's professional services, must be an integral, although incidental part of the physician's personal professional services, and must be performed under the physician's direct personal supervision. Second, a nonphysician practitioner such as a physician assistant or nurse practitioner may be licensed under state law to perform a specific medical procedure and may be able to perform the procedure without physician supervision and have the services separately covered and paid for directly by Medicare as physician's assistant or nurse practitioner services. Medicare only covers procedures and services that are performed in accordance with state license.

Billing Requirements

Prior to billing for diabetes outpatient self-management training services, all providers must submit to the Medicare contractor an Education Recognition Program (ERP) certificate from the American Diabetes Association (ADA). Send the ERP certification to:

Medicare Registration

P.O. Box 44021

Attn: ERP Certificate

Jacksonville, FL 32231-4021

To avoid delays in payment for services, be sure to include a cover letter and your Provider Identification Number (PIN) with the ERP certificate. Note: For multiple providers in a group setting, each individual provider must submit a copy of the ERP certificate with a cover letter and his/her individual PIN. Individuals or entities interested in obtaining an ERP certificate should contact the American Diabetes Association National Office at 1-888-232-0822. A certificate of recognition from the ERP ensures that the recognized educational program has met the National Diabetes Advisory Board Standards.

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HCPCS Coding

The following HCPCS codes have been established for the outpatient diabetes self-management training services:

G0108:Diabetes outpatieit self-management training services, individual session,per 60 minutes of training

G0109:Diabetes outpatient self-management training services, group session, per individual, per 60 minutes of training.

Reimbursement amounts are:

Participating:

Code: G0108
Loc 01/02: 52.91
Loc 03: 57.78
Loc 04: 60.82

Code: G0109
Loc 01/02: 31.39
Loc 03: 34.33
Loc 04: 36.21

Non-Participating:

Code: G0108
Loc 01/02: 50.26
Loc 03: 54.89
Loc 04: 57.78

Code: G0109
Loc 01/02: 29.82
Loc 03: 32.61
Loc 04: 34.40

Limiting Charge:

Code: G0108
Loc 01/02: 57.80
Loc 03: 63.12
Loc 04: 66.45

Code: G0109
Loc 01/02: G0109
Loc 03: G0109
Loc 04: 39.56

General Billing Guidelines

Services for diabetes outpatient self-management training must be billed with the appropriate HCPCS code G0108 or G0109, in one hour increments only. If the training session lasts 90 minutes, only 60 minutes can be billed for that session.

The billing of an evaluation and management code is not mandatory before the billing of the diabetes self-management education codes.

The number of patients in a group does not need to be identified when billing for procedure code G0109.

Claims received prior to submitting the ERP certification or for services performed outside of the certification period will be denied payment. Appeal rights will not be honored. Providers are encouraged to refile any denied claims after receiving notification from Medicare Registration that the ERP certification has been received and Medicare Part B of Florida's files have been updated.

Diabetes outpatient self-management training services rendered in a Federal Qualified Health Center (FQHC) or a Rural Health Center (RHC) setting by a nonphysician practitioner will be denied payment, since the payment to the facility covers the charges for the professional services of Nurse Practitioners (NPs), Physician Assistants (PAs) and Clinical Nurse Specialists (CNSs).

Diabetes outpatient self-management training services are subject to deductible and coinsurance.

Billing Guidelines for Non-Physician Practitioners

Employers of physician assistants (PAs) must bill the Medicare Part B program for professional services furnished by the PA, as well as services furnished as an incident-to the professional services of a PA. The PA's physician supervision (or a physician designated by the supervision physician or employer as provided under State law or regulation) is primarily responsible for the overall direction and management of the PA's professional activities and for assuring that the services provided are medically appropriate for the patient. Pursuant to section 4512 (c) of the Balanced Budget Act, Medicare payment for PA services is made only to the PA's employer regardless of whether the PA is employed as a W-2 employee or whether the PA is acting as an independent contractor. Also, while a PA has an option in terms of selecting employment arrangements, only the employer can bill a carrier or intermediary for the PA's services.

Any service furnished by a PA must be furnished under the general supervision of a physician. General supervision does not require the physician to be present on the premises and immediately available while all services are being furnished. Rather, the physician may be reached by telephone in case of an emergency. However, any services furnished incident-to the professional services of the PA must be furnished while the PA is present on the premises and immediately available in case of an emergency while these ancillary services are being furnished. Accordingly, any services furnished incident to the professional service of a PA must comply with all of the "incident-to" requirements mentioned above.

Clinical nurse specialists and nurse practitioners may bill the Medicare Part B program directly for services that are performed in collaboration with a physician. They may also bill the program directly for services furnished as an incident to their professional services in which case the direct supervision requirement in particular and all the incident-to requirements apply.

HCFA requires that CNs, NPs and the employers of the PAs to submit claims to the Part B carrier under their own respective billing numbers for their professional services furnished in facilities or other provider settings except in the case where the services of these nonphysician practitioners are furnished to patients in rural health clinics (RHCs) and federally qualified health centers (FQHCs). Payment for these services of these nonphysician practitioners in the RHC/FQHC setting is bundled under the facility cost payment that is made by the intermediary under the all inclusive rate.

Advance Notice/Liability Information

Providers are liable for denials that are the result of lack of certification, and delils when the services are rendered outside the certification period. The beneficiary cannot be held liable for denials in these situations. This applies to both assigned and nonassigned claims.

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National Diabetes Advisory Board Standards (NDAB)

A certified provider must meet all of the following NDAB standards and be recognized by the American Diabetes Association.

I. STRUCTURAL STANDARDS:

A. Organizational support by sponsoring organization

Standard 1: Maintain written policy affirming education as integral component of diabetes care.

Standard 2: Provide education resources needed to achieve objectives for target population, including adequate space, personnel, budget and instructional materials.

Standard 3: Clearly define and document organizational relationships, lines of authority, staffing, job descriptions, and operational policies.

B. Community needs assessment

Standard 4: Assess service area to define target population and determine appropriate allocation of personnel and resources.

C. Program management

Standard 5: Establish standing advisory committee including at least a physician, nurse educator, dietitian, behavioral science expert, consumer, and community representative to oversee the program.

Standard 6: The advisory committee should participate in annual planning to determine target population, program objectives, participant access, and follow-up mechanisms, instructional methods, resource requirements, and program evaluation.

Standard 7: Professional program staff should have sufficient time and resources for lesson planning, instruction, documentation, evaluation, and follow up.

Standard 8: Assess community resources periodically.

D. Program staff

Standard 9: Designate a coordinator responsible for program planning, implementation, and evaluation.

Standard 10: Program instructors should include at least a nurse educator and dietitian with recent didactic and experiential training in diabetes clinical and educational issues. Certification as diabetes educator by the National Certification Board of Diabetes Educators is recommended.

Standard 11: Professional program staff should obtain continuing education about diabetes, educational principles, and behavioral change strategies.

E. Curriculum

Standard 12: The program must be capable of offering, based on target population needs, instruction in the following 15 content areas:

diabetes overview

stress and psychosocial adjustment

family involvement and social support

nutrition

exercise and activity

medications

monitoring and use of results

relationships among nutrition, exercise, medication, and glucose levels

prevention, detection and treatment of acute complications

prevention, detection and treatment of chronic complications

foot, skin, and dental care

behavior change strategies, goal setting, risk factor reduction, and problem solving

benefits, risks and management options for improving glucose control

preconception care, pregnancy, and gestational diabetes

use of health care systems and community resources.

Standard 13: Use instructional methods and materials appropriate for the target population.

F. Participant Access

Standard 14: Establish a system to inform the target population and potential referral sources of availability and benefits of the program.

Standard 15: The program must be conveniently and regularly available.

Standard 16: The program must be responsive to requests for information and referrals from consumers, health professionals, and health agencies.

II. PROCESS STANDARDS

A. Assessment

Standard 17: Develop and update an individualized assessment for each participant, including medical history and health status; health services utilization; risk factors; diabetes knowledge and skills; cultural influences; health beliefs, attitudes, behavior and goals; support systems; barrier to learning; and socioeconomic factors.

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B. Plan and Implementation

Standard 18: Develop an individualized education plan, based on the individualized assessment, in collaboration with each participant.

Standard 19: Document the assessment, intervention, evaluation, and follow up for each participant, and collaboration and coordination among program staff and other providers, in a permanent record.

C. Follow up

Standard 20: Offer appropriate and timely educational intervention based on periodic reassessments of health status, knowledge, skills, attitude, goals, and self-care behaviors.

III. OUTCOME STANDARDS

A. Program

Standard 21: The advisory committee should review program performance annually, and use the results in subsequent planning and program modification.

B. Participant

Standard 22: The advisory committee should annually review and evaluate predetermined outcomes for program participants.

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Medicare Part B covers a specimen collection fee and travel allowance for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient; payment is made based on the clinical laboratory fee schedule.

The information contained in this article is effective for claims received on or after October 1, 1998, for services rendered on or after January 1, 1998.

The travel codes allow for payment either on a per mileage basis (procedure code P9603) or on a flat rate per trip basis (procedure code P9604). Payment of the travel allowance is made only if a specimen collection fee and laboratory procedure(s) for which it is drawn are also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses.

Under either method, when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip for both Medicare and non-Medicare patients, the purpose being to exclude payment for non-Medicare patients. The billing laboratory must prorate claims based on the instructions and examples that follow.

Per Mile Travel Allowance (P9603)

Reimbursement is made based on 75 cents per mile for a per mile travel allowance (procedure code P9603). The per mile travel allowance is to be used in situations where the average trip to patients' homes is longer than 20 miles round trip, and is to be pro-rated in situations where specimens are drawn or picked up from non-Medicare patients in the same trip. At no time will the laboratory be allowed to bill for more miles than are reasonable or for miles not actually traveled by the laboratory technician. In examples 1 and 2 that follow, the actual miles traveled is entered in the days or units field (block 24G on the HCFA 1500 claim form).

Example 1: A laboratory technician travels 60 miles round trip from a lab in a city to a remote rural location, and back to the lab to draw a single Medicare patient's blood. The total reimbursement would be $45.00 (60 miles x $.75 per mile).

Example 2: A laboratory technician travels 40 miles from the lab to a Medicare patient's home to draw blood, then travels an additional 10 miles to a non-Medicare patient's home and then travels 30 miles to return to the lab. The total miles traveled would be 80 miles. The claim submitted for the Medicare patient would be for one half of the miles traveled or $30.00 (40 x .75).

Flat Rate Travel Allowance (P9604)

Reimbursement is made based on an allowance of $7.50 one way. The flat rate travel allowance is to be used in areas where average trips are less than 20 miles round trip. The flat rate travel fee is to be pro-rated for more than one blood drawn at the same address, and for stops at the homes of Medicare and non-Medicare patients. The pro-ration is done by the laboratory when the claim is submitted based on the number of patients seen on that trip. The specimen collection fee will be considered for payment for each patient encounter. In examples 3, 4 & 5, the units billed must equal 2, in order to be reimbursed for the return trip.

Example 3: A laboratory technician travels from the laboratory to a single Medicare patient's home and returns to the laboratory without making any other stops. The flat rate billed would be calculated as follows: 2 x $7.50 for a total amount of $15.00, with a units billed equal 2.

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Example 4: A laboratory technician travels from the laboratory to the homes of five patients to draw blood, four of the patients are Medicare patients and one is not. An additional flat rate would be charged to cover the 5 stops and the return trip to the lab (6 x $7.50 =$45.00). Each of the claims submitted would be for $9.00 ($45.00 /5 = $9.00). Since one of the patients is non-Medicare, four claims would be submitted with a pro-rated flat rate of $9.00 each, and the units billed equal to 2.

Example 5: A laboratory technician travels from a laboratory to a nursing home and draws blood from 5 patients and returns to the laboratory. Four of the patients are on Medicare and one is not. The $7.50 flat rate is multiplied by two to cover the return trip to the laboratory (2 x $7.50 = $15.00) and then divided by five (1/5 of $15.00 = $3.00). Since one of the patients is non-Medicare, four claims would be submitted with a pro-rated flat rate of $3.00 each, and the units billed equal to 2.

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Q0159: Corrected Pricing for Adenoscan

In the July/August 1998 edition of the Medicare B UPDATE!, the price for Adenoscan 90 mg/30 ml (procedure code Q0159) was published incorrectly. The correct pricing is:

Code: Q0159
Descriptor: Adenoscan 90 mg/30 ml single use vial
Par Allowance: $212.56
Non-Par Allowance: $201.93
Limiting Charge: $244.44

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Diagnostic Tests:

76090, 76091: Billing for a Diagnostic Mammogram Converted from a Screening Mammography

An article on page 34 of the July/August 1998 edition of the Medicare B Update! discussed the new coverage benefit that allows a radiologist to order additional mammography views without an additional order from the treating physician when a screening mammography shows a potential problem. This article indicated that when a radiologist's interpretation results in additional films on the same day, the mammography is no longer considered a screening exam, and that only the diagnostic X-rays may be billed using procedure codes 76090 (Mammography, unilateral) or 76091 (Mammography, bilateral).

New Modifier Developed

Effective for claims processed on or after October 1, 1998, when billing a diagnostic mammogram that has been the result of a screening mammogram that showed a potential problem, providers must use modifier GH (diagnostic mammogram converted from screening mammogram on the same day).

UPIN Required

When a radiologist orders additional films based on the findings of the screening mammography, the radiologist becomes the ordering physician, and must supply his or her UPIN. If the UPIN is not included on the claim, the claim will be returned as unprocessable.

For additional information about this benefit, see the article referenced above.

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84999QW, 86308QW, 86588QW: Additional CLIA Waived Tests

On June 19, 1998, several tests were granted waived status under the Clinical Lab Improvement Amendment (CLIA): The tests, their assigned procedure codes, and the 1998 clinical laboratory fee schedule amounts for these tests are:

CODE: 84999QW
DESCRIPTION: Litmus Concepts FemExam TestCard (from vaginal swab)
REIMBURSEMENT INDIVIDUAL CONSIDERATION

CODE: 86308QW
DESCRIPTION: Wyntek Diagnostics OSOM Mono Test (whole blood)
REIMBURSEMENT $7.15

CODE: 86308QW

DESCRIPTION: Seradyn Color Q Mono (whole blood)
REIMBURSEMENT $7.15

CODE: 86588QW
DESCRIPTION: Meridian Diagnostics ImmunoCard STAT Strep A (direct from throat swab)
REIMBURSEMENT $13.05

CODE: 86588QW
DESCRIPTION: Jant Pharmacal AccuStrip Strep A (II) (direct from throat swab)
REIMBURSEMENT $13.05

Entities performing waived tests are required to report the procedure code for the test plus procedure code modifier QW (CLIA waived test) where applicable (e.g., 86588QW). Such CLIA waived tests submitted without procedure code modifier QW will be denied payment.

Providers issued a certificate for waived CLIA tests may only perform services liste in the waived CLIA tests category. A list of tests granted waived status under CLIA was published on page 68 of the December 1997 Medicare B Update! Special Issue: 1998 HCFA Common Procedure Coding System and Medicare Physician Fee Schedule Database Update, page 27 of the May/June 1998 Update!, and page 18 of the March/April 1998 Update!

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Medicine

90723, 90724: Promoting Influenza and Pneumococcal Vaccinations!

The flu season is here! Please remember to promote influenza and pneumococcal vaccinations, both Medicare Part B covered preventive health care benefits. These vaccines greatly reduce hospital admissions for pneumonia and deaths due to complications from influenza. Research shows that a provider's recommendation appears to be a strong motivator for a patient to get vaccinated. Research also shows that systems-oriented, provider and beneficiary interventions, or a combination of all three, work in promoting these two vaccinations.

Standing orders are one example of a systems-oriented intervention that a hospital, public health clinic, nursing home, or home health agency can use to increase immunization rates. For example, a physician could write a standing order in the hospital inpatient setting requiring the assessment and vaccination of all Medicare patients. A missed opportunity in the inpatient hospital setting occurs when a beneficiary is discharged without being offered and receiving an influenza and/or pneumococcal vaccination. Missed opportunities can often result in a beneficiary being readmitted to a hospital for influenza and related illnesses, like pneumonia. Unfortunately, missed vaccination opportunities occur in all settings. Systems-oriented interventions, like standing orders, are one way of reducing missed opportunities. Please note that a standing order is not

required for Medicare coverage of influenza immunizations, but it is required for coverage of pneumococcal vaccinations.

Provider and beneficiary interventions are also effective in reducing missed vaccination opportunities. Physicians and their office personnel can promote influenza and pneumococcal vaccinations by hanging posters on their walls as a reminder to them and their patients, and using wall charts to track immunizations. Most importantly, physicians can make influenza and pneumococcal vaccinations available in their office or refer patients to other health care providers for these vaccinations. Beneficiary interventions, like direct mail and phone calls, are also worthwhile. Postcards and phone calls to beneficiaries help remind them to get vaccinated.

A combination of system, provider and beneficiary interventions has been proven effective in increasing immunization rates, especially when the provider intervention is part of the strategy. Simply put, Medicare beneficiaries are most likely to get immunized when their physician specifically recommends vaccination. We ask that providers realize their significant roles and discuss and promote influenza and pneumococcal vaccinations with their patients.

Please remember that while influenza immunizations are seasonal and should be given every year in the fall, pneumococcal vaccinations can be given at any time of the year.

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Generally, one pneumococcal vaccination after the age of 65 is all that a person needs to protect himself/herself for a lifetime. However, persons who are considered at highest risk, like persons with chronic illnesses, like diabetes, and cardiovascular or pulmonary disease, and people with compromised immune systems, like chronic renal failure, should ask their doctor if a booster pneumococcal vaccination is necessary. If any person 65 and over is unsure of his/her pneumococcal vaccination status, revaccination is recommended and will be covered by Medicare Part B.

Your Medicare contractor can provide you with brochures and posters free-of-charge to display in your offices to promote both influenza and pneumococcal vaccinations. To request these materials or for instructions on how to bill Medicare for influenza and pneumococcal vaccinations, please call the Provider Customer Service Department at (904) 634-4994.

Thank you for your help in bringing this important preventive health care benefit to Medicare beneficiaries.

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99238, 99239: Hospital Discharge by Telephone is Not Payable by Medicare

Hospital discharge codes (99238-99239) are to be utilized by the physician to report all services provided to a patient on the date of discharge (if the discharge is other than the date of admission).

The discharge includes: a final examination of the patient, discussion of the hospital stay, instructions for continuing care, preparation of discharge records, prescriptions, and referral forms (if a referral is made). These services are expected to be furnished to the patient face to face. Thus, a physician cannot discharge a patient via telephone and receive reimbursement from Medicare.

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Modifier 22 - Unusual Procedural Services

Procedure code modifier 22 (Unusual procedural services) is used to describe services provided which are greater than that usually required for the listed procedure. Claims submitted with modifier 22 require additional documentation to justify the medical need and additional payment for the services. This documentation must consist of a separate narrative statement describing services that exceed the procedure code submitted in addition to an operative report. Procedures submitted without this documentation will not be considered for additional payment, even at the individual review level.

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Top Additional Information Request Letters Affecting Independent Practicing Physical/Occupational Therapists

This article outlines the "top" additional information requests identified during the first and second quarter of fiscal year 1998. Additionally, we have outlined the billing requirements and a few key tips to avoid receiving additional information request letters. There has been a significant increase in requests for "unique physician identification numbers (UPINs)"and "date the patient was last seen by attending physician" for claims submitted by Independent Physical/Occupational Therapists.

Additional information request letters may result from simple processing/completion errors. To ensure that you are aware of the appropriate actions to take when you receive an additional information request letter, we have provided tips to avoid denials/additional information request letters.

The following information outlines the claim completion(HCFA-1500) and the billing requirements for services rendered by an independently practicing physical or occupational therapist only.

DOCUMENTATION: Date patient was last seen by the attending/referring physician and UPIN number of that physician (e.g. 020198 D12345)

HCFA 1500 BLOCK#: Block 19

Example: Date Last Seen (block #19)

19 Reserved For Local Use
020198 D12345

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Development Questions 019 and 411

DEVELOPMENT QUESTION: 019
DEVELOPMENT MESSAGE: Please indicate the full name and UPIN of the referring/attending physician for services performed on _____.
TIPS TO AVOID DEVELOPMENT: A UPIN is required on services filed by independent physical/occupational therapists. Indicate UPIN of the attending physician in block 19 of the HCFA 1500 claim form. If filing electronically refer to instructions below.

DEVELOPMENT QUESTION: 411
DEVELOPMENT MESSAGE: Please provide the date the patient was last seen by the attending physician for physical/occupational therapy services performed on _____.
TIPS TO AVOID DEVELOPMENT: The date last seen by the attending physician (MMDDYY) format as well as the UPIN of the attending physician must be indicated in block 19 of the HCFA 1500 form. If filing electronically refer to instructions below.

Electronic Filing

NSF

RECORD/FIELD: EA0. 20
FIELD NAME: Referring physician provider ID number
POSITIONS: 80-94

RECORD/FIELD: EA0. 22
FIELD NAME: Referring physician last name
POSITIONS: 120-139

RECORD/FIELD: EA0. 23
FIELD NAME: Referring physician first name
POSITIONS: 140-151

RECORD/FIELD: EA0. 24
FIELD NAME: Referring physician middle initial
POSITIONS: 140-151

RECORD/FIELD: EA0. 46
FIELD NAME: Date last seen by attending physician (CCYYMMDD) format
POSITIONS: 267-251

ANSI 837

TABLE: 2
SEQUENCE: 250.B
SEGMENT NM1
DATA ELEMENT: 09 (UP)
FIELD NAME: Referring provider ID numbe

TABLE: 2
SEQUENCE: 250.B
SEGMENT NM1
DATA ELEMENT: 03 (DN, 1)
FIELD NAME: Referring provider last name

TABLE: 2
SEQUENCE: 250.B
SEGMENT NM1
DATA ELEMENT: 04
FIELD NAME: Referring provider first name

TABLE: 2
SEQUENCE: 250.B
SEGMENT NM1
DATA ELEMENT: 05
FIELD NAME: Referring provider middle initia

TABLE: 2
SEQUENCE: 135.D
SEGMENT DTP
DATA ELEMENT: 03 (304)
FIELD NAME: Date last seen

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Local and Focused Medical Review Policies

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 initiatives. Both 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 this section are effective for claims processed October 19, 1998, and after, unless otherwise noted.

Advance Notice Information

This is to remind readers that advance notice applies to all medical policies published in the Focused and Local Medical Review section of the July/August Medicare B Update!

Sources of Information

The sources of information used in the development of these policies may be obtained by accessing the Medicare Online BBS.

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J9999 Off-Label Use of Chemotherapy Drugs

The following are the complete documentation requirements for the off-label use of chemotherapy drugs. The medical policy, which was effective for claims processed on or after August 17, 1998, was published on page 46 of the July/August 1998 issue of the Medicare B Update!

Documentation Requirements

Medical record documentation maintained by the performing physician must substantiate the medical necessity for the use of these chemotherapy drugs by clearly indicating the condition for which these drugs are being used. This documentation is usually found in the history and physical or in the office/progress notes.

Advance Notice

Applies to medical necessity (see page 4).

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Skilled Nursing Facility Guidelines for Part B Services

Description

According to Florida Statute 408.032(19), a Skilled Nursing Facility (SNF) is an institution, or a distinct part of an institution, which is primarily engaged in providing skilled nursing care and related services to inpatients who require medical or nursing care, or rehabilitation services for the resident's rehabilitation.

Federal regulations require SNFs and Nursing Facilities (NFs) to provide each resident with an initial and periodic comprehensive assessment. This is done to ensure that the residents' medical, nursing, mental and psychological needs are identified, a plan of treatment is executed, and the needs are met through the treatment plan. The care plan must be devised by an interdisciplinary team which, at a minimum, includes the attending physician and the registered nurse responsible for the resident's primary care. The components of the care plan, as defined by the needs of the patient, are documented on the physician's order sheet and is signed by both the attending physician and the resident's primary care registered nurse.

The physician's order sheet is used to list medications, diet, activities, and hygienic needs which are generally dictated by the plan of care. In addition, the physician's order sheet may be used to list various provider specialities that will participate in the total care of the resident such as audiology, optometry, podiatry, psychology, psychiatry, physical therapy, and occupational therapy.

The physician should never order, authorize or certify services which are not medically necessary. Medical necessity of a service must be documented in the resident's medical record by the physician.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare will consider only those services and procedures medically necessary if used for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.

Laboratory tests, electrocardiograms, portable chest x-rays and other services and procedures are considered screening if they are not performed to diagnose an illness, not performed to assist the physician in treating an illness and/or not performed to make a change in the treatment plan of the resident.

"PRN" or "standing" orders which are used when a new resident, or when a new provider sees the resident, are screening and not reimbursable. Also, procedures and services for the purpose of obtaining baseline data from these services and procedures would be considered screening and, therefore, noncovered by Medicare. An exception would be any service specified as covered in the Medicare Manuals which would otherwise be considered screening or preventative such as mammograms, pap smears, flu and pneumococcal pneumonia vaccinations.

All consults which the attending physician requests must be medically necessary and not part of the care in which most or all residents receive as part of "routine" or "standing" orders, i.e., the care a resident receives from any provider must be specific, medically necessary and appropriate for that resident. If the attending physician consults another physician, for example, a physiatrist, the consult must meet the same requirements as any other consult, i.e., it must be medically reasonable and necessary. The consulted physician may assess the patient and order services which are medically necessary and reasonable. The documentation requirements for the physician who has been consulted are the same as for the attending physician, i.e., all ordered services must be medically necessary and reasonable.

Any service or procedure ordered because it is required by a third party, such as insurance companies or state regulatory agencies, and is not related to an illness, injury, symptom or complaint, is considered screening in nature and, therefore, noncovered by Medicare.

Medicare of Florida has published numerous policies related to laboratory and other diagnostic testing. The requirements as set forth in those policies should be the same when ordering and performing in a nursing facility (e.g., skilled, intermediate or custodial levels of care).

HCPCS Codes

Various diagnostic and therapeutic testing and other services and procedures which could be considered screening in nature.

ICD-9 Codes That Support Medical Necessity

N/A for this policy specifically, however, Medicare of Florida may have a written policy which includes appropriate diagnoses for the services performed. Therefore, these policies should be adhered to when ordering services and procedures in the nursing facility.

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Reasons for Denial

When a service or procedure is not clearly documented in a resident's medical record with respect both to its medical necessity and appropriateness.

When a resident's attending physician does not evaluate the resident prior to authorizing or ordering for a non-emergent service or procedure.

When another physician, whose attendance is requested by a resident or a resident's interested family member or legal guardian, does not evaluate the resident prior to but authorizing or ordering the service or procedure.

When a "PRN" or "standing order" is authorized by a physician for any provider specialty when the services of that provider are not medically necessary and appropriate.

When a "PRN" or "standing order" for any routine screening service is authorized by the physician and is not medically necessary and/or appropriate based on the resident's evaluation and/or assessment.

While all nursing facility residents require a comprehensive assessment, not everyone needs physical, occupational, or speech therapy evaluations or therapy services furnished by skilled therapists. Therefore, there is no requirement that the nursing facility provide further therapy evaluation or treatment when there has been no indication that the resident needs such services.

Noncovered ICD-9 Code(s)

N/A except where indicated in another Medicare of Florida policy that describes the service or treatment ordered.

Coding Guidelines

N/A

Documentation Requirements

HCFA requires SNFs to conduct periodic, comprehensive assessment of each resident to determine which services the resident needs. These assessments and a comprehensive plan of care/ change in plan of care that relates to the assessments should be clearly documented.

The medical necessity for each service, procedure or therapy performed must be clearly documented by the physician in the resident's medical record. The service or procedure ordered must clearly relate to an injury, an illness, a symptom(s), and/or complaint(s) of the resident. Documentation of medical necessity may be found in the physician's order sheet and resident's progress note.

In addition, when other providers are asked to evaluate and/or treat the resident, the medical necessity of the evaluation and treatment and who requested it should be on the physician's order sheet and in the resident's progress note. The provider requested to evaluate the resident must document the evaluation and the findings of that evaluation.

Other Comments

Physicians should refuse to order therapy evaluations, sign for therapy services, or sign certificates that the resident requires skilled therapy unless they believe the services are 1) medically necessary and appropriate and 2) require the skills of a therapist (for example, an order for services which could not be furnished by nursing staff because this would endanger the resident or it would not have the desired effect on the resident's outcome if performed by other than a skilled therapist). This applies regardless of whether the request for physician approval comes from the facility in connection with its annual assessments of all residents, or directly from the therapist with regard to specific services for a particular resident.

Any service, procedure, or therapy ordered for the resident must be medically necessary and appropriate for that particular resident and should clearly be documented by the physician ordering the service, procedure, or therapy.

Emergency services may be ordered prior to the physician evaluating the patient.

Rationale For Creating Policy

This policy was developed in order to determine when it is appropriate to order/perform therapeutic or diagnostic services for nursing facility patients. Also, it clearly indicates that the physician who writes the order for a service must also have documented in the resident's medical records the medical necessity of the service ordered.

CAC Notes

This policy does not express the sole opinion of the carrier or the Carrier Medial Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee which includes representatives from the Florida Academy of Family Physicians.

Advance Notice Statement

Applies to medical necessity (see page 4).

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52282: Correction to Urethral Stents Article

The coverage for urethral stents was published on pages 49-50 of the July/August 1998 Medicare B UPDATE!. Two of the contraindications listed were incorrectly published. On page 49 under the second list of contraindications, number 4 should read, "Patients with known or suspected prostate cancer." The word "treatable" has been removed. Also on page 50, contraindication number 10 should read, "Patients with bladder stones or neurogenic bladder." The word "current" has been removed.

As with the article pubished in the July/August edition, this information is effective for claims processed on or after August 17, 1998.

Advance Notice Statement

Applies to medical necessity (see page 4).

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76075, 76076, 76078, 78350, G0130-G0133: Bone Mineral Density Studies

The Balanced Budget Act of 1997 has made provisions for standardization of Medicare coverage of bone mass measurements. This standardized coverage is effective for claims with dates of service furnished on or after July 1, 1998. The Local Medical Review Policy (LMRP) for Bone Mineral Density Studies (76075) has been revised to incorporate this national provision. This policy revision is effective for claims with dates of service furnished

on or after July 1, 1998. Listed below is the revised LMRP for Bone Mineral Density Studies.

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

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

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

Precise calibration of the equipment is required for accuracy and to reduce variation of test results and risk of misclassification of the degree of bone density. Lack of standardization in bone mineral measurement remains an issue, and tests are best done on the same suitably precise instrument to insure accuracy. It is important to use results obtained with the same scanner when comparing a patient to a control population, as systematic differences among scanners have been found. To ensure reliability of bone mass measurements, the densitometry technologist must have proper training in performing this procedure. Malpositioning of a patient or analyzing a scan incorrectly can lead to great errors in bone mineral density studies.

A stationary bone densitometer is a device that is permanently located in an office. A mobile densitometer is one that is transported by vehicle from site to site. A portable densitometer is one that can be picked up and moved from one site to another.

Indications and Limitations of Coverage and/or Medical Necessity

A bone mineral density study is covered for the following indications. In addition, all coverage criteria listed below must be met.

- A patient with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture. For this indication use ICD-9 code 733.02 for idiopathic osteoporosis, ICD-9 code 733.90 for osteopenia, or ICD-9 codes 805.00-806.9 for vertebral fractures.

- A patient being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy. Use ICD-9 code 733.00 for unspecified osteoporosis, ICD-9 code 733.01 for postmenopausal osteoporosis, ICD-9 code 733.02 for idiopathic osteoporosis.

- A patient with known primary hyperparathyroidism. Use ICD-9 code 252.0 for hyperparathyroidism.

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- A patient on receiving (or expecting to receive) corticosteroid therapy (greater than 3 months, on the equivalent dose of 30 mg cortisone [or 7.5 mg prednisone] or greater per day. Use ICD-9 code 733.09 for drug-induced osteoporosis and ICD-9 code E932.0 for adrenal cortical steroids.

- A woman who is estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings. For this indication use ICD-9 code 256.2 (postablative ovarian failure) or 256.3 (other ovarian failure).

Coverage criteria for bone mass measurements are as follows:

- There must be an order by the individual's physician or qualified nonphysician practitioner treating the patient following an evaluation of the need for a measurement, including a determination as to the medically appropriate measurement to be used for the individual;

- This service must be furnished by a qualified supplier or provider of such services under at least the general level of supervision of a physician;

- This service must be reasonable and necessary for diagnosing, treating, or monitoring a individual as defined above; and

- This service must be performed with a bone densitometer or a bone sonometer device approved or cleared for marketing by the

FDA for bone mass measurement purposes, with the exception of dual photon absorptiometry devices.

Medicare may cover a bone mass measurement for a patient once every 2 years. However, if medically necessary, Medicare may cover a bone mass measurement for a patient more frequently than every 2 years. Examples of situations where more frequent bone mass measurements procedures may be medically necessary include, but are not limited to, the following medical circumstances:

- Monitoring patients on long-term glucocorticoid (steroid) therapy of more than 3 months; and

- Allowing for a confirmatory baseline bone mass measurement (either central or peripheral) to permit monitoring of patients in the future if the initial test was performed with a technique that is different from the proposed monitoring method (for example, if the initial test was performed using bone sonometry and monitoring is anticipated using bone densitometry, Medicare will allow coverage of baseline measurement using bone densitometry).

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

HCPCS Codes

G0130 Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites, appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

G0131 Computerized tomography bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine).

G0132 Computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel).

G0133 Ultra-sound bone mineral density study, one or more sites, appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

76075 Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)

76076 Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

76078 Radiographic absorptiometry (photodensitometry), one or more sites

78350 Bone density (bone mineral content) study, one or more sites; single photon absorptiometry

ICD-9 Codes That Support Medical Necessity

252.0
256.2
256.3
733.00
733.01
733.02
733.09
733.90
805.00-805.9
806.00-806.9
E932.0

Reasons for Denial

- When performed for indications other than those listed in the "Indications and Limitations of Coverage" section of this policy.

- Tests not ordered by the appropriate physician or qualified nonphysician practitioner who is treating the beneficiary are not reasonable and necessary. A physician or qualified nonphysician practitioner treating the beneficiary for purposes of this provision is one who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the patient.

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Bone density studies of any type including DEXA scans are not covered under the portable x-ray benefit. The benefit allows for x-ray films of the skeleton, chest or abdomen. Although bone density studies are radiology procedures, they are not x-ray films. Also, to be a benefit of portable x-ray services the equipment must be portable to provide services in the home.

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

Noncovered ICD-9 Code(s)

Any diagnoses not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.

Coding Guidelines

When performing bone mineral density studies, the CPT Code that reflects the procedure that was performed should be billed. See the HCPCS section for the appropriate CPT Codes.

Effective July 1, 1998, CPT Code 76070, 76070-26, and 76070-TC changed from an "A" (active code) to a "G" (not valid for Medicare purposes) status. Medicare uses other codes for reporting of, and payment for these services. Computerized tomography bone mineral density study should now be reported with HCPCS Codes G0131 and G0132.

Dual photon absorptiometry (CPT code 78351) remains a noncovered service under Medicare and may not be reported under HCPCS codes (76075) or (76076).

Photodensitometry (a noninvasive radiological procedure that attempts to assess bone mass by measuring the optical density of extremity radiographs with a photodensitometer) is reported using code 76078. Since this procedure is performed by taking an X-ray of the hand simultaneous with an X-ray of a "phantom", the X-ray of the hand is not reimbursed separately.

One of the indications listed in this policy under the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy requires a dual diagnosis to be submitted. Refer to this section of the policy.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the test and the test results. In addition, if the service exceeds the frequency parameter listed in this policy, documentation of medical necessity must be submitted. This information is usually found in the history and physical, office/progress notes, or 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 studies. The physician must state the clinical indication/medical necessity for the study in his order for the test.

****

78460-78465, 78478, and 78480: Myocardial Perfusion Imaging

On pages 37-38 of the May/June 1998 Medicare Part B Update, the local medical review policy for Myocardial Perfusion Imaging

(procedure codes 78460-78465, 78478, 78480) was published. Since that time, procedure codes 78464 and 78465 were evaluated based on a 1997 Focused Medical Review (FMR) aberrancy.

Analysis of 1997 Medicare claims data for the state of Florida indicated that the Florida Carrier has allowed significantly more reimbursement per 1,000 Medicare beneficiaries than Medicare has paid nationally for procedure codes 78464 and 78465 by the specialties of Cardiology, Internal Medicine, Family Practice, Vascular Surgery, and Diagnostic Radiology.

According to the data for procedure code 78464, it appears that some providers are billing the single study procedure code on different days, when a patient is having the rest portion and stress portion of the myocardial imaging on two consecutive days. As a result of these findings, a revision of this policy was needed to indicate the appropriate billing of myocardial perfusion imaging.

Based on the above information the following indication for performing a myocardial perfusion scan has been added to the policy:

- Follow-up within 48 hours of an abnormal multiple myocardial perfusion scan to determine whether the perfusion defect is related to myocardial scarring or myocardial ischemia. Usually only a single study is needed to evaluate this indication.

In addition, the following coding guideline has been added:

- When performing both the rest and stress portions of the myocardial perfusion imaging for any one of the covered indications, a multiple study procedure code (78461, 78465) should be billed regardless of whether the imaging occurs on the same day or two different days.

Also, the information provided in the Coding Guideline section regarding specific myocardial imaging agents such as Cardiolite and Thallium have been removed. The new statement reads as follows, "Myocardial imaging agents used for cardiac perfusion studies both at rest and at stress are covered when billed with procedure codes 78460-78465, 78478, and 78480."

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

Page 27 of the July/August 1997 Medicare B UPDATE! featured a list of diagnoses for which Lipid Profile/Cholesterol Testing (procedure codes 80061, 82178, 82465, 83715-83721, and 84478) would be considered medically necessary. Diagnosis range 414.10-414.9 (Aneurysm of heart), was changed to 414.10-414.19 (Aneurysm

of heart). This change is effective for claims processed on or after August 17, 1998

Advance Notice Statement

Applies to medical necessity (see page 4).

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82330: Ionized Calcium

The July/August edition of the Update! included an article (page 53) about coverage for ionized calcium. The diagnosis list published in that article is incomplete. The following diagnosis list is complete, and is effective for claims processed on or after August 17, 1998.

ICD-9 Codes That Support Medical Necessity

038.0-038.9
252.0
252.1
259.3
275.2
275.41
275.42
275.49
278.4
577.0-577.1
585
586.0
588.8
733.90
780.7
781.0
781.7
787.0-787.03
787.2
788.42
996.81
V42.0
V45.1
V56.0

Advance Notice Statement

Applies to diagnosis (see page 4).

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80299, 81099, 84999, 85999, 86849, 86999, 87999, 88099, 88199, 88299, 88399, and 89399: Pathology and Laboratory Unlisted Procedures

According to the Current Procedure Terminology (CPT-4) book, the following procedure codes are identified as unlisted services in the Pathology and Laboratory section: 80299, 81099, 84999, 85999,

86849, 86999, 87999, 88099, 88199, 88299, 88399, and 89399. Any time one or more of the unlisted procedure codes are billed, documentation supporting the medical necessity of the test must be submitted. Other pertinent information that should be included in the documentation is an adequate definition or description of the nature, extent, and need for the procedure; and the time, effort, and equipment necessary to provide the service. Additional items which may be included in the documentation are: complexity of the symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

When documentation is submitted to support the unlisted procedure code(s), the medical review personnel must be able to differentiate the information which supports the medical necessity for the unlisted service from the information for other laboratory services billed on the same day. It is expected that the medical records be clearly marked or labeled on the documentation in order to determine the information pertaining to the unlisted code. This can be done by highlighting, underlining, in a cover letter, or any other means. If the medical review personnel cannot determine the applicable documentation for the unlisted procedure code, the service will be denied.

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84484, 84512: Coverage for Troponin

Troponin is a muscle protein that attaches to both actin and tropomyosin. It is concerned with calcium binding and inhibiting cross-bridge formation. The distribution of these isoforms varies between cardiac muscle and slow- and fast-twitch skeletal muscle. Their importance lies in the fact that the isoforms troponin I and troponin T show a high degree of cardiac specificity, and therefore, have an important role in the diagnostic evaluation of a patient presenting with symptoms suggestive of a cardiac origin.

Cardiac Troponin I (cTnI) is highly specific for myocardial tissue, is thirteen times more abundant in the myocardium than CK-MB on a weight basis, is not detectable in the blood of healthy persons, shows a greater proportional increase above the upper limit of the reference interval in patients with myocardial infarction and remains elevated for seven to ten days after an episode of myocardial necrosis. In addition, measurements of cTnI are useful to clarify which increases in CK-MB are due to myocardial injury and which ones reflect acute or chronic skeletal muscle abnormalities.

Troponin T, the tropomyosin-binding protein of the regulatory complex located on the contractile apparatus of cardiac myocytes, is also a sensitive and specific marker for myocardial necrosis. Damaged heart muscle releases the protein, troponin T, which increases in the bloodstream as early as 3 hours after the onset of chest pain and remains at an elevated level for 2 to 7 days.

Troponin levels are considered medically reasonable and necessary to rule out myocardial injury only under the following conditions:

- patient presents with signs and symptoms of an acute myocardial infarction (prolonged chest pain often described as squeezing, choking, stabbing, etc., usually spreading across chest to the left arm; dyspnea, diaphoresis) which is confirmed by an electrocardiogram (EKG, ECG);

- patient presents with vague or atypical symptoms suggestive of a cardiac origin, which is not confirmed by an electrocardiogram; or

- patient presents with the diagnosis of unstable angina and a non Q-wave myocardial infarction with no ST elevation on the EKG.

Initially, it is expected that a qualitative Troponin level (procedure code 84512) is performed on a patient with suspected myocardial injury. If the results of the qualitative Troponin level is positive, then the quantitative level of Troponin I or Troponin T (procedure code 84484) is performed, usually with the same blood specimen, to determine if the symptoms are cardiac in nature. The Troponin C isoform is not useful in the management of myocardial infarction and it is not necessary to monitor both the T and I isoform.

The quantitative test is normally performed every 8-12 hours the first 24 hours. Once the determination is made whether myocardial injury has occurred, it is expected that a Troponin level will be performed only when the results are to be used in the active treatment of the patient.

Also, it is not necessary to use Troponin in addition to Creatine Kinase (procedure codes 82550-82554) in the management of patients with myocardial infarction.

To ensure the services are medically necessary, Troponin levels are covered only for the following diagnoses:

410.00-410.92

411.1

413.0-413.9

427.0-427.9

785.0

786.09

786.50-726.59

794.31

Reasons for Denial

Troponin levels 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 suspected myocardial injury.

When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9 Code(s)

Any diagnosis not included in the "ICD-9 Codes That Support Medical Necessity" section of this policy.

Coding Guidelines

One unit of troponin is equivalent to one order for 84484 or one order for 84512 regardless of the number or mix of isoforms provided. Therefore, regardless of the isoforms or mixture of isoforms provided, only one unit may be billed for each code.

Documentation Requirements

The medical records must document the medical necessity of the test including the test results. This information is usually found in the office/progress notes, emergency/hospital notes, and/or 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.

Advance Notice Statement

Applies to medical necessity (see page 4).
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85007-85031: CBC Diagnosis Revision

Page 35 of the July/August 1997 Medicare B Update! featured the policy on Complete Blood Count. The diagnosis range for "other dermatoses" was changed from 702.0-702.9 to 702.0-702.8. In

addition, the diagnosis for "acquired deformities of toe" was changed from 735.00-735.9 to 735.0-735.9.

Advance Notice Requirement

Applies to medical necessity

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93555, 93556: Billing for Radiologic Supervision for Cardiac Catheterization

Based on some recent questions regarding the billing of the radiology codes in the 70000 series of the Current Procedural Terminology (CPT-4) book for the supervision and interpretion of the injection procedures performed during a Cardiac Catheterization, clarification is being made.

According to the 1998 Current Procedure Terminology (CPT-4) book, the reporting of the imaging supervision, interpretation and report for the injection procedures (93539-93545) during cardiac catheterization should be billed with procedure codes 93555 and/or 93556. These codes represent the radiology companion codes for the injection procedures. Therefore, it is not appropriate to bill the radiology codes identified in the 70000 section of the CPT-4 book in addition to procedure codes 93555-93556.

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94760-94762: Noninvasive Ear or Pulse Oximetry for Oxygen Saturation

Pulse oximetry provides a simple, accurate, and noninvasive technique for the continuous or intermittent monitoring of arterial oxygen saturation. A small lightweight device attaches to the finger or toe and directs through the nailbed two wavelengths of light; a photodetector measures absorption. Arterial pulsation is used to gate the signal to the arterial component of blood contained within the nailbed.

Ear oximetry is a noninvasive method for evaluating arterial oxygenation. Ear oximeters are commonly used in sleep studies.

The policy published here is effective for claims processed on or after August 17, 1998.

Indications and Limitations of Coverage and/or Medical Necessity

Single and Multiple Determinations

Medicare Part B in Florida will consider ear or pulse oximetry for oxygen saturation (CPT Codes 94760, 94761) to be medically necessary when the patient has a condition resulting in hypoxemia and there is a need to assess the status of a chronic respiratory

condition, supplemental oxygen requirements and/or a therapeutic regimen (see Covered ICD-9 Codes).

HCPCS Codes

94760 Noninvasive ear or pulse oximetry for oxygen saturation; single determination

94761 Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (e.g., during exercise)

ICD-9 Codes That Support Medical Necessity

162.2-162.9
428.0
428.9
491.20-491.21
492.0-492.8
493.00-493.01
493.10-493.11
493.20-493.21
493.90-493.91
494
496
515
518.5
518.81
518.89
786.09

Continuous Overnight Monitoring

Medicare Part B in Florida will consider ear or pulse oximetry for oxygen saturation by continuous overnight monitoring (CPT code 94762) to be medically necessary in the following circumstances (see Covered ICD-9 Codes):

The patient must have a condition for which intermittent arterial blood gas sampling is likely to miss important variations and

The patient must have a condition resulting in hypoxemia and there is a need to assess supplemental oxygen requirements and/or a therapeutic regimen.

HCPCS Codes

94762: Noninvasive ear or pulse oximetry for oxygen saturation by continuous overnight monitoring (separate procedure)

ICD-9 Codes That Support Medical Necessity

Appropriate ICD-9 codes for ear or pulse oximetry for oxygen saturation by continuous overnight monitoring (CPT code 94762) include the following:

162.2-162.9
428.0
428.9
491.20-491.21
492.0-492.8
493.00-493.01
493.10-493.11
493.20-493.21
493.90-493.91
494
496
515
518.5
518.81
518.89
780.51
780.53
780.57
786.09

Reasons for Denial

The use of ear or pulse oximetry for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9 Code(s)

Any diagnoses not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.

Coding Guidelines

Reimbursement for noninvasive ear or pulse oximetry for oxygen saturation : single determination (CPT code 94760) is included in the basic allowance of noninvasive ear or pulse oximetry for oxygen saturation, multiple determination (CPT code 94761) when performed on the same day by the same provider.

Documentation Requirements

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

If the provider of oximetry studies 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 ordering/referring physician must state the clinical indication/medical necessity for the oximetry study in his order for the test.

Advance Notice Statement

Applies to medical necessity (see page 4).

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Calculation of EPO Payments

On page 10 of the November/December 1997 Medicare Part B Update, the calculation of EPO payments based on a 90-day rolling average hematocrit measurement was published. Effective immediately, this method of calculation, referred to as the Hematocrit Measurement Audit (HMA) will not be used.

It is expected that chronic renal failure patients receiving EPO for symptomatic anemia are being monitored through hematocrit levels (or equivalent hemoglobin) to maintain the hematocrit level within the target hematocrit level of 30-36 percent. The dosage of EPO required to maintain target hematocrit levels is subject to individual patient variation and should be calculated, according to patient response, with a goal not exceeding a hematocrit of 36 percent.

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95900, 95903, 95904: Nerve Conduction Studies

On pages 49-51 of the May/June 1998 Medicare B Update, the coverage for nerve conduction studies was published. Since the publication of the article, a range of diagnosis codes, 335.0-335.9, has been added to the "ICD-9 Codes That Support Medical Necessity" section of the policy. This addition is effective for claims processed on or after September 14, 1998.

Advance Notice Statement

Applies to diagnosis (see page 4).

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A CLOSER LOOK

All You Ever Wanted To Know About Crossovers!

Crossover is defined as the exchange of claim information from Medicare Part B carrier to another insurance carrier, such as an Automated Supplemental Insurer, to Medicaid, or to a Medigap

insurer. These type of crossovers eliminate the need for providers or beneficiaries to manually file paper claims for supplemental insurance to another insurer.

This article is designed to help providers understand the circumstances under which Medicare Part B of Florida will crossover Medicare payment data to various supplemental insurers. In this article, the following issues will be addressed:

- Automatic Crossover
- Medicaid Crossover
- Medigap Crossover
- How to Bill Medigap
- Medigap Payment Issued to Patient
- Medigap Listing
- Exceptions for Certain Insurers

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Table of Contents

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Automatic Crossover

Medicare Part B of Florida enters into contracts with private insurers to automatically cross over Medicare claim information electronically to the private insurer after our payment determination has been made. This type of crossover does not require the submission of policy information on each claim; instead Medicare claims are automatically sent to the private

insurer based on the patient's eligibility (as defined by their policy) for this transfer.

The private insurer provides the Medicare carrier an eligibility file (tape) of the subscribers eligible for the automated crossover. This eligibility file updates the individual's Medicare record for the automated crossover. The Medicare carrier does not manually add or delete an automated crossover. Only the eligibility file provided by the private insurer updates the Medicare records for the automated crossover.

A comprehensive list of the insurers and/or policies which have claims automatically crossed over from Medicare Part B of Florida follows. This information is now available on the Medicare Online Bulletin Board System (BBS) under the "Medigap Crossover Listing" section. Additions to this listing will be maintained, as well as being published in future issues of the Medicare B Update!

Not all policyholders of a particular insurer have policies that allow their claims to automatically crossover. Providers who are unsure of whether a patient's contract includes this automated crossover option should:

- Ask the patient if their supplemental policy includes the automated crossover option; or,

- Contact the patient's supplemental insurer to verify this information.

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Please keep in mind that the Medicare carrier does not have knowledge if the patient's plan has the automated option.

Automatic Crossover Insurers/Plans:

AARP/United HealthCare

Aetna Health Plans

AFSA Flightcare Supplemental (Administered by KVI)

Aid Association for Lutherans (Administered by Mutual of Omaha)

American Family Life Assurance (AFLAC)

American General

American Insurance Administrative Group (AIAG)

American Life and Accident (Administered by United American Insurance)

American Pioneer Life Insurance Company

American Postal Workers Union (APWU)

Anthem BCBS (Indiana)

AUSA Mastercare Supplemental (Administered by KVI)

Bankers Life & Casualty

Blue Cross Blue Shield of Alabama

Blue Cross Blue Shield of Florida

Blue Cross Blue Shield of Illinois

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Wisconsin

Caterpillar Incorporated

Central States Insurance

Claims Administration

Cologne Life Reinsurance

Colonial Penn Life Insurance

Continental General Insurance (Administered by Mutual of Omaha)

Continental Life Insurance

Empire Blue Cross Blue Shield

Employers Insurance of Wausau (Administered by Mutual of Omaha)

Federal Home Life Insurance (Administered by Mutual of Omaha)

First Providian Life and Health (Administered by Providian)

FRA Fleet Reserve Supplemental (Administered by KVI)

Garden State Life Insurance (Administered by Providian)

Gerber Medicare Select (Administered by Cologne Life Reinsurance)

Globe Life and Accident (Administered by United American Insurance)

Government Employee Hospital Association (GEHA)

Group Health Insurance (GHI)

Gulf Life (Administered by American General)

Hartford-Alexandria Virginia (Administered by Mutual of Omaha)

Hartford-Des Moines Iowa (Administered by KVI)

Harvest Life Insurance (Administered by Mutual of Omaha)

Health and Life Insurance Co. of America (Administered by Pioneer Life)

HealthSource Provident (Administered by Mutual of Omaha)

Highmark Inc. (Formerly Pennsylvania Blue Shield)

Humana Health Plan

Idealife Insurance-Ameriplus (Administered by AIAG)

Kirke-Van Orsdel (KVI)

Liberty National (Administered by United American Insurance)

Mail Handlers Health Benefit Plan (Administered by Claims Administration)

Medicaid (TITLE 19)

Medical Mutual of Ohio (Formerly BCBS of Ohio)

Medico Life Insurance (Administered by Mutual of Omaha)

Mennonite Mutual Aid (Administered by Mutual of Omaha)

Monumental General

Mutual of Omaha

Mutual Protective (Administered by Mutual of Omaha)

National Association of Letter Carriers (NALAC)

Nationwide

Physicians Mutual

Pioneer Life

Providian Life and Health Insurance

Pyramid Life Insurance (Administered by Mutual of Omaha)

Retired Officers (Administered by KVI)

SAMBA

Secure Care (Administered by Providian)

Standard Life & Accident

State Mutual Insurance Company (Administered by Mutual of Omaha)

TROA Mediplus (Administered by KVI)

Union Bankers Insurance

Unicare Life Insurance

Union Labor Life (Plans Administered by Providian)

Union Labor Life (Plans Administered by AIAG)

United American Insurance - Globe

United Commercial Travelers

United HealthCare (formerly Metrahealth)

Universal Fidelity Life (Administered by Pioneer Life)

USAA Life Insurance Company

Veterans Life Insurance (Administered by Providian)

Wakely Insurance (Administered by Mutual of Omaha)

World Insurance (Administered by Mutual of Omaha)

World Mutual of Providian (Administered by Providian)

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Medicaid

Medicaid provides the Medicare carrier with an eligibility file (tape) of the Medicaid enrollees. The eligibility file updates each enrollees Medicare record and the claims will automatically crossover to Medicaid for processing. Currently, this activity takes place without block 10d of the HCFA-1500 claim form being completed. In the future, it may be required to complete block 10d.

As a reminder, providers treating patients who are entitled to both Medicare and Medicaid the provider must accept assignment for Medicare services, regardless of your participation status in either program. For providers who accept Medicaid assignment, the total of Medicare and Medicaid's payment represent payment in full for the services rendered. In cases where Medicaid does not make payment for certain services based on program limitations, providers should follow Medicaid's guidelines for collection of these amounts.

Medicaid requires the issuance of a separate provider number for processing purposes. Medicaid will accept claims crossed over from Medicare only when the provider has a valid Medicaid provider number. If claims are crossed over to Medicaid and the provider does not have a Medicaid provider number, they are not accepted by Medicaid. Therefore, Medicaid has no record of these crossovers.

For providers who do not have a valid Medicaid provider number, a Medicaid enrollment form may be obtained by writing to:

Medicaid Enrollment Unit
PO Box 7070
Tallahassee FL 32314

Medigap Crossover

Medigap is a Medicare supplemental policy offered by a private entity to persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits by filling some of the "gaps" in Medicare coverage. Medigap policies are governed by individual state insurance departments under federal guidelines and regulations and fit into 10 standard Medigap plans.

Medigap does not include limited benefits coverage such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as plans offered by labor organizations. These types of plans are generally NOT Medigap policies and are exempt from the Medigap crossover process. Private insurers are not required to process crossover data for a subscriber whose policy is not a Medicare supplemental plan. See "Special Exceptions" in this article for more information.

Under the Omnibus Budget Reconciliation Act (OBRA) of 1987, The Medicare carrier is required to transfer (crossover) claim data to private insurers for claims submitted from a participating provider where the beneficiary maintains a "Medigap Policy." The beneficiary must agree to assign his/her benefits under a Medigap policy to the Medicare provider. The insurer will process the claim based on the information received from the Medicare carrier and payment for the supplemental benefit will be made directly to the participating provider.

This type of crossover is performed on a claim-by-claim basis for participating Medicare providers. The Medigap policy data must be submitted on each claim. See "HCFA-1500 Completion Requirements" in this article for complete instructions.

Listings of Medigap insurers are available on the Medicare Online Bulletin Board System (BBS) under the "Medigap Crossover Listing" section. Revisions to the list will be maintained, as well as being published in future issues of the Medicare B Update!

HCFA-1500 Completion Requirements for Medigap

Medicare will crossover Medicare payment data to a Medigap insurer only if requested to by the participating physician and suppliers. By adhering to the following guidelines, providers/suppliers, whether they bill electronically or on paper, payment data can be forwarded to the Medigap insurer.

The following information must be included on the HCFA-1500 claim form in order for Medicare payment data to be forwarded to the Medigap insurer. These instructions apply to specific blocks on the HCFA-1500 claim form designated to contain Medigap information. For complete HCFA-1500 claim form completion instructions, please refer to ther September/October 1997 Update!: HCFA-1500 Completion Requirements.

Payer Identification (PAYERID)

PAYERID is a project spearheaded by the Health Care Financing Administration (HCFA) in which a unique identifier will be assigned to every payer of health care claims. The implementation date for this initiative has not been established.

Please continue using the Florida carrier-assigned five-digit Medigap insurer number where the PAYERID is referenced.

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Medigap Field Requirements

Item 9

Enter the last name, first name, and middle initial of the enrollee in a Medigap policy, if it is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank.

Item 9a

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

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

Item 9b

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

Item 9c

Leave blank if a Medigap PAYERID is entered in item 9d. Otherwise enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two letter postal code, and zip code copied from the Medigap insured's Medigap identification card. For example: 1257 Anywhere St MD 21204

Item 9d

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

NOTE: PAYERID has not been implemented. Please continue using the Florida carrier-assigned five-digit Medigap insurer number.

Item 13

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

NOTE: Only participating physicians and suppliers are to complete item 9 and its subdivisions, and only when the beneficiary wishes to assign his/her benefits under a medigap policy to the participating physician or supplier.

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

Florida Carrier-Assigned Medigap ID#

We encourage the use of the Medigap insurer's carrier-assigned number (item 9d). This simplifies the Medigap claim submission and improves processing efficiency of the claims. The Florida carrier-assigned numbers can be found in the "Medigap Crossover Listing" on the Medicare Online Bulletin Board System (BBS).

Electronic Filing

Providers billing electronic claims should also follow the standardized HCFA-1500 claim form completion requirements when submitting Medigap information. If you are unsure about how to enter the Medigap information into your computer, contact your Electronic Software Support Vendor.

Paper Filing

It is important for providers who submit claims on paper to be sure that all entered information is aligned within the field parameters, typed or machine printed in courier font, 12-point size, and dark print. This will enable the Optical Character Recognition (OCR) automated scanning system to accurately read and interpret the character entries.

How Will You Know If The Crossover Was Successful?

The provider will be notified when Medicare payment data is forwarded to the supplemental insurer. This notification will be made on the Standard Paper Remittance Advice Notice (PRN) sent to the provider.

The following Medicare Claim Level Remarks Codes will be sent to the provider on the PRN.

If the claim is automatically crossed over to the supplemental insurer based on patient's eligibility. In some cases the name of the supplemental insurance carrier will be given;

MA18: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.

If the claim is crossed over to the Medigap insurer;

MA18: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.

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If complete Medigap information is not provided on the HCFA-1500 claim form, or if more than one Medigap insurer is listed, the Medicare payment information will not be crossed over;

MA19: Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.

It is the responsibility of the provider to collect any supplemental insurance payment from the beneficiary when the beneficiary's insurer is not a Medigap insurer, or the provider does not participate in Medicare;

MA08: You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.

Adjustments

Claims which require adjustments by the carrier will be crossed over to the Medigap insurer if payment information was previously crossed over to the Medigap insurer. However, not all insurers who offer automatic crossovers based on patient eligibility accept the crossover of adjustment payment information.

Returned Medigap Crossover Claims

Situations arise when the Medigap insurer may return the actual crossover claim to the Medicare carrier. This could be the result of:

- Not a Medicare Supplemental "Medigap" Plan

- Unable to Identify the Individual

- Invalid Policy Number

- Lapsed Coverage

When this occurs, we send the return crossover claim to the provider with the reason identiied for the return.

Should you receive our notification of a returned Medigap crossover claim, please verify the patient's current suplemental insurance and submit the claim directly to the appropriate insurer if additional benefits are due. Please do not refile the returned Medigap claim to the Medicare carrier.

To avoid returned crossover claims, please verify the patient's records to ensure you have current supplemental insurance information on file and also understand the type of supplemental plan.

Medigap Payment Made to the Patient

Any private Insurer who offers Medigap policies is regulated under the federal legislation as outlined in the Omnibus Budget Reconciliation Act (OBRA) of 1987.

If the Insurer sends the payment to the patient, you must first verify if the patient's supplemental policy is a true Medigap policy. It may be indicated on the patient's supplemental insurance card, or contact the supplemental insurer to verify the type of plan.

No, the patient's policy is NOT a Medigap policy. The insurer will make payment based on the patient's contract. Retirement plans offered by employers or unions are not subject to the rules that apply to Medigap policies.

Yes, the patient's policy is a Medigap policy. You should contact that insurer and remind them that they are required by OBRA 1987 to make their supplemental payment directly to you when you have complied with all requirements.

If the insurer persists in paying the patient on valid Medigap policy holders, you may report this to the State Insurance Department for the state in which the insurer is located. The Florida Department of Insurance Consumer Helpline can provide you with additional information. The helpline number is 1-800-342-2762.

Or, you may write our Medigap coordinator for assistance.

Medicare Part B
PO Box 2078
Jacksonville FL 32231
Attn: Medigap Coordinator

Medigap Listing for Medicare Part B of Florida

Where Can You Get the Listing?

The Medigap Crossover Listing is available on the Florida Medicare Online Bulletin Board System (BBS) to view, search, or copy (download). This listing provides the Insurer Name, Address, the five-digit Florida carrier-assigned ID number, and if the claim is cross to the insurer.

Medigap insurers are added, revised, and deleted on an ongoing basis. The Medicare Online BBS is updated as these changes are made. You should check the Medigap section of the Medicare Online BBS on a regular basis (monthly), or check future issues of the Medicare B Update! for insurer updates.

Since the Medigap Listing is available on the Medicare Online BBS and the listing is continuously changing we will no longer be publishing a paper Medigap listing.

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The Florida Medicare Online BBS is an unattended personal computer that accepts calls from your own computer. This allows you to access the Medigap Crossover Listing, and other information such as the UPIN Directory, Publications, Fee Schedules, and much more! The Medicare Online BBS is available 24 hours a day, 7 days a week. And now the service is toll-free for participating Medicare providers.

You can access the Medicare Online BBS using any communications program you wish (i.e., ProComm, QuickLink, HyperTerminal, etc.). If you are unable to use your communication software or do not have any, we offer a FREE communications program. The Medicare Online access number is (800) 838-8859, or the Jacksonville Florida area should use 791-6991. If you have questions regarding the Medicare Online BBS, contact our Help Line at (904) 791-8384.

Special Exception for Certain Insurers

Certain insurers notified Medicare Part B of Florida of exceptions that apply to their plans. Specifically, they provided information to help identify their "Medigap" plans. The following exceptions should be made when using the Medigap crossover for the following insurers.

Anthem BCBS, Cincinnati OH
Medigap ID Number 45016

Anthem BCBS (Ohio) individual Medicare Supplemental Medigap plans can be identified by the Identification Card. The ID card for Individual Medigap plans have the letter "B" shown before the identification number.

Other plans in which the number is preceded with letters such as "LOR, NGM, HBI, and ARM" are GROUP PLANS. These types of plans are not Medicare Supplemental Medigap plans and should not be submitted as Medigap.

Bankers Commercial Life, Dallas TX
Medigap ID Number 53008

Bankers Commercial Life Medicare Supplemental Medigap policy numbers begin with the letters MP, MMP, and SM. These letters are then followed by up to six numbers.

Other plans in which the number is preceded with letters such as MMSD or MHMS are not Medigap Plans. These plans should not be submitted as Medigap.

BCBS of California, Chico CA
Medigap ID Number 15111

BCBS of California's Medicare Supplemental Medigap plans can be recognized by the following plan numbers:

500913, 500914, 500916, 500917, 500918, 500919, 500920, 500921, 50922, 500923, 500924, 500927, 50028, PS2901, PS2902, PS2911, PS2912, SAN001, SAS001, SFN001, SFS001, SHN001, SHS001, SIN001, and SIS001.

Other plans issued by BCBS of California not listed above are not Medigap plans and should not submitted as Medigap.

BCBS of Hawaii, Honolulu HI
Medigap ID Number 21001

BCBS of Hawaii only processes Medigap claims for Hawaii Medical Service Association (HMSA) members. The HMSA members can be identified with policy numbers beginning with XLA or XLB.

BCBS of Northeastern New York, Albany NY
Medigap ID Number 42157

BCBS of Northeastern New York Medicare Supplemental Medigap plan identification card list the type of coverage as "Complimentary". The Medigap plans include the following Group Numbers:

0956600, 0957300, 0963200, 0964200, 0966600, 0983200, 0984300, 0987200, 0987300, 0988000, 0988200, and W988000.

Other types of coverage plans issued by BCBS of Northeastern New York are not Medicare Supplemental plans and should not be submitted as Medigap. Only Complimentary plans listed in the above group numbers are Medicare Supplemental plans.

Kanawha Insurance, Lancaster SC
Medigap ID Number 50019

Kanawha Medicare Supplemental Medigap plans can be identified by the Policy Number.

If the policy number is the individual's social security number this is a GROUP PLAN. These types of plans are not Medicare Supplemental Medigap plans and should not be submitted as Medigap.

However, policy numbers other than the individual's social security number, the plan may be a Medicare Supplemental Medigap plan.

If unsure about the type of plan, you may call Kanawha to verify the type of supplemental coverage. Their toll-free number is: 800-635-4252.

Principal Mutual Life, Omaha NE
Medigap ID Number 37015

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

Principal Mutual Life's Medigap plans can be identified by the Insurance Card. Their Medigap identification card (reverse side) will provide the statement "Medigap Coverage NOTE: PLEASE NOTIFY YOUR DOCTOR/MEDICAL PROVIDER THAT THIS IS MEDIGAP COVERAGE". Also, the Medigap policy numbers begin with the following prefix: N81493, N81494, N81496-N81498, N82112, N82332, N83125, N83350, N83373, N83500, N83634, N83980, N84020, N84740, N84775, N85418, N85561, N86558-N86581, N86583-N86585, N86587-N86589, N86591-N86598, N87748, N88118-N88156.

Other Principal Mutual Life plans (employer or group) which the identification card does not include the above statement and the policy number does not begin with the prefix above are not Medigap plans and should not be submitted as Medigap.

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State Farm Regional, Winter Haven FL
Medigap ID Number 19033

State Farm Medicare Supplemental Medigap plans can be identified by the policy number. The Medigap policies are identified by policy numbers which begin with "H" followed by up to eleven numbers. An example is "H12345675959. These plans can be submitted as Medigap.

Another plan issued by State Farm is a Group Medical Plan. This is a comprehensive medical plan, not a Medicare Supplemental plan. The group medical plan can be identified by policy numbers which begin with "HG00003 or HG00004". An example is "HG000049999". The Group Medical plans should not be submitted as Medigap.

Crossover Tips:

The following tips have been developed to assist providers in the crossover process.

- Make a copy of your patient's insurance card for your office records.

- Talk to your patients about the types of supplemental insurance they may have. Determine if the insurance is a Medigap policy or an Automated crossover. If the patient has a policy which includes the automated crossover feature, no further action is necessary. However, if the plan is NOT Medigap and we do not contract with that private insurer for automated electronic crossover the patient should file his/her own supplemental claim.

- Verify whether the patient's secondary insurance has changed at each visit.

- Use only the five digit Medigap insurer number on both paper and electronic claims. Use of this number on your claims eliminates the need for other insurer information (name, address) and simplifies the completion, submission, and processing of Medigap claims.

- Report only one Medigap insurer on your claim form. If more than one Medigap insurer is listed, the Medicare claim data will not be crossed over. The beneficiary should decide which insurer to report when he/she has more than one supplemental insurer.

- Remember to allow at least 45 days after receipt of the Standard Paper Remittance Advice Notice for the processing of claims crossed over to a supemental insurer before inquiring to that insurer about the status of a claim.

- Check the Medigap section of the Medicare Online BBS on a regular basis (i.e., monthly) or future issues of the Medicare B Update! for insurer updates. Medigap Insurers and Automated Crossover Insurers are updated on an ongoing basis.

It is important to remember that if a beneficiary assigns his/her Medigap benefits to a participating provider, the provider may not collect the co-insurance prior to filing the Medicare claim.

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WHAT'S NEW FOR EMC?

Elimination of Funding EMC Toll-Free Lines for Participating Physicians and Suppliers

As part of incentives to increase participation, the Health Care Financing Administration (HCFA) made available toll-free lines to providers for electronic media claims (EMC) transmission. Unfortunately, because of budget constraints, HCFA can no longer continue this incentive. Effective January 1, 1999, we can no longer provide EMC toll-free telephone service to participating physicians and suppliers. As your Medicare carrier, it is extremely important for us to assist you during this transition in order to avoid any interruption in your submission of electronic claims. It is our goal to help you obtain quality, affordable long distance telephone service. While the decision on which company to select is yours, there are a variety of charge features from which to choose. Please be aware that we cannot pay any long distance service to deliver your electronic claims submissions to us. As your Medicare carrier, we must also remind you that, at this time, we cannot accept electronic claims via the Internet as this would risk the privacy of Medicare beneficiary data. However, HCFA is exploring the Internet option.

We will provide additional information to our participating electronic providers and their senders and vendors in future editions of this publication, and in separate mailings. This information will include the toll numbers which will replace the toll-free numbers (this information is not available at this writing).

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GENERAL EMC INFORMATION

What Can Prevent Claim Rejects?

This article was published in the last edition of the Medicare B UPDATE! The HCFA-1500 fields in this article differ from those previously published. The fields referenced in this article are the correct ones. This article is being republished in its entirety for readers' convenience.

The Provider Electronic Services department is striving to reduce the amount of claims that reject for front-end edit errors. These claims are not entered into the processing system which causes no payment on your Medicare claims. We have listed below the top three high volume errors for the month of May 1998 along with preventive actions. Do not transmit any claims until these errors are resolved.

Error Message: INV/MISS CLIA

LocationRecord & Field/HCFA 1500 Form: NSF FA0 - 34 Position - 164-178, 1500 claim form, Block 23

Explanation: CLIA # is invalid or missing from the claim.As of 1/1/98 all physician offices and laboratories billing clinical diagnostic lab services require a CLIA number.

Preventive Action: Read Medicare B Update! article (Jan/Feb'98-pg 43) for HCFA's CLIA requirements. Make corrections and re-transmit the entire claim. Talk with your vendor to have edits placed in your system to prevent this error fromoccuring. If you do not have a CLIA number call the Agency for Healthcare Administration at 850/487-3063

Error Message: PRV NOT IN GROUP

LocationRecord & Field/HCFA 1500 Form: NSF FA0 - 23, 1500 claim form, Block 24K

Explanation: You have entered a performing provider number that is not a part of the PA group billingfor services.

Preventive Action: Verify suffix of the performing provider you have entered. Make corrections and re-transmit the entire claim. If you are sure you have entered the correct provider number

with/without suffix, contact the Customer Service Area at 904/634-4994.

Error Message: INV PROV NBR

LocationRecord & Field/HCFA 1500 Form: NSF 1.04 BA0 - 02, NSF 2.0 BA0 - 09, 1500 claim form, Block 33

Explanation: The number you have entered for the billing provider is not valid on the Medicare B provider files

Preventive Action: Verify the number you have entered as the billing provider. Make correction and re-transmit the entire claim. If you are sure you have keyed the correct number, then contact the Customer Service Department at 904/634-4994.

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Completion of EDI Enrollment Form

Effective for claims transmitted July 1, 1998 and after, providers who have not completed the HCFA-mandated EDI enrollment form authorizing electronic transmission of claims will not be able to send claims electronically. The claims will reject with error message "NO EDI ON FILE." The EDI enrollment form must be on file for the provider number indicated in the BA0 record field 02.0 (NSF version 1.04) or the BA0 record field 09.0 (NSF version 2.0).

Procedure codes Q0181 (Unspecified oral dosage form of anti-emetic drug) effective 3/30/98, and J8999 (Prescription drug oral, chemotherapeutic, not otherwise specified) effective 6/29/98, have been approved for electronic transmission. The narrative record (HA0 05.0) has been opened for providers to submit supporting documentation for claims processing.

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Electronic Claim Status

The Electronic Claim Status (ECS) system is an automated mechanism used to obtain the status of pending claims for the electronic media claim (EMC) sender location. To access the data, a sender dials into the Blue Cross Blue Shield of Florida computer to retrieve a file containing claim information for both EMC and paper claim systems that are pending in the Medicare Part B system for 14 days or more. The ECS file is organized by the patient's last name for each billing provider. Using the ECS system eliminates the need for the provider/supplier to request claim information from the Provider Customer Service and the EMC Support areas.

The sender number and the mailbox identification assigned for EMC transmissions must be used to retrieve the ECS file. The communication requirements are the same as the requirements for EMC transmissions. For more information about Electronic Claim

Status, please, contact the Electronic Data Interchange (EDI) Department at (904)791-6895.

DON'T DELAY!!! CALL (904) 791-6895 FOR MORE DETAILS

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PC-ACE : Medicare's Free Software

PC-ACE and the Pentium II Processor

If you plan to purchase or have purchased a personal computer with a Pentium II Processor, be aware that the Bananacom Communications we supply with the PC-ACE(tm) product will not support the Pentium II Processor. We suggest purchasing Procomm Connections Data Terminal & FTP software for Windows 95 or Windows NT 4.0 at a cost between $100.00 and $150.00. If you are having trouble locating the Communications software please contact the PC-ACE(tm) Support at (904) 355-0313. Once you have received the software please contact our office and we will provide you with a script and installation instructions.

PC-ACE Software Replacement

We are funded by the Health Care Financing Administration (HCFA) to provide the PC-ACE(tm) software product free of charge to providers who are interested in sending their claims electronically. No additional monies, however, are allocated for the replacement of lost or missing software. With this in mind, the PC-ACE(tm) department is forced by budget restraints to begin charging a nominal administration fee of $25.00 for each replacement set of diskettes effective immediately.

Testing Requirements for PC-ACE

Prior to transmitting your first Commercial claims in PRODUCTION, you must send and pass a TEST transmission. When preparing claims for transmission, you will see the message: "Is this to be a test or production transmission". Answer T for test. The transmission will be reviewed to ensure valid Commercial payers are used, and to ensure potential errors, which could cause the claims to reject, do not exist. You will be contacted within one business day regarding the results of your test. Only after you have passed your test, will you placed in a production status. Claims sent in production without a sucessful test will not be forwarded to the clearinghouse payer.

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When Was the Last Time You Transmitted a Claim?

Any electronic submitter identification number issued to a physician, a billing service, or a clearinghouse that has not been used within the last six months may be deleted from our files. If you are still interested in transmitting your Medicare B claims electronically, please call the PES Marketing Department

at (904) 791-8767. We are here to assist you with your move into the world of electronic production.

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YEAR 2000

HCFA Sets Up A Vaccination Program Against The Millennium Bug

Everyone who hasn't been marooned on a desert island must have heard of the millennium bug by now!

Many computer systems in the public and private sectors will be affected by the Year 2000 Millennium (Y2K) bug if no action is taken in a necessary debugging procedure.

For many years, computer systems have carried two-position date fields. Unless modified, the fields will assume the year 2000 is 1900. This misinterpretation will cause systems to shutdown, result in calculation errors or place at risk the inter-action with other data systems.

Year 2000 bugs have already run amok in a few data systems as discussed in recent newspaper articles. A commonly reported error is that some credit card processing systems cannot accept credit cards with expiration dates of 2000 or later. Such systems reject the "0" as invalid, thereby causing a major problem for both businesses and their customers. A similar error may already have occurred in some health care providers' offices data systems when patients attempted to pay their bills with credit cards having expiration dates of 2000 and beyond.

In essence, health care providers have many chances of becoming bedeviled by Y2K bugs not only in the credit card processing system but in their other systems such as automated payroll, billing, appointment, and patient records. This same Y2K problem also applies to many diagnostic and treatment machines that have an internal clock built in their computer chips or software, including personal computers.

To avoid the Y2K bug, computer users should contact the vendor who provided the software, hardware, or medical equipment, to make sure that it is certified to continue working properly in the year 2000.

The Y2K bug is not only an operational nuisance but a legal liability issue as well. Many attorneys believe that unless a business (health care provider) takes "reasonable and prudent" measures to avoid Y2K bugs, they could be liable for any harm or damage that their customers (patients) and suppliers may incur.

While the systems in your health care organization may be bug-free, the cashflow operation can still be disrupted if the managed care and fee-for-service payers have bugs in their

systems that prevent claims from being received, processed, or paid.

In conjunction with Medicare carriers and intermediaries, the Health Care Financing Administration (HCFA) is working diligently to make sure that Medicare's computer systems and networks will be Y2K bug-free. For example, HCFA has a program to systematically assess, renovate and test each mission critical system in all its facilities, as well as those of each carrier and intermediary by December 31, 1998.

This target will have given HCFA a full year to fix any problems that might have escaped detection during renovation and testing. In addition, Medicare carriers and intermediaries will test their electronic data inter-changes with the hospital information system, billing system, and billing service. This testing ensures that these systems interface and work properly with no interruption in claims and payments processing after the clock ticks at midnight on January 1, 2000.

From President Clinton to Donna E. Shalala to Nancy-Ann DeParle, there is support and urgency for the Y2K project. "At HCFA, everyone has a commitment to ensure that Medicare customers will not encounter payment disruptions caused by a bug in our systems," Gary Christoph, HCFA's Chief Information Officer recently said.

In addition to vendors, the Internet is a good place to look for more information about Y2K problems. The following Web sites contain useful information:

http:\\www.year2000.com(general technical and legal information);
http:\\www.FDA.gov/cdrh/yr2000/yr2000.html(medical equipment);
http:\\www.HCFA. gov (Medicare).

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Reminder to Paper Claim Filers: Millennium Update Changes to the HCFA-1500 Instructions Effective October 1, 1998

As of October 1, 1998, you will be required to enter 8-digit birth dates on Form HCFA-1500 for Medicare, Part B claims. This includes entering 2-digit months (MM) and days (DD), and 4-digit years (CCYY). The reporting requirement for 8-digit birth dates will not require a revision to the HCFA-1500 claim form. However, the instructions and printing specifications for the HCFA-1500 claim form were changed so 8-digit birth dates can be reported.

HCFA-1500 Fields Affected by New Reporting Requirement

Item 3 - Patient's Birth Date
Item 9b - Other Insured's Date of Birth
Item 11a - Insured's Date of Birth

Please note that 8-digit birth dates must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the HCFA-1500 claim form, the space between month, day, and year is delineated by a dotted, vertical line.

To illustrate, if the patient's birthdate is January 21, 1935, then you would enter the following in item 3 of Form HCFA-1500:

3. Patient's Birth Date

MM	DD	YY
01	21	1935

If you do not submit 8-digit birth dates as of October 1, 1998, your claim will be returned to you as unprocessable.

HCFA-1500 Fields Not Affected by New Reporting Requirement

Item 11b - Employer's Name or School Name
Item 12 - Patient or Authorized Person's Signature Date
Item 14 - Date of Current Illness, Injury, or Pregnancy
Item 16 - Dates Patient Unable to Work in Current Occupation
Item 18 - Hospitalization Dates Related to Current Illness
Item 19 - Reserved for Local Use
Item 24a - Date(s) of Service
Item 31 - Signature of Physician/Supplier

NOTE: Item 15 is not required for Medicare, Part B services.

You may enter either a 6- or 8-digit date for these fields (items 11b, 12, 14, 16, 18, 19, 24a, or 31) as of October 1, 1998.

If you choose to enter 8-digit dates for these fields, please note the following:

- Form HCFA-1500 does not have to be revised to capture 8-digit dates for the above fields.

- All date fields, except for item 24a, must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On Form HCFA-1500, the space between month, day, and year is delineated by a dotted, vertical line.

- Item 24a must be reported as one continuous number (i.e., MMDDCCYY), without any spaces between month, day, and year. By entering a continuous number, the date(s) in item 24a will penetrate the dotted, vertical lines used to separate month, day, and year. Our claims processing system will be able to process your claim if you penetrate these vertical lines. However, all 8-digit dates reported must stay within the confines of item 24a.

- Do not compress or change the font of the "year" field in item 24a to keep the date within the confines of item 24a. If you enter a continuous number in item 24a with no spaces between month, day, and year, you will not need to compress the "year" field to remain within the confines of item 24a.

- The "from" date in item 24a must not run into the "to" date field, and the "to" date must not run into item 24b.

- Dates reported in item 24a must not be reported with a slash between month, day, and year.

- If you decide to enter 8-digit dates for items 11b, 12, 14, 16, 18, 19, 24a, or 31, you must enter 8-digit dates for all these fields. For instance, you are not permitted to enter 8-digit dates for items 11b, 12, 14, 16, 18, 19, 31 and a 6-digit date for item 24a. The same applies to those who wish to submit 6-digit dates for these fields.

If you do not adhere to the above requirements, your claim will be returned to you as unprocessable as of October 1, 1998.

Note for Electronic Claim Senders

Electronic Media Claims (EMC) filing requirements differ from those above. Vendors have been notified of these changes. To find out how the Year 2000 issues affect you, contact your vendor.

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What Does Y2K Readiness Mean?

The Year 2000 (Y2K) computer problem affects myriad types of mainframe, mid-range and personal computer hardware, and diverse forms of software. Experts are predicting that the cost to correct the Year 2000 problems worldwide will be in the range of hundreds of billions of dollars. In addition, some experts have expressed concerns that some companies may not complete the corrective work on time and may suffer some Y2K-related computer system shutdowns. The main reasons for these concerns are:

- Over 500 software languages are involved, with automated corrective tools being available for only a few of the languages;

- There is an apparent shortage of trained programmers to do the manual corrective work required; and

- A substantial number of companies are reportedly behind schedule in their corrective work and testing.

Many companies, including your Medicare contractor, are actively and aggressively working the Y2K readiness issues. Other entities

that may affect you if a plan for the Year 2000 readiness is not implemented are banks, credit unions, credit cards, pharmacies, mortgage and insurance companies.

As we approach the year 2000, many changes must be implemented, not only to the computer systems but to the procedures that provide input data for the computer systems. Places of business may be vulnerable to impacts caused by the Year 2000 issue. Some of the equipment and devices that may be affected by the Y2K issue are:

- PC hardware and software,
- X-ray machines,
- Electronic/digital medical equipment that uses date/time entries,
- Electronic/digital monitoring equipment that uses date/time entries,
- Electronic media claim (EMC) software if you submit claims electronically.

Computers and computer software are not the only items that can be affected by the Year 2000 issue. The following is a list of common devices used in the home or office which could also be affected:

- Answering machines
- Fax machines
- Security systems
- Fire and smoke alarms
- Sprinkler systems
- Indoor and outdoor lighting (set on a timer)
- Items with automatic timers such as a pool pump
- Elevator panels
- Air conditioner systems
- Safety vaults with time locks
- Televisions and VCRs
- Radios and stereo systems
- Telephones
- Clocks and alarm clock radios
- Automobiles containing sophisticated computer chips in the electronic system.

General information about the Year 2000 is available on the following web sites:

http://www.fcc.gov/year2000
http://www.y2k.gov
http://www Rx@2000.org
http://www.hcfa.gov/Medicare/edi/edi.htm

Please note: We do not endorse the information contained at these sites.

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Duplicate Medicare Remittance Notices

Duplicate copies of Medicare Remittance Notices (MRNs) are not available except in unusual circumstances (e.g., original MRN was destroyed, original had missing pages, etc.).

In these unusual situations, providers may request duplicate MRNs by calling (904) 634-4994 or by writing to:

Medicare Part B
PO Box 2360
Jacksonville FL 32231

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Refund of Medicare Part B Funds

One of the accountabilities of the Medicare Part B Financial Services Department is the collection of Medicare Part B funds that have been overpaid for various reasons.

The department receives checks from providers' offices refunding substantial amounts of money after detecting the existence of Medicare Part B overpaid funds. The providers' offices detect these overpayments as a result of internal audits, review of office records, identification and detection of billing errors, cleaning of patient's accounts, etc.

Very often, these refund checks are received with insufficient or no information to properly credit the refunded amount to the appropriate beneficiaries' accounts.

Any time an overpayment is identified in our office you need to refund the overpaid amount to Medicare Part B. It is not necessary for you to wait for our office to request the overpayment.

To ensure timely and accurate posting of these overpayments, please include, along with the refund check,

- a detailed explanation of the reason for the refund,

- a list of the beneficiaries involved in the refund. The list must include for each beneficiary:

- the beneficiary's first and last name

- the beneficiary's health insurance claim number

- the date of service(s) in question

- the procedure code(s) involved in the overpayment

- the amount being refunded for each overpaid service.

Make the refund check payable to Medicare Part B and send the refund check and the appropriate documentation to:

Medicare Part B
Financial Services Department
P.O. Box 44141
Jacksonville, Fl 32231-0048

Requests for underpayments or request for additional payment must be sent to

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

Refer to the Financial Services Department insert in the March/April 1998 Medicare B Update! for additional information.

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Documentation for Rehabilitation Medicine Visits

The following are the documentation requirements for physiatrist rehabilitation medicine visits that have exceeded the accepted standards of medical practice:

- Progress notes for dates of service in question

- Written periodic reassessment that must include a statement addressing all of the following:
  Beneficiary's improvement, decline or stabilization from a medical and rehabilitation perspective.

This may include:

- Psychological support utilized for psycho/social adjustment

- Laboratory results

- Evaluation of therapeutic appliance and/or modification of activities of daily living

- Medical/paramedical consults which expedite the rehabilitative process

- Progress of the patient's integration into the community

- Changes in treatment indicative of the beneficiary's progress

- Estimated length of treatment

- Justification for extending the length of treatment

- Discharge planning

Documentation from a team conference directed by a physician that contains all of the required information will be considered reassessment.

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New Provider Applications are Available for Distribution

The Health Care Financing Administration (HCFA) has released new provider enrollment applications. We have been instructed to utilize these new applications and to no longer accept the previously used applications after September 30, 1998. We encourage the utilization of the new forms for new applicants, groups enrolling new members, and changes that are not currently in progress. For identification purposes, the previous applications have the form number and revision date (5/97) in the lower left corner of the application where the latest version has the form number and revision date (1/98) indicated in the lower left hand corner.

All 5/97 revised versions of form HCFA-855 that are in progress prior to September 30, 1998, will continue to be processed through completion. This includes but is not limited to applications that have been returned to the applicant by the Medicare contractor, (e.g., application initially received by the Medicare contractor or State Agency prior to September 30, 1998 (postmark date) then returned to the applicant for any reason and subsequently resubmitted to the Medicare contractor or State Agency after September 30, 1998). All 5/97 versions of form HCFA-855 received by the Medicare contractor or State Agency for the first time after September 30, 1998, will be returned to the applicant.

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What's the Difference?

Outlined below are the most significant changes regarding the new Medicare General Enrollment Application form (HCFA-855), the Individual Reassignment of Benefits form (HCFA-855R), and the Change of Information form (HCFA-855C):

The entire application form may no longer be copied or reproduced with original signatures. Only original blue (HCFA-855), pink (HCFA-855C) and green (HCFA-855R) applications will be accepted. Certain sections within the application may be copied and submitted with the original application forms.

A W9 form is no longer acceptable as tax identification documentation. A copy of the CP 575 or any IRS document confirming the Tax Identification Number (e.g., 8109 tax coupon) must be included with the application. Groups/organizations who have never completed a HCFA-855 application form (implemented 5/96) must submit a copy of the IRS document with HCFA-855C and HCFA-855R forms to prevent delays in processing. Not-for-profit organizations must submit a copy of the 501(c)(3) approval notification from the IRS.

Certification/Attestation statements on all forms must be signed by the applicant or authorized representative. The authorized representative must be an officer, chief executive officer, senior or majority partner, director, owner, or someone who can obligate and commit the individual or entity to Medicare laws and regulations. Entities may appoint an authorized representative by submitting a documented delegation of authority from a company officer. The delegation of authority must include a statement indicating the appointed representative understands and agrees to abide by the conditions outlined in the certification statement (section 18) of the HCFA-855 form. The Social Security Number of the appointed representative must be indicated with the effective date. The company officer and all appointed representatives must sign the application or delegation of authority to certify that he/she is authorized to bind the entity. If changing authorized representatives, form HCFA-855C must be signed by a company officer. An appointed authorized representative may not change this information.

Form HCFA-855R completely replaces form HCFA-855G. Individuals reassigning their benefits must complete form HCFA-855R. Section 13 of form HCFA-855 should only be completed by business organizations (e.g., groups reassigning benefits to a hospital).

Two individuals requesting reimbursement under the same tax identification number must enroll as a group.

Please ensure you read the helpful hints document included in the application package as well as the application instructions in order to prevent delays in processing and returns. It is better to supply too much information, rather than leave sections blank and have the application returned as incomplete.

If you are enrolling a new provider, updating information on an existing provider, or adding a group member, please call the Customer Service Department at (904) 634-4994 to obtain a new application. The matrix on the following page may assist you in determining which sections of the HCFA-855 form must be completed for new providers.

Changes

Changes to any provider information should be reported utilizing form HCFA-855 or form HCFA-855C. Although all changes may be reported utilizing form HCFA 855, form HCFA-855C may be used for reporting changes such as name, address, phone, specialty, requests for cancellation of provider numbers, addition or deletion of an authorized representative, or potential termination of current ownership. If the changes are not one of these items, they must be reported utilizing form HCFA-855. The certification statement must always be signed by an authorized representative (see above for definition of authorized representative) when submitting form HCFA-855 or HCFA-855C.

Certified Providers

If you are a provider with one of the specialties listed below and are interested in becoming a Medicare provider, the Agency For Health Care Administration (AHCA) should be contacted to begin the enrollment process. The telephone number for AHCA is (850) 487-2717.

Accredited Hospital
Ambulatory Surgical Center
Christian Science Hospital
Community Mental Health Center
Comprehensive Outpatient Rehabilitation Facility (CORF)
ESRD Facility
Federally Qualified Health Center
Home Health Agency
Hospice
Indian Health Service Facility
Non-accredited Hospital
Occupational Therapist
Physical Therapist
Portable X-ray Supplier
Rehabilitation Facility/Outpatient Therapy Facility
Rural Health Clinic
Rural Primary Care Hospital
Skilled Nursing Unit/Facility

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COMPLETING THE HCFA 855 NON-CERTIFIED PROVIDERS
--form not available in this format--

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When Is Medicare Primary or Secondary?

Medicare identifies a beneficiary for secondary payment when information provided indicates there may be other primary insurance involvement. This information may come from claims submitted to Medicare where other insurance involvement has been indicated or if the Social Security Administration provided Medicare with this information. Sometimes, other insurance carriers notify Medicare that there is other insurance involvement. In any of these instances, the beneficiary's entitlement records are identified as having other insurance primary to Medicare. Future claims are then processed according to the Medicare Secondary Payer (MSP) guidelines.

How Can I Get My Claim Reprocessed When Medicare Is the Primary Payer?

Claims denied by Medicare due to other insurance involvement may be reprocessed if there is no other insurance primary to

Medicare. In such cases, providers may instruct the beneficiary to contact Medicare Part B to have the beneficiary's eligibility records updated. The beneficiary may call the Medicare Part B Beneficiary Customer Service Area, where the information can be easily taken over the phone, or the beneficiary may write to Medicare. When writing, the beneficiary must indicate that Medicare is the primary insurance, and provide the necessary information (generally, retirement dates of both the beneficiary and spouse are needed). Once the beneficiary has contacted the Medicare office, the beneficiary's file will be updated and all claims involved will be reprocessed. Until this information is updated on the beneficiary's file, subsequent claims may continue to be denied payment; however, all claims will be reprocessed.

NOTE: This information can only be provided by the beneficiary, the beneficiary's legal representative, or the beneficiary's spouse.

What Happens When the Beneficiary's Eligibility Records Are Updated?

Once it is established that a beneficiary is not covered by other insurance, several things will happen:

- The beneficiary's file is updated to reflect Medicare as primary payer;

- All pending claims awaiting a response for MSP information are released for processing; and

- All claims denied based on suspected Medicare Secondary Payer involvement will be reprocessed.

The beneficiary may call 1-800-333-7586 to provide the necessary information to update our records.

Or write to:

Medicare Secondary Payer (MSP)
P.O. Box 44078
Jacksonville, FL 32231

What if Medicare Is the Secondary Payer?

In cases where the beneficiary or their spouse are not retired and have other insurance coverage, or have other liability insurance consideration, that insurance plan is required by law to pay first (it is considered the primary plan). Depending on the type of other program involvement, Medicare may have to consider the claims for secondary benefits.

When filing a claim for secondary consideration, you should include a copy of the Employer Group Health Plans (EGHP) payment

sheet or Explanation of Benefits. This information is needed to calculate any Medicare Secondary Payer benefits consideration.

If your claim has been denied because you did not supply the EGHP payment sheet, and Medicare is the beneficiary's secondary insurer, you may refile your claim with the payment sheet to the address below.

Medicare Secondary Payer (MSP)
P.O. Box 44078
Jacksonville, FL 32231

What if the Service Was Related to an on-the-Job Injury and Workers Compensation Will Pay?

Medicare does not pay secondary benefits on charges paid by Workers Compensation. The claim should be filed with the Workers Compensation insurer only.

If your claim was paid by Medicare in error, due to eligibility for Workers Compensation, the money should be refunded to the address below with an explanation that Workers Compensation has paid the claim.

Medicare Part B
Financial Services
P.O. Box 44141
Jacksonville, FL 32231

What if the Service Was Related to an Auto Accident or a "Slip-and-Fall" Situation (No-Fault Policies)?

If a beneficiary is in an accident where the automobile insurer is responsible for charges on an injury which resulted from an auto accident, the claim and the primary payment sheet should be submitted to the MSP department for consideration if the automobile benefits do not cover all charges. Medicare will pay once all automobile benefits are exhausted, IF a claim for damages has not or will not be filed. Medicare pays as the primary insurer if the entire allowance on the auto insurance claim was applied to the deductible, regardless of the amount of the deductible.

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If a claim for damages will be filed, whether it is related to an automobile accident or a liability suit brought against an organization due to an accident which occurred on the premises, Medicare may make payments on a "conditional basis". "Conditional" payment is where the individual is responsible for refunding the payment when an automobile or liability insurer makes payment.

The following represents the current policies with respect to provider and supplier billing options when Medicare is secondary to liability insurance.

- If the provider/supplier chooses to bill Medicare for a conditional payment, they must withdraw claims against the liability insurer or a claim placed on the beneficiary's settlement.

- If the provider/supplier chooses to continue their claims against the liability insurance settlement, they may not also bill Medicare.

- If the provider/supplier chooses not to bill Medicare during the Medicare filing period, they may not bill Medicare after this period has expired even if they are unable to collect from the proceeds of the liability insurance settlement. Medicare claim filing limits apply in these situations.

- The provider/supplier must bill only the liability insurer, unless they have evidence that the liability insurer will not pay within the 120 day "prompt" period. If there is such evidence, Medicare may be billed for conditional payment, provided the documentation is submitted to support the fact that payment will not be made promptly.

- If the liability insurance claim is not finally resolved after the 120 day "prompt" period has ended, the provider/supplier may, but is not required to bill Medicare for conditional payment.

Medicare Secondary Payer Limiting Charge Guidelines

According to the Social Security Act Amendments of 1994, legislation prohibits a non-participating provider who does not accept assignment from billing or collecting amounts above the applicable limiting charge, regardless of who would be responsible for payment.

Additionally, regardless of which insurance company is the primary insurer, if a patient is covered by Medicare, a non-participating provider must bill no more than the Medicare limiting charge for any date of service after December 31, 1994. No person(s) may bill or collect an actual charge for the service in excess of the limiting charge.

If an assigned claim is filed, the provider may not charge a beneficiary for Medicare covered services if the provider received an amount which equals or exceeds Medicare's allowance from both a Group Health Plan (GHP) and Medicare. If the amount paid by the GHP exceeds this amount, the provider may accept the GHP payment as full payment without violating Medicare's assignment agreement. A Medicare participating provider does not have to submit an assigned claim to the GHP; however, any claim submitted to Medicare must be assigned.

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New Clean Claim Interest Rate

Effective for claims processed on or after July 1, 1998, clean paper and electronic claims that have not been paid by the thirtieth day after the date of receipt will accrue 6.0 percent interest.

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New Interest Rate for Overpayments

Medicare Part B assesses interest on overpaid amounts which are not refunded in a timely manner. Medicare Regulation CFR 405.376 provides for the assessment of interest if the overpaid amount is not refunded within 30 days from the overpayment demand letter date. The interest rate on overpayments is based on the higher of the private consumer rate (PCR) or the current value of funds (CVF) rate.

Effective July 31, 1998, the interest rate applied to Medicare overpayments is 13.75 percent based on the new revised PCR rate. The following table lists the interest rates for prior periods.

Period: October 24, 1996 - January 22, 1997
Interest Rate: 13.375

Period: January 23, 1997 - April 23, 1997
Interest Rate: 13.625

Period: April 24, 1997 - July 24, 1997
Interest Rate: 13.50%

Period: July 25, 1997 - October 23, 1997
Interest Rate: 13.75%

Period: October 24, 1997 - January 27, 1998
Interest Rate: 13.875%

Period: January 28, 1998 - May 12, 1998
Interest Rate: 14.50%

Period: May 13, 1998 - July 30, 1998
Interest Rate: 14.00%

Period: July 31, 1998 - to the Present
Interest Rate: 13.75%

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Medigap Insurer Updates

The following updates have been performed to the Medigap Insurer listing on our Florida Medicare Online Bulletin Board System (BBS). You can view these changes in the Medigap Section of the Medicare Online BBS.

Address Changes:

Number: 14002
Insurer Name: Arkansas BCBSPO Box 2181Little Rock AR 72203

Number: 42142
Insurer Name: American ProgressivePO Box 130Pensacola FL 32591

Number: 27004
Insurer Name: BCBS of KentuckyPO Box 37690Louisville KY 40233

Number: 50003
Insurer Name: BCBS of South CarolinaPO Box 100133Columbia SC 29202

Number: 46027
Insurer Name: MEGA Life & Health InsurancePO Box 548801Oklahoma City OK 7315

Number: 14006
Insurer Name: USAble Life InsurancePO Box 46337Madison WI 53744

Name Changes:

Number: 24003
Former Name: Acordia Senior Benefits
Changed To: Anthem BCBS *

Number: 24045
Former Name: BCBS of Indiana
Changed To: Anthem BCBS *

Number: 57007
Former Name: King Co Med Blue Shield
Changed To: Regence Blue Shield

Number: Regence Blue Shield
Former Name: Pennsylvania Blue Shield
Changed To: Highmark, Inc

  * Anthem Blue Cross Blue Shield located in Indiana.

Exempt "Non-Medigap Insurers"

These insurers do not offer Medicare Supplemental "Medigap" plans and are exempt from the Medigap crossover process.

Our Medigap Insurer List has been updated to change each insurer identification number listed below to an EXEMPT status. Each number is inactive and we will no longer crossover payment data to these insurers.

Number: 48137

Insurer Name: Benefit Plan

Number: 19322
Insurer Name: Florida Commercial Trust

Number: 27018
Insurer Name: Freedom Life Insurance

Number: 31022
Insurer Name: Harvard Community Health

Number: 27011
Insurer Name: HCP

Number: 42210
Insurer Name: Health Care Plan

Number: 32017
Insurer Name: HRM Claim Management

Number: 34008
Insurer Name: Intercontinental Life

Number: 40019
Insurer Name: Intercontinental Life

Number: 23096
Insurer Name: International Brotherhood Team

Number: 15020
Insurer Name: Lockheed Medical

Number: 19812
Insurer Name: Lockheed

Number: 30052
Insurer Name: MEBA

Number: 42063
Insurer Name: National Benefit Life

Number: 42130
Insurer Name: National Benefit Life

Number: 53085
Insurer Name: National Health Insurance

Number: 53126
Insurer Name: National Health Insurance

Number: 53128
Insurer Name: National Health Insurance

Number: 59020
Insurer Name: Midwestern National

Number: 19096

Insurer Name: Pepsi Cola

Number: 19042
Insurer Name: Senior Service Agency

Number: 42117
Insurer Name: TIAA Major Medical

Number: 15036
Insurer Name: Western States

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New Medicare Part B Claim Review Form

Medicare Part B has developed a new Request For Review form that simplifies and standardizes filing requirements for reviews. The new review form allows the provider of service to clearly specify the reason(s) he or she disagrees with the original claim determination (section 5). The new form also provides space for a comprehensive and detailed explanation of any additional information that should be considered when the claim is reviewed (section 7). Completion of these two sections are critical to the correct processing of your review request.

Using the new review form will make handling requests for reviews easier and more efficient for providers' offices. If all related information (dates of service, procedure codes, etc.) are filled in on the form as requested, copying and mailing of additional medical records should be significantly reduced (the current requirements for documentation for certain review types have not changed). In pilot testing, Medicare has found that when the new Request For Review form was submitted with all sections completed, processing time was substantially improved.

A copy of the new review form is provided on the following page. The form also can be downloaded or printed from Medicare's Bulletin Board System (BBS).

Begin using the new form immediately. Follow the instructions on the reverse side of the form and submit your request to:

Medicare Part B Review Department
P.O. Box 2360
Jacksonville, Florida 32231

NOTE: one form should be submitted per Medicare patient, per claim.

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Request For Review of a Medicare Part B Claim

-- form not available in this format --

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Instructions for Completing the Request For Review Form

-- form not available in this format --

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IMPORTANT ADDRESSES:

CLAIMS SUBMISSIONS

Routine Paper Claims

Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating Providers

Medicare Part B
Participating Providers
P.O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic Claims

Medicare Part B Chiropractic Unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance Claims

Medicare Part B Ambulance Dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare Secondary Payer

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

ESRD Claims

Medicare Part B ESRD Claims
P.O. Box 45236
Jacksonville, FL 32232-5236

COMMUNICATIONS

Review Requests

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

Fair Hearing Requests

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

Administrative Law Judge Hearing

Administrative Law Judge Hearing

P.O. Box 45001

Jacksonville, FL 32231-5001

Status/General Inquiries

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

Overpayments

Medicare Part B
Financial Services
P.O. Box 44141
Jacksonville, FL 32231-0048

DURABLE MEDICAL EQUIPMENT (DME)

DME, Orthotic or Prosthetic Claims

Palmetto GBA
Medicare DMERC Operations
P.O. Box 100141
Columbia, SC 29202-3141

ELECTRONIC MEDIA CLAIMS (EMC)

EMC Claims, Agreements and Inquiries

Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

MEDICARE PART B ADDITIONAL DEVELOPMENT

Within 40 days of initial request:

Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-2537

Over 40 days of initial request:

Submit the charge(s) in question, including information requested, as you would a new claim to:

Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

MISCELLANEOUS

Fraud and Abuse

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

Medicare Claims for Railroad Retirees:

MetraHealth
RRB Medicare
P. O. Box 10066
Augusta, GA 30999-0001

Provider Change of Address:

Provider Registration Departmen
tBlue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32231-1109

and

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

Provider Education:

For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:
Medicare Part B
Provider Education Department

P. O. Box 2078
Jacksonville, FL 32231-0048

For Seminar Registration:
Medicare Part B
Provider Education Department
P. O. Box 45157
Jacksonville, FL 32231

Limiting Charge Issues:

For Processing Errors:

Medicare Part B
P.O. Box 2360
Jacksonville, FL 32231-0048

For Refund Verification:

Medicare Part B
Compliance Monitoring
P.O. Box 2078
Jacksonville, FL 32231-0048

Provider Participation and Group Membership Issues;
Written Requests for UPINs, Profiles & Fee Schedules:

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

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MEDICARE ONLINE
Electronic Bulletin Board System (BBS)

FREE - Florida Electronic Bulletin Board System (BBS)

WHAT IS THE BBS?

The BBS is a Bulletin Board System maintained in a computer similar to your own, located at Medicare of Florida. It enables you to access vast amounts of important Medicare (Part A and B) claims processing information and is available to anyone (there are no restrictions), from anywhere (not restricted to FL) and is available 24 hours a day, 7 days a week. Access can be obtained by using your office and/or home computer, via a TOLL FREE telephone line.

WHAT'S AVAILABLE:

Once you've connected to the BBS you can view and search through information while on line. You will also be able to copy the same information to your own computer by downloading for future access. You'll find information on the BBS like:

Medicare Part A - Medical Policies, Bulletins, Reason Codes, etc.

Medicare Part B - UPIN Directory, Medigap Listing, Publications (UPDATE!), Fee Schedules, Local Medical Policies, EDI Format Specifications Manuals, Medpard Directories, etc.

Computer Based Training (CBT) - Free Interactive electronic educational software programs for Part A and B are available to download for use in your office. These programs can be used as training and/or hiring tools. Available modules: Fraud and Abuse, ICD-9-CM, Front Office, World of Medicare, CPT Coding for Beginners, Evaluation and Management, Claims Completion Requirements for Part B - HCFA 1500 and Part A - HCFA 1450.

(CBT is also available on line at www.medicaretraining.com)

WHAT YOU NEED TO ACCESS:

- Personal Computer (PC)

- Telephone Line with long distance access - a dedicated line is suggested but not required.

- Modem - internal or external

- Communication Software - There are dozens of programs available such as Hyperterminal, PCAnywhere, Procomm, etc. Most computers purchased within the last five years that have modems, include communication software. Follow your communication software instructions to set up access to the BBS using the Medicare Online BBS phone numbers.

The following are some of the communication software options available:

- Windows95 comes with a built in terminal based communication software called Hyperterminal and can be accessed by: selecting Start, then Programs, then Accessories and then Hyperterminal. Follow the set-up instructions on screen to access the BBS.

- FREE Windows-based communication software is available for your use. Once you access the BBS you can download this program from

the Computer Based Training section. If you are unable to use your existing communication software (i.e., Hyperterminal, etc.) to access the BBS to download this program, it can be mailed to you. Fax your request on office letterhead which indicates your office name, address and contact name, to (402)895-5816.

TOLL-FREE ACCESS

All users - outside Jacksonville FL: (800)838-8859

Users within Jacksonville FL area: (904)791-6991

USER ID AND PASSWORD:

Upon initial access to the BBS, you will be taken through an on-line registration process that will enable you to assign your own User-ID and Password. It's very important that you write this information down exactly as you entered it (including any special characters)! You will need your User-ID and Password for future access to the BBS.

VOICE BBS HELP LINE:

Questions, comments and concerns: (904)791-8384

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Windows 95 Access to the "Medicare Online BBS"
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Windows 95 Access to the "Medicare Online BBS"
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1999 Medicare Part B of Florida
PYYSICIAN AND NON PHYSICIAN PRACTIONER FEE SCHEDULE OF ALLOWANCES

The 1999 Medicare Part B fee schedule will be available for PURCHASE AND DISTRIBUTION ON OR AFTER NOVEMBER 16, 1998 in either booklet or diskette format. The booklets and disks contain 1999 payment rates for all Florida localities. These fees apply to services performed between January 1 and December 31, 1999. While these fees are subject to change during the course of a year, neither the booklet nor the diskettes are updated as these

changes occur. Revisions to fees will be published in future issues of the Medicare B Update!

Please note that the booklet and diskette DO NOT INCLUDE 1999 payment rates for clinical laboratory services, mammography screenings and DMEPOS items, These amounts will be published in future issues of the Medicare B Update!

The 1999 Medicare Part B fee schedule will be available FREE of charge through the MEDICARE ONLINE BBS (Electronic Bulletin Board System) . Refer to page 63 of this Update! for information on how to access it. In addition, the fee schedule rates will also be available through the Express Line Audio Response Unit (ARU) at (904) 353-3205. Callers will have 15 minutes on each call to obtain current fees using a touch tone phone.

To order the 1999 Medicare Fee Schedule Booklet or Disk, please complete this form ON OR AFTER OCTOBER 1, 1998 and return with payment to:

Provider Education Department
Medicare Part B
PO Box 2078
Jacksonville FL 32231-0048

Please make check/money order payable to:

BCBSFL- FCSO ACCOUNT #754-250
(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)

Check format requested:

Booklet $9.39 $_____ Quantity: _____

Diskette $9.39 $_____ Quantity: _____

Sales Tax $ .61 (6.5%) +_____

TOTAL $10.00 $_____

PLEASE PRINT

Practice/Company Name _____

Addressee _____
Last First MI

Address _____

City _____

State _____ Zip _____

Phone Number _____

Contact Name _____

ALL ORDERS MUST BE PREPAID! ------ DO NOT FAX! ------

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ORDER FORM - 1998 PART B MATERIALS

The following materials are available for purchase by Medicare providers. To order these items, please complete and submit this form along with your check/money order payable to Blue Cross Blue Shield of FL with the account number listed by each item. PLEASE NOTE: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

UPDATE SUBSCRIPTION - For non-provider entities or providers who need additional copies at other office locations, an annual subscription is available. This subscription includes all issues published during calendar year 1998 (back issues sent upon receipt of order).
Number Ordered: _____
Account Number: 754245 Cost Per Item: $75.00

PROCEDURE/DIAGNOSIS RELATIONSHIP FILE - This is a printout of the most current file used during claims processing to determine coverage for procedures subject to specific diagnosis criteria. This document is designed to assist providers by outlining coverage criteria in order to limit their financial liability for these procedures.
Number Ordered: _____
Account Number: 754245 Cost Per Item: $15.00----------

MEDICARE ONLINE BULLETIN BOARD (BBS) SOFTWARE - This self-installing communications software allows you to dial into our electronic BBS to obtain various claims processing information (i.e., Physicians Fee Schedule, UPIN and Medigap listings, Part A and B medical policies, Part B publications, Part A Bulletins, MEDPARD directory etc.).
Number Ordered: _____
Account Number: N/A Cost Per Item: FREE----------

Subtotal $ _____

Tax (6.5%)$ _____

Total $ _____

Mail this form with payment to:

Medicare Part B Provider Education Department
P.O. Box 2078
Jacksonville, FL 32231-0048

Contact Name: _____

Provider/Office Name: _____

Phone Number (including area code): _____

FAX Number (including area code): _____

Mailing Address: _____

City: _____

State: _____ Zip: _____

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ORDER FORM - 1998 MEDIFEST AND SPECIALTY SEMINAR BOOKS

1998 MEDIFEST BOOK - This is the same manual provided to Medifest attendees and includes information on claim form completion instructions, local medical review policies, home health services and more.Number Ordered: _____
Account Number: 754245 Cost Per Item: $75.00----------
---------- ----------1998 SPECIALTY SEMINAR BOOKS - This is the same manual provided to specialty seminar attendees and includes information on coding, coverage and medical policy, basic CPT, ICD.9.CM, primary care, evaluation and management documentation guidelines and more.

_____ ASC _____ Ambulance _____ Anesthesia
_____ Cardiology _____ Clinical Lab _____ Dermatology

_____ Gastroenterology
_____ IPL/IDTF
_____ Mental Health
_____ Nephrology
_____ Neurology/Neurosurgery
_____ Nurse Practitioner/CNS/Physician Assistant
_____ Oncology
_____ Orthopaedics
_____ Physical/Occupational Therapy
_____ Podiatry
_____ Radiology

_____ Urology

NOTE: Please indicate (X) the books you would like to purchase.
Number Ordered: _____
Account Number: 754245 Cost Per Book: $25.00----------
---------- ----------
Subtotal $ _____

Tax (6.5%)$ _____

Total $ _____

Mail this form with payment to:

Medicare Part B Provider Education Department
P.O. Box 2078
Jacksonville, FL 32231-0048

Contact Name: _____

Provider/Office Name: _____

Phone Number (including area code): _____

FAX Number (including area code): _____

Mailing Address: _____

City: _____

State: _____ Zip: _____

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PHONE NUMBERS

PROVIDERS

Express Line/ARU

Status Inquiries:

904-353-3205

Specialty Customer Service Reps:

904-634-4994

Medicare Online BBS

Access:

1-800-838-8859

1-904-791-6991

Technical Problems:

1-904-791-8384

BENEFICIARY

Outside Duval County (in Florida):

1-800-333-7586

Duval County (or outside Florida):

904-355-3680

Hearing Impaired:

1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this service by providers is not permitted and may be considered program abuse.

EMC

EMC Billing Problems/Guidelines:

904-354-5977

EMC Start-Up:

904-791-8767

EMC Front-End Edits/Rejects:

904-791-8767

PC-ACE Support:

904-355-0313

Testing:

904-354-5977

Help Desk (Confirmation/Transmission):

904-791-9880

OCR

Printer Specifications/Test Claims:

904-791-6912

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(END OF FILE)