July/August 1998 Medicare B UPDATE! Publication
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HCFA
Health Care Financing Administration
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FIRST COAST SERVICE OPTIONS, INC.
A HCFA Contracted Carrier and Intermediary
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Highlights:

Volume 11, Number 4
July/August 1998

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New Provider Applications Received

The May/June issue of the Medicare B Update! contained an article regarding new provider applications that were to be implemented May 1, 1998. The Health Care Financing Administration (HCFA) has postponed implementation of these new applications until August 1, 1998. A grace period will be established to allow for the completion of old forms in process.

Until August 1, 1998, all providers should continue to use the applications currently in place. The applications currently in use have (5/97) after the form number at the bottom of each page (e.g., HCFA 855 (5/97)). A brief overview of when each application should be used and copies of the HCFA 855C and HCFA 855G may be found on page 51 of the September/October 1997 Medicare B Update! Clarification points on completing applications may be found on page 75 of the January/February 1998 Medicare B Update! See page 71 of this edition for information

about the most common reasons that applications are being returned to providers.

New Application Information

The new applications will be mailed on and after August 1, 1998. Note that effective with the new applications, photocopies are not acceptable. Providers must complete original copies of the applications.

The new provider applications can be obtained by calling the Medicare Part B Provider Customer Service Department at (904) 634-4994.

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What's New

Are You Ready for the October 1, 1998 Millennium Change Deadline? Beginning October 1, 1998, claims that are not "millennium compliant" will be returned as unprocessable. See the front page of the May/June 1998 Medicare B Update! for more information about this critical change. All providers are urged to make the necessary changes immediately. Please, do not wait until October 1, 1998, to make these changes!

Nurse Practitioner Services

A list of codes that represents services that could potentially be performed by an ARNP and could potentially be covered by Medicare of Florida is included on page 17.

ICD-9-CM Update

The latest revision to the ICD-9-CM coding structure will take effect on October 1, 1998. To allow providers sufficient time to obtain and begin to use the new diagnosis codes, Medicare Part B of Florida will recognize both the existing and new versions of the codes until December 31, 1998. See page 19 for more information.

Change to Screening Mammography Benefit

A new benefit allows radiologists to order additional films without consulting the beneficiary's physician if abnormal pathology is evident in the screening mammography films and if the woman is still at the testing site. See page 34 for more information.

Influenza and Pneumococcal Pneumonia Vaccine Information

Studies have shown that a physician's suggestion is the single greatest factor that influences a patient's decision to receive an influenza or pneumococcal pneumonia vaccine. Medicare Part B reimburses for both the influenza and pneumococcal pneumonia vaccines. See page 35 for additional information.

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Cynthia Moore

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:

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

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A Physician's Focus

Don't Believe Everything You Hear

As I attended many sessions of the FMA at our annual meeting, I became aware of several concerns regarding Medicare payments and policies. Many of these concerns were based upon inaccurate information. Others had been addressed and we believe resolved before the meeting. Because other physicians may have similar concerns, I have listed the more important issues and Medicare's answers below:

FMA question:
Will Medicare delay implementation of the 1998 Evaluation and Management Guidelines (E & M) beyond July 1, 1998?

Medicare answer:
The implementation of the 1998 Evaluation and Management Guidelines has been postponed indefinitely. HCFA continues to work with the American Medical Association to develop acceptable E & M Guidelines. In the meantime, all Medicare carriers have been instructed to use either the 1995 guidelines or the 1998 guidelines, whichever is more favorable to the provider.

FMA question:
Does Florida Medicare plan to audit 38 percent of Florida physicians in the next year?

Medicare answer:
No. The number of physicians to be audited by Florida Medicare in the next year has not yet been determined, but it will be a much lower number.

FMA question:
Why shouldn't Medicare pay interest on clean claims not paid within 35 days?

Medicare answer:

Medicare pays interest on clean claims not paid within thirty days. The current interest rate is 6.25 percent.

FMA question:
Is Medicare deliberately delaying payments of claims to physicians to generate savings to the Medicare program?

Medicare answer:
No. We have made no change in how we pay claims, and we continue to issue payment checks every work day.

Don't believe everything you hear about Medicare. If it doesn't sound right, check your Medicare B Updates! for the answer. If you can't find the answer in the Update!, give customer service a call. Here at Medicare, we are always happy to provide information about what is still the best remaining private pay health insurance around.

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

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Medifest Seminar Information; refer to Seminar Schedules at the Main Menu of this BBS.

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GENERAL INFORMATION

Revisions to the 1998 Medicare Physician Fee Schedule Database
The 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 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.
This special notice includes information about the second quarter revisions to the 1998 Medicare Physician Fee Schedule Database (MPFSDB).

Bilateral Rules Apply to Three Additional Codes
Bilateral procedures rules apply to the following three procedure codes. When billed bilaterally, these codes are allowed at 150 percent.

30130 Excision turbinate, partial or complete

30140 Submucous resection turbinate, partial or complete
31090 Sinusotomy combined, three or more sinuses (unilateral)

For complete information about bilateral procedures rules, see page 26 of the December 1997 Medicare B Update! Special Issue: 1998 HCPCS and MPFSDB Update.
This change is effective for services rendered on or after January 1, 1998.

Magnetic Resonance Angiography
The status code for the following procedure codes has changed from noncovered to restricted coverage:

74185 Magnetic resonance angiography (MRA), abdomen, with or without contrast material(s)
71555 Magnetic resonance angiography (MRA), chest (excluding myocardium), with or without contrast material(s)

Both of these codes may be billed using the TC (technical component only) and 26 (professional component only) modifiers.
This change is effective for services rendered on or after April 1, 1998.
Note that Medicare Part B of Florida does not cover these procedures. If any changes to that coverage occur, medical policy information will be published in a future issue of the Medicare B Update!

New Codes Used to Report Bone Mineral Density Studies
Two new procedure codes have been developed to use when billing for bone mineral density studies. The new codes are:

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).

Both of these codes may be billed with the 26 (Professional component only) and TC (Technical component only) modifiers.

The reimbursement amounts are:

Code: G0131

Participating Fees
Loc 1&2: 119.96
Loc 3: 132.60
Loc 4: 142.49

Non-Participating Fees
Loc 1&2: 113.96
Loc 3: 125.97
Loc 4: 135.37

Limiting Charge
Loc 1&2: 131.06
Loc 3: 144.87

Loc 4: 155.67

Code: G0131 TC

Participating Fees
Loc 1&2: 106.58
Loc 3: 118.34
Loc 4: 127.4

Non-Participating Fees
Loc 1&2: 101.25
Loc 3: 112.42
Loc 4: 121.04

Limiting Charge
Loc 1&2: 116.44
Loc 3: 129.29
Loc 4: 139.20

Code: G0131 26

Participating Fees
Loc 1&2: 13.38
Loc 3: 14.26
Loc 4: 15.07

Non-Participating Fees
Loc 1&2: 12.71
Loc 3: 13.55
Loc 4: 14.32

Limiting Charge
Loc 1&2: 14.62
Loc 3: 15.58
Loc 4: 16.46

Code: G0132

Participating Fees
Loc 1&2: 39.21
Loc 3: 43.08
Loc 4: 46.24

Non-Participating Fees
Loc 1&2: 37.25
Loc 3: 40.93
Loc 4: 43.93

Limiting Charge
Loc 1&2: 42.84
Loc 3: 47.06
Loc 4: 50.52

Code: G0132 TC

Participating Fees
Loc 1&2: 27.51
Loc 3: 30.58
Loc 4: 32.99

Non-Participating Fees
Loc 1&2: 26.13
Loc 3: 29.05
Loc 4: 31.34

Limiting Charge
Loc 1&2: 30.05
Loc 3: 33.41
Loc 4: 36.04

Code: G0132 26

Participating Fees
Loc 1&2: 11.70
Loc 3: 12.50
Loc 4: 13.25

Non-Participating Fees
Loc 1&2: 11.12
Loc 3: 11.88
Loc 4: 12.59

Limiting Charge
Loc 1&2: 12.78
Loc 3: 13.66
Loc 4: 14.48

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The new codes replace procedure code 76070 (Computerized tomography bone mineral density study, one or more sites). This change is effective for services rendered on or after July 1, 1998. To allow providers time to adjust their billing patterns, there is a 90-day grace period for this change.

New Code for PHP Occupational Therapy
The following procedure code has been developed for use when billing for occupational therapy in a partial hospitalization program:

G0129
Occupational therapy requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day.

This change is effective for services rendered on or after January 1, 1998. Medical policy information will be published in a future issue of the Medicare B Update!

Single Energy X-Ray Study
A new code has been developed for use when billing for single energy x-ray studies. The code is:

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

This change is effective for services rendered on or after July 1, 1998.
Note that Medicare Part B of Florida does not cover this procedure. If any changes to that coverage occur, medical policy information will be published in a future issue of the Medicare B Update!

Ultra-sound Bone Mineral Density Study
A new code has been developed for use when billing for ultra-sound bone mineral density studies. The code is:

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

This change is effective for services rendered on or after July 1, 1998. Note that Medicare Part B of Florida does not cover this procedure. If any changes to that coverage occur, medical policy information will be published in a future issue of the Medicare B Update!

Assistant-at Surgery No Longer Paid for Certain Codes
Effective for services rendered on or after January 1, 1998, Medicare Part B will no longer pay for assistants-at-surgery for the following procedure codes:

19340	20650	20920	20931	21120	21493	23044	23101	23106
23130	23170	23180	23415	23480	23921	24130	24136	24145
24160	24164	24354	24565	24566	24582	25450	25455	25520
25931	26205	26215	26416	26476	26665	26676	26685	26706
27000	27062	27185	27235	27330	27425	27437	27475	27477
27485	27496	27516	27600	27601	27606	27635	27640	27641
27680	27681	27695	27696	27707	27730	27732	27734	27766
27784	27792	28020	28035	28050	28060	28062	28070	28072
28110	28111	28112	28119	28200	28208	28285	28310	28312
28315	28340	28341	28344	28436	28456	28485	28496	28531
28636	28645	28666	28675	28755	29815	29819	29830	37720
37730	40761	44340	47001	47552	47554	47630	49250	53060
53080	53240	53250	53502	53520	54160	54400	54401	54435
54600	54620	55530	55870	56352	56355	58800	61001	61106
61130	61151	61210	61215	61735	61750	61751	61760	61770
61793	61888	62201	62294	63615	64577	64778	64782	64783
65125	65130	65135	65140	65155	65175	65272	65273	65290
65865	65870	65875	65880	65920	66150	66500	66505	66605
66680	66682	66986	67005	67015	67025	67115	67120	67218

67250 67314 67318 67334 67906 68320 68335 68362 68500
68505 68540 68550 69501 69650 69676 69700 69905

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Nurse Practitioner Guidelines

An outline of the new coverage and billing requirements for nurse practitioner services was published on page 21 of the March/April 1998 Medicare B Update! A notation was made indicating that the requirements may be temporary due to clarification from the Health Care Financing Administration.

The following questions and answers have been developed to supplement the information previously published. Further information regarding the billing guidelines for nurse practitioners, physician assistants and clinical nurse specialists is forthcoming.

Q.
Should Nurse Practitioners receive their own provider numbers? Under what circumstances?

A.
All Nurse Practitioners who wish to bill services independently under the Medicare program should have their own provider number. It is expected that nurse practitioners, physician assistants and clinical nurse specialists must obtain individual provider numbers in the near future. At this time, services by nurse practitioners may be reported by any of the following methods:

Services which meet the requirements as nurse practitioner services may be billed independently by the nurse practitioner with the appropriate nurse practitioner modifiers or by the employer with the appropriate nurse practitioner modifiers.

Services by nurse practitioners which meet the requirements under the "incident to" provision may be billed by the physician or physician group which employs the nurse practitioner as "incident to" services.

Q.
Can Nurse Practitioners render services under their own provider number and/or for a physician working under the "incident to" provision?

A.
Services by nurse practitioners may be billed as nurse practitioner services or under the "incident to" provision. However, the appropriate requirements must be met for either of the coverage provisions. For example:

During the course of a week, a nurse practitioner may provide services with or without the direct supervision of a physician. In those instances where there is no direct physician supervision, the services should be reported as nurse

practitioner services (i.e., the nurse practitioner modifiers should be reported). In those instances where there is direct supervision (i.e., the physician is in the office suite and immediately available to assist the nurse practitioner), the services may be billed under the "incident to" provision as long as the services are incident to the personal professional services of the physician.

Q.
Can a Nurse Practitioner be part of a PA Group? Can Nurse Practitioners form a PA group?

A.
Yes, a Nurse Practitioner may be part of a PA Group. Additionally, a group of Nurse Practitioners could form a PA Group.

Q.
Can Nurse Practitioners supervise other employees of the physician, in his absence, and bill the services incident to the physician's service?

A.
No. Services furnished under the supervision of a nurse practitioner cannot be billed "incident to" the physician's services.

Q.
Can Nurse Practitioners, since they are "performing physician services", have services performed for them by other employees "incident to" their services, and bill them under their Nurse Practitioner number as a physician would under the "incident to" method of billing?

A.
Yes. Services furnished under the supervision of a nurse practitioner may be billed "incident to" the nurse practitioner's services. Therefore, these types of services should be reported as nurse practitioner services (i.e., report the appropriate nurse practitioner modifiers).

Q.
What procedures can a Nurse Practitioner bill? Need specific information on the evaluation and management services.

A.
The state license for a Nurse Practitioner does not specifically detail those services that a Nurse Practitioner may perform in CPT-like, procedure code terms. Additionally, the competencies of each Nurse Practitioner are very individualized depending on the practice area of their competency and focus. Medicare of Florida has worked with the liaison of the Florida Nurses Association to define those services likely to be being performed by Nurse Practitioners. A current list of "approved procedures" for nurse practitioners is included on the following page.

With regard to evaluation and management services, a Nurse Practitioner should be able to perform and bill any for which he or she has the competencies to perform.

Q.
What happens to the TEAM CONCEPT?

A.
In essence, the "team concept" is obsolete.

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Nurse Practitioner Services
The following list of codes was developed as a guide for Advanced Registered Nurse Practitioners (ARNPs) and represents those services that could potentially be performed by an ARNP and potentially covered by Medicare of Florida. There are codes on the list that, although an ARNP is licensed or authorized to perform, may not be reimbursable through Medicare due to existing national or local medical review policies.
The following list of codes does not represent the sole opinion of the carrier or the Carrier Medical Director. Although the final decision rests with the carrier, this list was developed in cooperation with the Carrier Advisory Committee representative from the Florida Nurses' Association and other professional nurses throughout Florida.

HCPCS Level II Codes for Use by Advanced Registered Nurse Practitioners
G Codes Temporary Procedures/Professional Services: G0001, G0002, G0008-G0010, G0025-G0027, G0050, G0101, G0107, G0110-G0116

J Codes Drugs Administered (including oral and chemotherapy drugs): J0120-J9999

M Codes Medical Services: M0064, M0101

P Codes Pathology and Laboratory Services: P2028-P2038, P3000-P3001, P7001, P9010-P9015, P9603-P9604, P9610, P9615

Q Codes Miscellaneous Services: Q0034, Q0081, Q0083-0085, Q0091, Q0111-Q0115, Q0132, Q0136, Q0144, Q0156-Q0157, Q9920-Q9940

CPT Codes for Use by Advanced Registered Nurse Practitioners
Office or Other Outpatient Services: 99201-99205, 99211-99215

Hospital Observation Services: 99217-99220

Hospital Inpatient Services: 99221-99223, 99231-99233, 99234-99236, 99238-99239

Consultations:99241-99245, 99251-99255, 99261-99263, 99271-99275

Emergency Department Services: 99281-99285, 99288

Critical Care Services: 99291, 99292

Neonatal Intensive Care: 99295-99297

Nursing Facility Services: 99301-99303, 99311-99316

Domiciliary, Rest Home, or Custodial Care Services: 99321-99323, 99331-99333

Home Services: 99341-99345, 99347-99350

Prolonged Services: 99354-99360

Case Management Services: 99361-99362, 99371-99373

Care Plan Oversight Services: 99374, 99375, 99377-99380

Preventive Medicine Services: 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429

Newborn Care: 99431-99440

Special Evaluation and Management Services: 99450, 99455, 99456

Other Evaluation and Management Services: 99499

Anesthesia: All Codes

Surgery:

10060-10061, 10080-10081, 10120-10121, 10140, 10160, 11000, 11001, 11010-11012, 11040- 11044, 11055-11057, 11100, 11101, 11200, 11201, 11300-11303, 11305-11308, 11310-11313, 11400-11404, 11406, 11420-11424, 11426, 11440-11444, 11446, 11719-11721, 11730-11732, 11740, 11765, 11975-11977, 12001, 12002, 12004-12007, 12011, 12013-12018, 12020, 12021, 16000, 16010, 16020, 16025, 16030, 17000, 17003, 17004, 17110, 17111, 17250, 17340, 17360, 17380, 17999, 19000, 19001

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Respiratory System:
30000, 30020, 30124, 30300, 30901, 30999, 31500, 31502, 31505, 31511, 31575, 31577, 31599, 31603, 31605, 31612, 31720, 31730, 31899, 32000, 32002, 32960, 32999

Cardiovascular System:
36000, 36400, 36405, 36406, 36410, 36415, 36420, 36425, 36430, 36440, 36450, 36455, 36468-36471, 36481, 36488-36491, 36493, 36500, 36510, 36530, 36532, 36535, 36600, 36620, 36625, 36660, 36800, 36860

Digestive System:
40800, 40804, 40899, 41800, 41805, 42809, 42960, 42970, 42999, 43760, 46600, 46604, 46608, 46900, 46916, 46924

Urinary System: 50688, 51700, 51705, 51720, 53670, 53675

Male Genital System: 54050, 54056, 54065, 54150, 54152, 54250, 55899

Laparoscopy/Hysteroscopy: 56350

Female Genital System:
56405, 56420, 56501, 56515, 56605, 56606, 56700, 56720, 56740, 57061, 57065, 57100, 57105, 57130, 57135, 57150, 57160, 57170, 57180, 57400, 57410, 57415, 57452, 57454, 57460, 57500, 57505, 57510, 57511, 57513, 57520, 57522, 57800, 57820, 58100, 58120, 58300, 58301, 58321, 58322, 58323, 58974, 58976, 58999

Maternity Care and Delivery:
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Nervous System:
62270, 62273, 62274, 62276, 62277, 62278, 62279, 62280, 62282, 62288, 62289, 64400, 64402, 64405, 64408, 64410, 64412, 64413, 64415, 64417, 64418, 64420, 64421, 64425, 64430, 64435, 64440-64443, 64445, 64450, 64505, 64508, 64510, 64520, 64530, 64600, 64605, 64610, 64620, 64622, 64623, 64630, 64640, 64680, 64999

Eye and Ocular Adnexa: 65205, 65210, 65220, 65222

Auditory System: 69000, 69020, 69090, 69200, 69205, 69210, 69220, 69222, 69400, 69401, 69424

Radiology: All Codes

Organ or Disease Oriented Panels: 80049, 80050, 80051, 80054, 80055, 80058, 80059, 80061, 80072, 80090, 80091, 80092

Drug Testing: All Codes

Urinalysis: All Codes

Chemistry: All Codes

Hematology and Coagulation: All Codes

Immunology: All Codes

Transfusion Medicine: All Codes

Microbiology: All Codes

Other Procedures: All Codes

Immunization Injections: 90700-90714, 90716-90721, 90724-90728, 90730, 90732, 90733, 90735, 90737, 90741, 90742, 90744-90749

Therapeutic or Diagnostic Infusions: 90780, 90781

Therapeutic or Diagnostic Injections: 90782-90784, 90788, 90789, 90799

Psychiatry:
90801, 90802, 90804-90819, 90821-90829, 90846-90857, 90862, 90875, 90876, 90880, 90882, 90885, 90887, 90889, 90899

Biofeedback: 90901, 90911

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Gastroenterology: 91000, 91055, 91100, 91105, 91299

Ophthalmology: 92081, 92082, 92083, 92100, 92230, 92283, 92499

Special Otorhinolaryngologic Services:
92504, 92506, 92507, 92508, 92511, 92525, 92526, 92531-92534, 92541-92548, 92551-92553

Cardiovascular:
92950, 92953, 92960, 93000, 93005, 93010, 93012, 93014, 93015-93018, 93024, 93040-93042, 93224-93227, 93230-93233, 93235-93237, 93268, 93270-93272, 93278, 93770, 93784, 93786, 93788, 93790, 93797, 93798, 93799

Pulmonary:
94010, 94060, 94070, 94150, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94400, 94450, 94620, 94640, 94642, 94650-94652, 94656, 94657, 94660, 94662, 94664, 94665, 94667, 94668, 94680, 94681, 94690, 94720, 94725, 94750, 94760, 94761, 94762, 94770, 94772, 94799

Allergy and Clinical Immunology:
95004, 95010, 95015, 95024, 95027, 95028, 95044, 95052, 95056, 95060, 95065, 95070, 95071, 95075, 95078, 95115, 95117, 95120, 95125, 95130-95134, 95144-95149, 95165, 95170, 95199

Neurology and Neuromuscular Procedures:

95805-95808, 95810-95813, 95816, 95819, 95822, 95830-95834, 95851, 95852, 95857, 95858, 95860, 95861, 95863, 95864, 95867-95870, 95872, 95875, 95900, 95903, 95904, 95925-95927, 95930, 95933, 95934, 95936, 95937, 95950, 95951, 95953-95958, 95961, 95962, 95999

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Central Nervous System Assessments/Tests: 96100, 96105, 96110, 96111, 96115, 96117

Chemotherapy: 96400, 96405, 96406, 96408, 96410, 96412, 96414, 96425, 96450, 96520, 96530, 96542, 96545, 96549

Physical Medicine and Rehabilitation: 97010, 97012, 97014, 97016, 97018, 97020, 97022, 97024, 97026, 97028, 97032-97036, 97039, 97110, 97112, 97113, 97116, 97122, 97124, 97139, 97150, 97250, 97260, 97261, 97265, 97504, 97520, 97530, 97535, 97537, 97542, 97545, 97546, 97703, 97750, 97770, 97780, 97781, 97799

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Latest ICD-9-CM Update Effective October 1, 1998

The latest update to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis coding structure will take effect October 1, 1998. For claims processed on or after this date, Medicare Part B of Florida will recognize both the existing and new versions of ICD-9-CM to allow physicians sufficient time to obtain and begin to use the new codes. For claims processed on or after January 1, 1999, detail lines which include missing or invalid ICD-9-CM diagnosis codes will either be returned by Medicare Part B of Florida as unprocessable (assigned) or developed for a complete diagnosis code (unassigned). To avoid payment delays related to the use of invalid or incomplete ICD-9-CM diagnosis codes, providers must utilize the most recent ICD-9-CM coding materials and code each condition to its highest level of specificity. As a reminder to paper claim billers, the one-digit reference code number (1-4) corresponding to the ICD-9-CM diagnosis code(s) listed in item 21 must be entered in item 24e for each service.

How to Obtain ICD-9-CM Materials

Medicode Publications offers a variety of hard copy and electronic versions of the latest ICD-9-CM coding structure. A softbound standard version of Volumes 1 and 2 sells for $51.95, and the spiral bound deluxe or compact (6" x 9") editions sell for $66.95. Various versions of ICD-9-CM, CPT, and HCPCS software are also available for purchase; ask your Medicode representative about their special offers on these products. For further information, contact Medicode at 1-800-999-4600.

St. Anthony's Publishing also offers 1999 ICD-9-CM materials; the softbound version sells for $69.95, and a binder version which includes quarterly updates sells for $149.00. For further information, contact St. Anthony's at 1-800-632-0123.

The American Medical Association also offers 1999 ICD-9-CM materials; the cost for the AMA ICD-9-CM code book is $52.95 for AMA members and $65.95 for non-members. For further information, call the AMA at 1-800-621-8335.

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

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Correct Coding Concerns
Several providers have asked what they should do when they have concerns about correct coding edit pairs. Providers who have concerns about correct coding edit pairs should submit those concerns in writing to:

The Correct Coding Initiative
AdminaStar Federal
P.O.. Box 50469
Indianapolis, IN 46250-0469

As a reminder, the carrier cannot make any changes to the correct coding edit pairs.

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Change to Block 32 of the HCFA-1500
The Health Care Financing Administration is operating one "global payment demonstration," and expects to operate two more within the coming months. The current demonstration is the Cardiac Artery Bypass Graft Demonstration (CABG) at six sites, and new demonstrations are the Participating Centers of Excellence Demonstration and the Medicare Provider Partnership Demonstration. In these demonstrations, a single global payment is made to the hospital or Physician Hospital Group (PHO) for services to Medicare beneficiaries. Under these demonstrations, physicians do not bill the carrier directly for their services; the hospital or PHO is responsible for dividing the lump sum payment from the carrier into parts for the hospital and the physicians.
Although none of these demonstrations are taking place in Florida at this time, providers are being advised of a change to the instructions for completing block 32 of the HCFA-1500 claim form, and the applicable electronic fields. This is because of a problem that has been identified as occurring frequently for

demonstration patients. The problem arises when patients are transferred to a demonstration hospital from a non-demonstration hospital. During the hospital stay at a demonstration site, it is possible that there may be physician bills from an originating non-demonstration hospital for patients who have been transferred from the originating hospital. Medicare Part B of Florida will pay physicians for medically necessary services furnished at a non-demonstration hospital on the same day the patient is transferred to a demonstration hospital.
When billing for services rendered to patients in this situation, providers should follow these revised instructions for block 32 of the HCFA-1500 claim form:

If a physician performs a service(s) in a hospital (Place of Service Codes=21, 22, or 23), the physician must enter the Medicare provider number, in addition to name and address. When entering the Medicare provider number, precede each number with HSP. You are permitted to bill one provider number per claim.

Note that the "Medicare provider number" referred to above is the PIN# of the facility where the service(s) was rendered. Finally, note that the providers or entities that participate in the demonstration project(s) must enter the PIN and complete address.

Electronic Claims
Electronic claims senders should:

Report the Lab/Facility Name in NSF record EA0, field 39 for version 3.01, or field 37 for versions 1.04 and 2.00 AND in the ANSI X12 837 report the name in 2-250.A-NM103

Report the Lab/Facility ID in NSF record EA1, field 4, AND in the ANSI X12 837 report the ID in 2-250.A-NM109

Report the Lab/Facility Address in NSF record EA1, fields 6,7,8,9, and 10 AND in the ANSI X12 837 report the address in 2-265.A-N3 and 2-270.A-N4

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G0105, G0120: Colorectal Cancer Screening
In the December 1997 Florida Medicare Part B Update! Special Issue pages 84-86, the conditions for coverage of Colorectal Cancer Screening based on the Balanced Budget Act of 1997 were published.
Since that time an all inclusive list defining patients at high risk has been developed. The following diagnosis list applies only to procedure codes G0105 (Screening colonoscopy) and G0120 (Barium enema).

555.0 - 555.9
556.0 - 556.9
558.1 - 558.9

V10.05
V10.06
V12.72
V16.0
V18.5

Coding Guidelines
When billing procedure code G0105 (Screening colonoscopy) or G0120 (Barium enema), submit the applicable ICD-9 diagnosis for high risk:

For patients with a close relative who has had colorectal cancer or a family history of hereditary nonpolyosis colorectal cancer, utilize diagnosis V16.0;

For patients with a family history of familial adenomatous polyposis, utilize diagnosis V18.5;

For patients with a personal history of adenomatous polyps, utilize diagnosis V12.72;

For patients with a personal history of colorectal cancer, utilize diagnosis V10.05 or V10.06;

For patients with an inflammatory bowel disease utilize diagnosis 555.0-555.9, 556.0-556.9, or 558.1-558.9.

Any time the scheduled colorectal screening service turns into a diagnostic/therapeutic service, the applicable diagnostic/therapeutic procedure code should be billed.

Documentation Requirements
Medical record documentation maintained by the provider must indicate that the service provided was screening in nature. In addition, if procedure code G0105 (Screening colonoscopy) or G0120 (Barium enema) is billed, the documentation should support that the patient is at high risk. This information is usually found in the office/progress notes, history/physical, and/or procedure note.

Advance Notice Requirement
Applies to the frequency of coverage (see page 4).

****
G0123, G0124, 88142: Screening Pap Smear Clarification
Clarification was recently received regarding reimbursement for the technical component of procedure code G0124 (Screening cytopathology, cervical or vaginal (any reporting system) collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician) when billed as "professional component only" with the 26 modifier.
In the March/April 1998 issue of the Medicare B Update!, it was written that G0124-26 is paid off the physician fee schedule and is incorrect. This is no longer true. G0124-26 is paid from the clinical laboratory fee schedule at 100 percent. Deductible does not apply to this code. (The only time that this procedure code

is paid under the physician fee schedule is when it is provided to hosptial inpatients.)

Corrected Pricing
The reimbursement for procedure code 88142 was published incorrectly in the March/April 1998 issue of the Update! The correct reimbursement amount is $13.92.

Additional Information
For additional information about the screeing pap smear benefit, see the following publications:

March/April 1998, page 28
March/April 1998, page 31
January/February 1998, page 15

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G0125, G0126: Pricing Increase for PET Scans
New pricing has been developed for Positron Emission Technology (PET) lung imaging (procedure codes G0125, G0126). This pricing is effective for claims received on or after June 15, 1998, and will be automatically applied retroactively to all claims for this service received on or after January 1, 1998. The new pricing is:

CODE: G0125

PARTICIPATING FEES
Loc 01/02: 1984.38
Loc 03: 2192.82
Loc 04: 2349.33

NON-PARTICPATING FEES
Loc 01/02: 1885.16
Loc 03: 2083.18
Loc 04: 2231.86

LIMITING CHARGE
Loc 01/02: 2167.94
Loc 03: 2167.94
Loc 04: 2566.64

CODE: G0125 TC

PARTICIPATING FEES
Loc 01/02: 1914.94
Loc 03: 2119.67

Loc 04: 2272.83

NON-PARTICPATING FEES
Loc 01/02: 1819.19
Loc 03: 2013.69
Loc 04: 2159.19

LIMITING CHARGE
Loc 01/02: 2092.07
Loc 03: 2315.74
Loc 04: 2483.07

CODE: G0125 26

PARTICIPATING FEES
Loc 01/02: 69.43
Loc 03: 73.15
Loc 04: 76.50

NON-PARTICPATING FEES
Loc 01/02: 65.96
Loc 03: 69.49
Loc 04: 72.68

LIMITING CHARGE
Loc 01/02: 75.85
Loc 03: 79.91
Loc 04: 83.58

CODE: G0126

PARTICIPATING FEES
Loc 01/02: 2003.94
Loc 03: 2213.67
Loc 04: 2371.37

NON-PARTICPATING FEES
Loc 01/02: 1903.74
Loc 03: 2102.99
Loc 04: 2252.80

LIMITING CHARGE
Loc 01/02: 2189.30
Loc 03: 2418.44
Loc 04: 2590.72

CODE: G0126 TC

PARTICIPATING FEES
Loc 01/02: 1914.94
Loc 03: 2119.67
Loc 04: 2272.83

NON-PARTICPATING FEES
Loc 01/02: 1819.19
Loc 03: 2013.69
Loc 04: 2159.19

LIMITING CHARGE
Loc 01/02: 2092.07
Loc 03: 2092.07
Loc 04: 2483.07

CODE: G0126 26

PARTICIPATING FEES
Loc 01/02: 88.99
Loc 03: 94.00
Loc 04: 98.54

NON-PARTICPATING FEES
Loc 01/02: 84.54
Loc 03: 89.30
Loc 04: 93.61

LIMITING CHARGE
Loc 01/02: 93.61
Loc 03: 102.70
Loc 04: 107.65

As a reminder, reimbursement for the radio tracer/radiopharmaceutical (procedure code A4641) is bundled into the PET lung imaging reimbursement. Providers should not bill separately for the radio tracer/ratiopharmaceutical.
Coverage information for PET lung imaging was published on page 30 of the May/June 1998 Medicare B Update!

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Pricing for Injectable Drugs
Reimbursement amounts for most drugs are updated quarterly, except for chemotherapy drugs, which are updated monthly. Payment

for drugs is based on 95 percent of the median average wholesale price (AWP) for generic drugs and/or brand drugs, which is based on the Drug Topics Red Book.
The table on pages 23-33 includes a complete list of injectable drugs in procedure code order, with the description, maximum allowance, non-participating allowance, and limiting charge amounts. This information is effective for claims processed on or after January 1, 1998.
As a reminder, if the injectable drug billed does not appear on this list, it must be submitted using the unlisted procedure code J3490 (for non-chemotherapy agents) or J9999 (for chemotherapy agents). Paper and electronic claims must include the name of the drug, its strength, dosage, and number of injections.

The injectable drug price list appears on pages 23-33.

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G0127, 11719: Clarification on Billing Guidelines for Trimming of Dystrophic or Nondystrophic Nails
During a recent meeting with the leadership of the Florida Podiatric Medical Association, a number of billing and coding issues were discussed. One of the major issues involved the appropriateness of billing procedure code 11719 (trimming of nondystrophic nails) and procedure code G0127 (trimming of dystrophic nails) together for patients who have both dystrophic and nondystrophic nails trimmed during a visit.
Because these procedure codes encompass the trimming of up to ten nails and are priced accordingly, the use of both procedure codes in these situations represent duplicate billing.
Providers should use the procedure code that best describes the services rendered. For example, if a provider trims three nondystrophic nails and one dystrophic nail, procedure code 11719 should be billed. If an equal number of dystrophic and nondystrophic nails are trimmed (for example, two dystrophic and two nondystrophic), the provider should bill procedure code G0127.
Effective immediately, the use of the 59 modifier to receive payment for both procedure codes 11719 and G0127 will be considered highly inappropriate and abusive.

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Page 23 see the following information
Page 24
Page 25
Page 26
Page 27
Page 28
Page 29
Page 30
Page 31
Page 32
Page 33

Injectable Drug Price List:

Key: "NC" refers to noncovered procedure
"IC" refers to individual consideration

Code: A9600
Descriptor: Injection, Strontium-89 Chloride, per 10 ml
Par Allowance: $614.65
Non-Par Allowance: $583.92
Limiting Charge: $706.84

Code: J0120
Descriptor: Injection, Tetracycline, up to 250 mg - generic
Par Allowance: $11.56
Non-Par Allowance: $10.98
Limiting Charge: $13.29

Code: J0150
Descriptor: Injection, Adenosine, 6 mg
Par Allowance: $27.36
Non-Par Allowance: $25.99
Limiting Charge: $31.46

Code: J0170
Descriptor: Injection, Adrenalin, epinephrine, up to 1 ml ampule
Par Allowance: $1.37
Non-Par Allowance: $1.30
Limiting Charge: $1.57

Code: J0190
Descriptor: Biperiden, 5 mg - lactate
Par Allowance: $3.16
Non-Par Allowance: $3.00
Limiting Charge: 3.63

Code: J0205
Descriptor: Alglucerase, per 10 units -
Par Allowance: $37.52
Non-Par Allowance: $35.64
Limiting Charge: $43.14

Code: J0207
Descriptor: Injection, amifostine, 500 mg
Par Allowance: $306.77
Non-Par Allowance: $291.43
Limiting Charge: $352.78

Code: J0210
Descriptor: Methyldopate HCL, up to 250 mg
Par Allowance: $8.97
Non-Par Allowance: $8.52
Limiting Charge: $10.31

Code: J0256
Descriptor: Injection, alpha 1 - proteinase inhibitor, human, 500 mg
Par Allowance: $99.75

Non-Par Allowance: $94.76
Limiting Charge: $114.71

Code: J0270
Descriptor: Injection, alprostadil, per 1.25 mcg
Par Allowance: $2.36
Non-Par Allowance: $2.24
Limiting Charge: $2.71

Code: J0280
Descriptor: Injection, aminophyllin, up to 250 mg
Par Allowance: $1.27
Non-Par Allowance: $1.21
Limiting Charge: $1.46

Code: J0290
Descriptor: Injection, ampicillin sodium, up to 500 mg
Par Allowance: $1.06
Non-Par Allowance: $1.01
Limiting Charge: $1.21

Code: J0295
Descriptor: Injection, ampicillin sodium, .sulbactam sodium, 1.5 gm
Par Allowance: $6.87
Non-Par Allowance: $6.53
Limiting Charge: $7.90

Code: J0300
Descriptor: Injection, amobarbital, up to 125 mg
Par Allowance: $2.20
Non-Par Allowance: $2.09
Limiting Charge: $2.53

Code: J0330
Descriptor: Injection, succinylocholine chloride, up to 20mg
Par Allowance: $0.08
Non-Par Allowance: $0.08
Limiting Charge: 0.09

Code: J0340
Descriptor: Injection, nandrolone phenpropionate, up to 50 mg
Par Allowance: $7.87
Non-Par Allowance: $7.48
Limiting Charge: $9.05

Code: J0350
Descriptor: Injection, anistreplase, per 30 units
Par Allowance: $2,386.33
Non-Par Allowance: $2,267.01
Limiting Charge: $2,744.27

Code: J0360
Descriptor: Injection, hydralazine HCI, up to 20 mg
Par Allowance: $7.62
Non-Par Allowance: $7.24
Limiting Charge: $8.76

Code: J0380
Descriptor: Injection, metaraminol bitartrate, per 10 mg
Par Allowance: $1.11
Non-Par Allowance: $1.05
Limiting Charge: $1.27

Code: J0390
Descriptor: Injection, chloroquine HCI, up to 250 mg
Par Allowance: $14.98
Non-Par Allowance: $14.23
Limiting Charge: $17.22

Code: J0400
Descriptor: Injection, trimethaphan camsylate, up to 500 mg
Par Allowance: $27.17
Non-Par Allowance: $25.81
Limiting Charge: $31.24

Code: J0460
Descriptor: Injection, atropine sulfate, up to 0.3 mg
Par Allowance: $1.54
Non-Par Allowance: $1.46
Limiting Charge: $1.77

Code: J0470
Descriptor: Injection, dimercaprol, per 100 mg
Par Allowance: $16.91
Non-Par Allowance: $16.06
Limiting Charge: $19.44

Code: J0475
Descriptor: Injection, baclofen, 10 mg
Par Allowance: $204.25
Non-Par Allowance: $194.04
Limiting Charge: $223.14

Code: J0500
Descriptor: Injection, dicylomine HCI, up to 20 mg
Par Allowance: $1.80
Non-Par Allowance: $1.71
Limiting Charge: $2.07

Code: J0510
Descriptor: Injection, benzquinamide HCI, up to 50 mg
Par Allowance: $5.47
Non-Par Allowance: $5.20
Limiting Charge: $6.29

Code: J0515
Descriptor: Injection, benztropine mesylate, per 1 mg
Par Allowance: $3.53
Non-Par Allowance: $3.35
Limiting Charge: $4.06

Code: J0520

Descriptor: Injection, bethanechol chloride, mytonachol or urecholine up to 5 mg
Par Allowance: $5.01
Non-Par Allowance: $4.76
Limiting Charge: $5.76

Code: J0530
Descriptor: Injection, penicillin G benzathine and penicillin G procaine up to 600,00 units
Par Allowance: $6.81
Non-Par Allowance: $6.47
Limiting Charge: $7.83

Code: J0540
Descriptor: Injection, penicillin G benzathine and penicillin G procaine, up to 1, 200,000 units
Par Allowance: $13.63
Non-Par Allowance: $12.95
Limiting Charge: $15.67

Code: J0550
Descriptor: Injection, penicillin G benzathine and penicillin G procaine, up to 2, 400, 000 units
Par Allowance: $27.26
Non-Par Allowance: $25.90
Limiting Charge: $31.34

Code: J0560
Descriptor: Injection, penicillin G benzathine, up to 600,000 units
Par Allowance: $5.06
Non-Par Allowance: $4.81
Limiting Charge: $5.81

Code: J0570
Descriptor: Injection, penicillin G benzathine, up to 1200,000 units
Par Allowance: $12.23
Non-Par Allowance: $11.62
Limiting Charge: $14.06

Code: J0580
Descriptor: Injection, penicillin G benzathine, up to 2400,000 units
Par Allowance: $20.25
Non-Par Allowance: $19.24
Limiting Charge: $23.28

Code: J0585
Descriptor: Botulinum Toxin type A, per unit
Par Allowance: $4.18
Non-Par Allowance: $3.97
Limiting Charge: $4.80

Code: J0590
Descriptor: Injection, ethylnorepinephrine HCI, 1 ml
Par Allowance: $4.17

Non-Par Allowance: $3.96
Limiting Charge: $4.79

Code: J0600
Descriptor: Injection, edetate calcium disodium, up to 1000 mg
Par Allowance: $33.12
Non-Par Allowance: $31.46
Limiting Charge: $38.08

Code: J0610
Descriptor: Injection, calcuuium gluconate, per 10 ml
Par Allowance: $1.37
Non-Par Allowance: $1.30
Limiting Charge: $1.57

Code: J0620
Descriptor: Injection, calcium glycerophosphate and calcium lactate, per 10 ml
Par Allowance: $3.37
Non-Par Allowance: $3.21
Limiting Charge: $3.88

Code: J0630
Descriptor: Injection, calcitonin-salmon, up to 400 units
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J0635
Descriptor: Injection, calcitriol, 1 mcg ample
Par Allowance: $12.57
Non-Par Allowance: $11.94
Limiting Charge: $14.46

Code: J0640
Descriptor: Injection, leucovorin calcium, per 50 mg
Par Allowance: $19.50
Non-Par Allowance: $18.53
Limiting Charge: $22.42

Code: J0670
Descriptor: Injection, mepivacaine HCI, per 10 ml
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J0694
Descriptor: Injection, cefozitin sodium, 1 g
Par Allowance: $9.64
Non-Par Allowance: $9.16
Limiting Charge: $11.09

Code: J0696
Descriptor: Injection, ceftriaxone sodium, per 250 mg
Par Allowance: $11.88
Non-Par Allowance: $11.29
Limiting Charge: $13.66

Code: J0697
Descriptor: Injection, sterile cefuroxime sodium, per 750 mg
Par Allowance: $6.10
Non-Par Allowance: $5.80
Limiting Charge: $7.01

Code: J0698
Descriptor: Injection, Cefotaxime sodium, per g
Par Allowance: $12.12
Non-Par Allowance: $11.52
Limiting Charge: $13.94

Code: J0702
Descriptor: Injection, betamethasone acetate and betamethasone sodium phosphate, per 3 mg
Par Allowance: $4.47
Non-Par Allowance: $4.25
Limiting Charge: $5.14

Code: J0704
Descriptor: Injection, betamethasone sodium phosphate, per 4 mg
Par Allowance: $3.34
Non-Par Allowance: $3.27
Limiting Charge: $3.95

Code: J0710
Descriptor: Injection, cephapirin sodium, up to 1 g
Par Allowance: $1.56
Non-Par Allowance: $1.48
Limiting Charge: $1.79

Code: J0713
Descriptor: Injection, deftazidime, per 500 mg
Par Allowance: $6.75
Non-Par Allowance: $6.41
Limiting Charge: $7.76

Code: J0715
Descriptor: Injection, ceftizoxime sodium, per 500 mg
Par Allowance: $6.15
Non-Par Allowance: $5.84
Limiting Charge: $7.07

Code: J0720
Descriptor: Injection, chloramphenicol sodium succinate, up to 1 g
Par Allowance: $6.22
Non-Par Allowance: $5.91
Limiting Charge: $7.15

Code: J0725
Descriptor: Injection, chorionic gonadotropin, 1000 USP UNITS
Par Allowance: $3.02
Non-Par Allowance: $2.87
Limiting Charge: $3.47

Code: J0730
Descriptor: Injection, chlorpheniramine maleate, per 10 mg
Par Allowance: $0.28
Non-Par Allowance: $0.27
Limiting Charge: $0.32

Code: J0735
Descriptor: Injection, clonidine hydrochloride, 1 mg
Par Allowance: $48.45
Non-Par Allowance: $46.03
Limiting Charge: $55.71

Code: J0740
Descriptor: Injection, cidofavir, 375 mg
Par Allowance: $690.73
Non-Par Allowance: $656.19
Limiting Charge: $794.34

Code: J0743
Descriptor: Injection, cilastatin sodium imipenem, per 250 mg
Par Allowance: $13.62
Non-Par Allowance: $12.94
Limiting Charge: $12.94

Code: J0745
Descriptor: Injection, codeine phosphate, per 30 mg
Par Allowance: $0.62
Non-Par Allowance: $0.59
Limiting Charge: $0.71

Code: J0760
Descriptor: Injection, colchicine, per 1 mg
Par Allowance: $4.78
Non-Par Allowance: $4.54
Limiting Charge: $5.49

Code: J0770
Descriptor: Injection, colistimethate sodium, up to 150 m
Par Allowance: $33.77
Non-Par Allowance: $32.08
Limiting Charge: $38.83

Code: J0780
Descriptor: Injection, procholrperazine, up to 10 mg
Par Allowance: $2.60
Non-Par Allowance: $2.47
Limiting Charge: $2.99

Code: J0800
Descriptor: Injection, corticotropin, up to 40 units
Par Allowance: $4.55
Non-Par Allowance: $4.32
Limiting Charge: $5.23

Code: J0810
Descriptor: Injection, cortisone, up to 50 mg
Par Allowance: $2.76

Non-Par Allowance: $2.62
Limiting Charge: $3.17

Code: J0835
Descriptor: Injection, cosyntropin, per 0.25 mg
Par Allowance: $12.94
Non-Par Allowance: $12.29
Limiting Charge: $14.88

Code: J0850
Descriptor: Injection, cytomegalovirus immune globulin intravenousn (human) per vial
Par Allowance: $485.86
Non-Par Allowance: $461.57
Limiting Charge: $558.73

Code: J0895
Descriptor: Injection, deferoxamine mesylate, 500 mg, per 5 cc
Par Allowance: $10.63
Non-Par Allowance: $10.10
Limiting Charge: $12.22

Code: J0900
Descriptor: Injection, testosterone enanthate and estradiol valerate, up to 1 cc
Par Allowance: $1.49
Non-Par Allowance: $1.42
Limiting Charge: $1.71

Code: J0945
Descriptor: Injection, brompheniramine maleate, per 10 mg
Par Allowance: $0.81
Non-Par Allowance: $0.77
Limiting Charge: $0.93

Code: J0970
Descriptor: Injection, estrodiol valerate, up to 40 mg
Par Allowance: $2.31
Non-Par Allowance: $2.19
Limiting Charge: $2.66

Code: J1000
Descriptor: Injection, depo-estradiol cypionate, up to 5 mg
Par Allowance: $3.26
Non-Par Allowance: $3.10
Limiting Charge: $3.74

Code: J1020
Descriptor: Injection, methlprednisolone acetate, 20 mg
Par Allowance: $0.71
Non-Par Allowance: $0.68
Limiting Charge: $0.81

Code: J1030
Descriptor: Injection, methlprednisolone acetate, 40 mg
Par Allowance: $1.87
Non-Par Allowance: $1.78

Limiting Charge: $2.15

Code: J1040
Descriptor: Injection, methlprednisolone acetate, 80 mg
Par Allowance: $2.99
Non-Par Allowance: $2.84
Limiting Charge: $3.44

Code: J1050
Descriptor: Injection, medroxyprogesterone acetate, 100 mg
Par Allowance: $10.48
Non-Par Allowance: $9.96
Limiting Charge: $12.05

Code: J1055
Descriptor: Injection, medroxyprogesterone acetate for contraceptive use, 150 mg
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J1060
Descriptor: Injection, testosterone sypionate and estradiol cypionate up to 1 ml
Par Allowance: $1.57
Non-Par Allowance: $1.49
Limiting Charge: $1.80

Code: J1070
Descriptor: Injection, testosterone sypionate, up to 100 mg
Par Allowance: $1.31
Non-Par Allowance: $1.24
Limiting Charge: $1.50

Code: J1080
Descriptor: Injection, testosterone sypionate, 1 cc, 200 mg
Par Allowance: $2.26
Non-Par Allowance: $2.15
Limiting Charge: $2.60

Code: J1090
Descriptor: Injection, testosterone cypionate, 1 cc, 50 mg
Par Allowance: $0.65
Non-Par Allowance: $0.62
Limiting Charge: $0.75

Code: J1095
Descriptor: Injection, dexamethasone acetate, per 8 mg
Par Allowance: $4.17
Non-Par Allowance: $3.96
Limiting Charge: $4.79

Code: J1100
Descriptor: Injection, dexamethasone sodium phosphate, up to 4mg/ml
Par Allowance: $0.54
Non-Par Allowance: $0.51

Limiting Charge: $0.62

Code: J1110
Descriptor: Injection, dihydroergotamine mesylate, per 1 mg
Par Allowance: $12.01
Non-Par Allowance: $11.41
Limiting Charge: $13.81

Code: J1120
Descriptor: Injection, acetazolamide sodium, up to 500 mg
Par Allowance: $29.64
Non-Par Allowance: $28.16
Limiting Charge: $34.08

Code: J1160
Descriptor: Injection, digoxin, up to 0.5 mg
Par Allowance: $2.30
Non-Par Allowance: $2.19
Limiting Charge: $2.64

Code: J1165
Descriptor: Injection, phenytoin sodium, per 50 mg
Par Allowance: $0.62
Non-Par Allowance: $0.59
Limiting Charge: $0.71

Code: J1180
Descriptor: Injection, dyphylline, up to 500 mg
Par Allowance: $4.59
Non-Par Allowance: $4.36
Limiting Charge: $5.27

Code: J1190
Descriptor: Injection, dexrazoxane hydrochloride, per 250 mg
Par Allowance: $144.77
Non-Par Allowance: $137.53
Limiting Charge: $166.48

Code: J1200
Descriptor: Injection, diphenhydramine HCI, up to 50 mg
Par Allowance: $1.04
Non-Par Allowance: $0.99
Limiting Charge: $1.20

Code: J1205
Descriptor: Injection, chlorothiazide sodium, per 500 mg
Par Allowance: $9.06
Non-Par Allowance: $8.61
Limiting Charge: $10.42

Code: J1212
Descriptor: Injection, DMSO, Dimethyl Sulfoxide, 50%, 50ml
Par Allowance: $34.67
Non-Par Allowance: $32.94
Limiting Charge: $39.87

Code: J1230

Descriptor: Injection, methodene HCI, up to 10 mg
Par Allowance: $0.67
Non-Par Allowance: $0.64
Limiting Charge: $0.77

Code: J1240
Descriptor: Injection, Dimenhydrinate, up to 50 mg
Par Allowance: $1.77
Non-Par Allowance: $1.68
Limiting Charge: $2.03

Code: J1245
Descriptor: Injection, dipridamole, per 10 mg
Par Allowance: $23.22
Non-Par Allowance: $22.06
Limiting Charge: $26.70

Code: J1250
Descriptor: Injection, dobutamine HCI, per 250 mg
Par Allowance: $11.40
Non-Par Allowance: $10.83
Limiting Charge: $13.11

Code: J1320
Descriptor: Injection, amitriptyline HCI, up to 20 mg
Par Allowance: $0.85
Non-Par Allowance: $0.81
Limiting Charge: $0.97

Code: J1325
Descriptor: Injection, epoprostenol, 0.5 mg
Par Allowance: $15.43
Non-Par Allowance: $14.66
Limiting Charge: $17.74

Code: J1330
Descriptor: Injection, ergonovine maleate, up to 0.2 mg
Par Allowance: $4.50
Non-Par Allowance: $4.28
Limiting Charge: $5.17

Code: J1362
Descriptor: Injection, erthromycin gluceptate, per 250 mg
Par Allowance: $5.95
Non-Par Allowance: $5.66
Limiting Charge: $6.84

Code: J1364
Descriptor: Injection, erthromycin lactobionate, per 500 mg
Par Allowance: $8.24
Non-Par Allowance: $7.83
Limiting Charge: $9.47

Code: J1380
Descriptor: Injection,estradiol valerate, up to 10 mg
Par Allowance: $0.82
Non-Par Allowance: $0.78

Limiting Charge: $0.94

Code: J1390
Descriptor: Injection,estradiol valerate, up to 20 mg
Par Allowance: $1.42
Non-Par Allowance: $1.35
Limiting Charge: $1.63

Code: J1410
Descriptor: Injection, estrogen conjugated, per 25 mg
Par Allowance: $35.74
Non-Par Allowance: $33.95
Limiting Charge: $41.10

Code: J1435
Descriptor: Injection, estrone, per 1 mg
Par Allowance: $0.46
Non-Par Allowance: $0.44
Limiting Charge: $0.53

Code: J1436
Descriptor: Injection, etidronate disodium, per 300 mg
Par Allowance: $60.42
Non-Par Allowance: $57.40
Limiting Charge: $69.48

Code: J1440
Descriptor: Injection, filgrastim (G-CSF), 300 mcg
Par Allowance: $160.49
Non-Par Allowance: $152.47
Limiting Charge: $184.56

Code: J1441
Descriptor: Injection, filgrastim (G-CSF), 480 mcg
Par Allowance: $250.13
Non-Par Allowance: $237.62
Limiting Charge: $287.64

Code: J1455
Descriptor: Injection, foscarnet sodium, per 1, 000 mg
Par Allowance: $11.55
Non-Par Allowance: $10.97
Limiting Charge: $13.28

Code: J1460
Descriptor: Injection, gamma globulin, intramuscular, 1 cc
Par Allowance: $2.32
Non-Par Allowance: $2.20
Limiting Charge: $2.66

Code: J1470
Descriptor: Injection, gamma globulin, intramuscular, 2 cc
Par Allowance: $4.65
Non-Par Allowance: $4.42
Limiting Charge: $5.34

Code: J1480

Descriptor: Injection, gamma globulin, intramuscular, 3 cc
Par Allowance: $6.98
Non-Par Allowance: $6.63
Limiting Charge: $8.02

Code: J1490
Descriptor: Injection, gamma globulin, intramuscular, 3 cc
Par Allowance: $9.31
Non-Par Allowance: $8.84
Limiting Charge: $10.70

Code: J1500
Descriptor: Injection, gamma globulin, intramuscular, 5 cc
Par Allowance: $11.63
Non-Par Allowance: $11.05
Limiting Charge: $13.36

Code: J1510
Descriptor: Injection, gamma globulin, intramuscular, 6 cc
Par Allowance: $13.96
Non-Par Allowance: $13.26
Limiting Charge: $16.05

Code: J1520
Descriptor: Injection, gamma globulin, intramuscular, 7 cc
Par Allowance: $16.29
Non-Par Allowance: $15.48
Limiting Charge: $18.73

Code: J1530
Descriptor: Injection, gamma globulin, intramuscular, 8 cc
Par Allowance: $18.62
Non-Par Allowance: $17.69
Limiting Charge: $21.41

Code: J1540
Descriptor: Injection, gamma globulin, intramuscular, 9 cc
Par Allowance: $20.94
Non-Par Allowance: $19.89
Limiting Charge: $24.08

Code: J1550
Descriptor: Injection, gamma globulin, intramuscular, 10 cc
Par Allowance: $23.27
Non-Par Allowance: $22.11
Limiting Charge: $26.76

Code: J1560
Descriptor: Injection, gamma globulin, intramuscular, over 10 cc
Par Allowance: IC
Non-Par Allowance: IC
Limiting Charge: IC

Code: J1561
Descriptor: Injection, immune globulin, intravenous 500 mg
Par Allowance: $43.93

Non-Par Allowance: $41.73
Limiting Charge: $50.51

Code: J1562
Descriptor: Injection, immune globulin, intravenous 5 gms
Par Allowance: $380.00
Non-Par Allowance: $361.00
Limiting Charge: $437.00

Code: J1565
Descriptor: Injection, respiratory syncytial virus immune globulin, intravenous, 50 mg
Par Allowance: $628.45
Non-Par Allowance: $597.03
Limiting Charge: $722.71

Code: J1570
Descriptor: Injection, ganciclovier sodium, 500 mg
Par Allowance: $33.06
Non-Par Allowance: $31.41
Limiting Charge: $38.01

Code: J1580
Descriptor: Injection, Garamycin, gentamicin,up to 80 mg
Par Allowance: $4.74
Non-Par Allowance: $4.50
Limiting Charge: $5.45

Code: J1600
Descriptor: Injection, gold sodium thiomalate, up to 50 mg
Par Allowance: $11.95
Non-Par Allowance: $11.35
Limiting Charge: $13.74

Code: J1610
Descriptor: Injection, glucagon hydrochloride, per 1 mg
Par Allowance: $36.94
Non-Par Allowance: $35.09
Limiting Charge: $42.48

Code: J1620
Descriptor: Injection, gonadorelin hydrochloride, per 100 mcg
Par Allowance: $68.85
Non-Par Allowance: $65.41
Limiting Charge: $79.17

Code: J1625
Descriptor: Injection, gonadorelin hydrochloride, per 1mg
Par Allowance: DELETED
Non-Par Allowance: DELETED
Limiting Charge: DELETED

Code: J1626
Descriptor: Injection, granisetron hydrochloride, 100 mcg
Par Allowance: $16.85
Non-Par Allowance: $16.01
Limiting Charge: $19.37

Code: J1630
Descriptor: Injection, haloperidol, up to 5 mg
Par Allowance: $1.73
Non-Par Allowance: $1.64
Limiting Charge: $1.98

Code: J1631
Descriptor: Injection, haloperidol decanoate, per 50 mg
Par Allowance: $29.82
Non-Par Allowance: $28.33
Limiting Charge: $34.29

Code: J1642
Descriptor: Injection, heparin sodium, (Heparin Lock Flush) per 10 units
Par Allowance: $0.74
Non-Par Allowance: $0.70
Limiting Charge: $0.84

Code: J1645
Descriptor: Injection, dalteparin sodium, per 2500 IU
Par Allowance: $13.25
Non-Par Allowance: $12.59
Limiting Charge: $15.23

Code: J1650
Descriptor: Injection, enoxaparin sodium, 30 mg
Par Allowance: $15.96
Non-Par Allowance: $15.16
Limiting Charge: $18.35

Code: J1670
Descriptor: Injection, tetanus immune globulin, human up to 250 units
Par Allowance: $58.90
Non-Par Allowance: $55.96
Limiting Charge: $67.73

Code: J1690
Descriptor: Injection, prednisolone tebutate, up to 20 mg
Par Allowance: $3.89
Non-Par Allowance: $3.70
Limiting Charge: $4.47

Code: J1700
Descriptor: Injection, hydrocortisone acetate, up to 25 mg
Par Allowance: $1.69
Non-Par Allowance: $1.61
Limiting Charge: $1.94

Code: J1710
Descriptor: Injection, hydrocortisone sodium phosphate, up to 50 mg
Par Allowance: $4.80
Non-Par Allowance: $4.56
Limiting Charge: $5.52

Code: J1720
Descriptor: Injection, hydrocostisone sodium succinate, up to 100 mg
Par Allowance: $3.09
Non-Par Allowance: $2.94
Limiting Charge: $3.55

Code: J1730
Descriptor: Injection, diazoxide, up to 300 mg
Par Allowance: $97.23
Non-Par Allowance: $92.37
Limiting Charge: $111.81

Code: J1739
Descriptor: Injection, hydroxyprogesterone caproate, 125 mg/ml
Par Allowance: $1.29
Non-Par Allowance: $1.23
Limiting Charge: $1.48

Code: J1741
Descriptor: Injection, hydroxyprogesterone caproate, 250 mg/ml
Par Allowance: $2.60
Non-Par Allowance: $2.47
Limiting Charge: $2.99

Code: J1742
Descriptor: Injection, ibutilide fumarate, 1 mg
Par Allowance: $171.71
Non-Par Allowance: $163.12
Limiting Charge: $197.46

Code: J1760
Descriptor: Injection, iron dextran, 2 cc
Par Allowance: $35.81
Non-Par Allowance: $34.02
Limiting Charge: $41.18

Code: J1770
Descriptor: Injection, iron dextran, 5 cc
Par Allowance: $89.54
Non-Par Allowance: $85.06
Limiting Charge: $102.96

Code: J1780
Descriptor: Injection, iron dextran, 10 cc
Par Allowance: $179.09
Non-Par Allowance: $170.14
Limiting Charge: $205.95

Code: J1785
Descriptor: Injection, imiglucerase, per unit
Par Allowance: $3.75
Non-Par Allowance: $3.56
Limiting Charge: $4.31

Code: J1790

Descriptor: Injection, droperidol, up to 5 mg
Par Allowance: $3.26
Non-Par Allowance: $3.10
Limiting Charge: $3.74

Code: J1800
Descriptor: Injection, propranolol HCI, up to 1 mg
Par Allowance: $5.60
Non-Par Allowance: $5.32
Limiting Charge: $6.44

Code: J1810
Descriptor: Injection, droperidol and fentanyl citrate, up to 2 ml ampule
Par Allowance: $7.02
Non-Par Allowance: $6.67
Limiting Charge: $8.07

Code: J1820
Descriptor: Injection, insulin, up to 100 units
Par Allowance: $2.48
Non-Par Allowance: $2.36
Limiting Charge: $2.85

Code: J1825
Descriptor: Injection, interferon BETA - 1A, per 33 mcg
Par Allowance: $202.35
Non-Par Allowance: $192.23
Limiting Charge: $232.70

Code: J1830
Descriptor: Injection, interferon BETA - 1B, per 0.25 mg
Par Allowance: $68.40
Non-Par Allowance: $64.98
Limiting Charge: $78.66

Code: J1840
Descriptor: Injection, Kanamycin sulfate, up to 500 mg
Par Allowance: $3.19
Non-Par Allowance: $3.03
Limiting Charge: $3.67

Code: J1850
Descriptor: Injection, Kanamycin sulfate, up to 75 mg
Par Allowance: $3.08
Non-Par Allowance: $2.93
Limiting Charge: $3.54

Code: J1885
Descriptor: Injection, ketorolac tromethamine, per 15 mg
Par Allowance: IC
Non-Par Allowance: IC
Limiting Charge: IC

Code: J1890
Descriptor: Injection, cephalothin sodium, up to 1 g
Par Allowance: $10.26

Non-Par Allowance: $9.75
Limiting Charge: $11.79

Code: J1910
Descriptor: Injection, Kutapressin, up to 2 ml
Par Allowance: $11.47
Non-Par Allowance: $10.90
Limiting Charge: $13.19

Code: J1930
Descriptor: Injection, propiomazine HCI, up to 20 mg
Par Allowance: $3.93
Non-Par Allowance: $3.73
Limiting Charge: $4.51

Code: J1940
Descriptor: Injection, furosemide, up to 20 mg
Par Allowance: $0.91
Non-Par Allowance: $0.86
Limiting Charge: $1.04

Code: J1950
Descriptor: Injection, leuprolide acetate (for depot suspension) per 3.75 mg
Par Allowance: $395.43
Non-Par Allowance: $375.66
Limiting Charge: $454.74

Code: J1955
Descriptor: Injection, levocarnitine, per 1 gm
Par Allowance: $34.20
Non-Par Allowance: $32.49
Limiting Charge: $39.33

Code: J1960
Descriptor: Injection, levorphanol tartrate, up to 2 mg
Par Allowance: $2.80
Non-Par Allowance: $2.66
Limiting Charge: $3.22

Code: J1970
Descriptor: Injection, methotrimepraxine, up to 20 mg
Par Allowance: $21.55
Non-Par Allowance: $20.48
Limiting Charge: $24.78

Code: J1980
Descriptor: Injection, hyoscyamine sulfate, up to 0.25 mg
Par Allowance: $4.59
Non-Par Allowance: $4.36
Limiting Charge: $5.27

Code: J1990
Descriptor: Injection, chlordiazepoxide HCI, up to 100 mg
Par Allowance: $8.39
Non-Par Allowance: $7.97
Limiting Charge: $9.64

Code: J2000
Descriptor: Injection, lidocaine HCI, up to 50 cc
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J2010
Descriptor: Injection, lincomycin HCI, up to 300 mg
Par Allowance: $1.30
Non-Par Allowance: $1.24
Limiting Charge: $1.49

Code: J2050
Descriptor: Injection, liver, up to 20 mcg
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J2060
Descriptor: Injection, lorazepam, 2 mg
Par Allowance: $9.86
Non-Par Allowance: $9.37
Limiting Charge: $11.33

Code: J2150
Descriptor: Injection, mannitol, 25% in 50 ml
Par Allowance: $4.24
Non-Par Allowance: $4.03
Limiting Charge: $4.87

Code: J2175
Descriptor: Injection, meperidine HCI, per 100 mg.
Par Allowance: $0.75
Non-Par Allowance: $0.71
Limiting Charge: $0.86

Code: J2180
Descriptor: Injection, meperidine and promethazine, HCI, up to 50 mg
Par Allowance: $3.75
Non-Par Allowance: $3.56
Limiting Charge: $4.31

Code: J2210
Descriptor: Injection, methylergonovine maleate, up to 0.2 mg
Par Allowance: $3.01
Non-Par Allowance: $2.86
Limiting Charge: $3.46

Code: J2240
Descriptor: Injection, metovurine iodide, up to 2 mg
Par Allowance: $1.28
Non-Par Allowance: $1.22
Limiting Charge: $1.47

Code: J2260

Descriptor: Injection, milrinone lactate, per 5 ml
Par Allowance: $36.34
Non-Par Allowance: $34.52
Limiting Charge: $41.79

Code: J2270
Descriptor: Injection, morphine sulfate, up to 10 mg
Par Allowance: $0.74
Non-Par Allowance: $0.70
Limiting Charge: $0.85

Code: J2275
Descriptor: Injection, morphine sulfate (preservative-free sterile solution per 10 mg
Par Allowance: $9.64
Non-Par Allowance: $9.16
Limiting Charge: $11.08

Code: J2300
Descriptor: Injection, nalbuphine HCI, per 10 mg
Par Allowance: $1.13
Non-Par Allowance: $1.07
Limiting Charge: $1.29

Code: J2310
Descriptor: Injection, naloxone HCI, per 1 mg
Par Allowance: $3.24
Non-Par Allowance: $3.08
Limiting Charge: $3.73

Code: J2320
Descriptor: Injection, nandrolone decanoate HCI, up to 50 mg
Par Allowance: $5.75
Non-Par Allowance: $5.46
Limiting Charge: $6.61

Code: J2321
Descriptor: Injection, nandrolone decanoate HCI, up to 100 mg
Par Allowance: $11.51
Non-Par Allowance: $10.93
Limiting Charge: $13.23

Code: J2322
Descriptor: Injection, nandrolone decanoate HCI, up to 200 mg
Par Allowance: $16.17
Non-Par Allowance: $15.36
Limiting Charge: $18.59

Code: J2330
Descriptor: Injection, thiothixene, up to 4 mg
Par Allowance: $13.43
Non-Par Allowance: $12.76
Limiting Charge: $15.44

Code: J2350
Descriptor: Injection, niacinamide, niacin, up to 100 mg
Par Allowance: IC

Non-Par Allowance: IC
Limiting Charge: IC

Code: J2360
Descriptor: Injection, orphenadrine citrate, up to 60 mg
Par Allowance: $2.65
Non-Par Allowance: $2.52
Limiting Charge: $3.04

Code: J2370
Descriptor: Injection, phenylephrine HCI, up to 1 ml
Par Allowance: $2.94
Non-Par Allowance: $2.79
Limiting Charge: $3.38

Code: J2400
Descriptor: Injection, chloroprocaine HCI, per 30 ml
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J2405
Descriptor: Injection, ondansetron HCI, per 1 mg
Par Allowance: $5.80
Non-Par Allowance: $5.51
Limiting Charge: $6.67

Code: J2410
Descriptor: Injection, oxymorphoine HCI, up to 1 mg
Par Allowance: $3.53
Non-Par Allowance: $3.35
Limiting Charge: $4.05

Code: J2430
Descriptor: Injection, pamidronate disodium, per 30 mg
Par Allowance: $207.32
Non-Par Allowance: $196.95
Limiting Charge: $238.41

Code: J2440
Descriptor: Injection, papaverine HCI, up to 60 mg
Par Allowance: $3.49
Non-Par Allowance: $3.32
Limiting Charge: $4.01

Code: J2460
Descriptor: Injection, oxytetracycline HCI, up to 50 mg
Par Allowance: $0.89
Non-Par Allowance: $0.85
Limiting Charge: $1.02

Code: J2480
Descriptor: Injection, hydrochlorides of opium alkaloids, up to 20 mg
Par Allowance: $3.24
Non-Par Allowance: $3.08
Limiting Charge: $3.72

Code: J2510
Descriptor: Injection, penicillin G procaine, aqueous, up to 600,000 units
Par Allowance: $3.13
Non-Par Allowance: $2.98
Limiting Charge: $3.60

Code: J2512
Descriptor: Injection, pentagastrin, per 2 ml
Par Allowance: $35.48
Non-Par Allowance: $33.71
Limiting Charge: $40.80

Code: J2515
Descriptor: Injection, Pentobarbital Sodium, per 50 mg
Par Allowance: $0.88
Non-Par Allowance: $0.84
Limiting Charge: $1.01

Code: J2540
Descriptor: Injection, penicillin G potassium, up to 600,000 units
Par Allowance: $0.27
Non-Par Allowance: $0.26
Limiting Charge: $0.30

Code: J2545
Descriptor: Pentamidine isethionate, inhalation solution, per 300 mg through a DME
Par Allowance: $89.11
Non-Par Allowance: $84.65
Limiting Charge: $102.47

Code: J2550
Descriptor: Injection, promethazine HCI, up to 50 mg
Par Allowance: $0.84
Non-Par Allowance: $0.80
Limiting Charge: $0.96

Code: J2560
Descriptor: Injection, phenbarbital sodium, up to 120 mg
Par Allowance: $4.82
Non-Par Allowance: $4.58
Limiting Charge: $5.54

Code: J2590
Descriptor: Injection, oxtocin, up to 10 units,
Par Allowance: $1.15
Non-Par Allowance: $1.09
Limiting Charge: $1.32

Code: J2597
Descriptor: Injection, desmopressin acetate, per 1 mcg
Par Allowance: $4.67
Non-Par Allowance: $4.44
Limiting Charge: $5.37

Code: J2640
Descriptor: Injection, prednisolone sodium phosphate, up to 20 mg
Par Allowance: $0.66
Non-Par Allowance: $0.63
Limiting Charge: $0.75

Code: J2650
Descriptor: Injection, predinosolone acetate, up to 1 ml
Par Allowance: $0.36
Non-Par Allowance: $0.34
Limiting Charge: $0.41

Code: J2670
Descriptor: Injection, tolazoline HCI, up to 25 mg
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J2675
Descriptor: Injection, prgesterone, (Gesterol 50, Progestaject) per 50 mg
Par Allowance: $1.75
Non-Par Allowance: $1.66
Limiting Charge: $2.01

Code: J2680
Descriptor: Injection, fluphenzaine decanoate, up to 25 g
Par Allowance: $15.20
Non-Par Allowance: $14.44
Limiting Charge: $17.48

Code: J2690
Descriptor: Injection, procainamide HCI, up to 1 g
Par Allowance: $11.02
Non-Par Allowance: $10.47
Limiting Charge: $12.67

Code: J2700
Descriptor: Injection, ocacillin sodium, up to 250 mg
Par Allowance: $2.00
Non-Par Allowance: $1.90
Limiting Charge: $2.30

Code: J2710
Descriptor: Injection, neostrigmine methylsulfate, up to 0.5 mg
Par Allowance: $0.90
Non-Par Allowance: $0.86
Limiting Charge: $1.03

Code: J2720
Descriptor: Injection, protamine sulfate, per 10 mg
Par Allowance: $0.78
Non-Par Allowance: $0.74
Limiting Charge: $0.89

Code: J2725
Descriptor: Injection, protirelin, per 250 mg
Par Allowance: $23.45
Non-Par Allowance: $22.28
Limiting Charge: $26.96

Code: J2730
Descriptor: Injection, pralidoxime chloride, up to 1 g
Par Allowance: $28.34
Non-Par Allowance: $26.92
Limiting Charge: $32.59

Code: J2760
Descriptor: Injection, phentolamine mesylate, up to 5 mg
Par Allowance: $28.91
Non-Par Allowance: $27.46
Limiting Charge: $33.24

Code: J2765
Descriptor: Injection, metoclopramine HCI, up to 10 mg
Par Allowance: $1.97
Non-Par Allowance: $1.87
Limiting Charge: $2.26

Code: J2790
Descriptor: Injection, Rho (D) immune globulin, human, one dose package
Par Allowance: $79.44
Non-Par Allowance: $75.47
Limiting Charge: $91.35

Code: J2800
Descriptor: Injection, methocarbamol, up to 10 ml
Par Allowance: $4.38
Non-Par Allowance: $4.16
Limiting Charge: $5.037

Code: J2820
Descriptor: Injection, sargramostim (GM-CSF) 50 mcg
Par Allowance: $22.38
Non-Par Allowance: $21.26
Limiting Charge: $24.45

Code: J2860
Descriptor: Injection, secobarbital sodium, up to 250 mg
Par Allowance: $7.61
Non-Par Allowance: $7.23
Limiting Charge: $8.75

Code: J2910
Descriptor: Injection, aurothioglucose, up to 50 mg
Par Allowance: $13.14
Non-Par Allowance: $12.48
Limiting Charge: $15.11

Code: J2912
Descriptor: Injection, sodium chloride, 0.9%, per 2 ml

Par Allowance: $0.99
Non-Par Allowance: $0.94
Limiting Charge: $1.13

Code: J2920
Descriptor: Injection, methylprednisolone sodium succinate, up to 40 mg
Par Allowance: $3.23
Non-Par Allowance: $3.07
Limiting Charge: $3.71

Code: J2930
Descriptor: Injection, methlprednosolone sodium sucdinate, up to 125 mg
Par Allowance: $6.75
Non-Par Allowance: $6.41
Limiting Charge: $7.76

Code: J2950
Descriptor: Injection, promazine HCI, up to 25 mg
Par Allowance: $0.45
Non-Par Allowance: $0.43
Limiting Charge: $0.52

Code: J2970
Descriptor: Injection, methicillin sodium, up to 1 g
Par Allowance: $5.57
Non-Par Allowance: $5.29
Limiting Charge: $6.40

Code: J2995
Descriptor: Injection, streptokinase, per 250,000 IU
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J2996
Descriptor: Injection, alteplase recombinant, per 10 mg
Par Allowance: $261.25
Non-Par Allowance: $248.19
Limiting Charge: $300.43

Code: J3000
Descriptor: Injection, streptomycin, up to 1 g
Par Allowance: $3.75
Non-Par Allowance: $3.56
Limiting Charge: $4.31

Code: J3010
Descriptor: Injection, fentanyl citrate, up to 2 ml
Par Allowance: $1.58
Non-Par Allowance: $1.50
Limiting Charge: $1.81

Code: J3030
Descriptor: Injection, sumatriptan succinate, 6 mg
Par Allowance: $37.72

Non-Par Allowance: $35.83
Limiting Charge: $43.37

Code: J3070
Descriptor: Injection, pentazocine HCI, up to 30 mg
Par Allowance: $3.19
Non-Par Allowance: $3.03
Limiting Charge: $3.67

Code: J3080
Descriptor: Injection, chlorprothixene, up to 50 mg
Par Allowance: $4.87
Non-Par Allowance: $4.63
Limiting Charge: $5.60

Code: J3105
Descriptor: Injection, terbutaline sulfate, up to 1 mg
Par Allowance: $2.00
Non-Par Allowance: $1.90
Limiting Charge: $2.30

Code: J3120
Descriptor: Injection, testosterone enanthate, up to 100 mg
Par Allowance: $0.92
Non-Par Allowance: $0.87
Limiting Charge: $1.05

Code: J3130
Descriptor: Injection, testosterone enanthate, up to 200 mg
Par Allowance: $1.81
Non-Par Allowance: $1.72
Limiting Charge: $2.08

Code: J3140
Descriptor: Injection, testosterone suspension, up to 50 mg
Par Allowance: $0.97
Non-Par Allowance: $0.92
Limiting Charge: $1.11

Code: J3150
Descriptor: Injection, testosterone propionate, up to 100 mg
Par Allowance: $1.57
Non-Par Allowance: $1.49
Limiting Charge: $1.80

Code: J3230
Descriptor: Injection, chlorpromazine HCI, up to 50 mg
Par Allowance: $2.85
Non-Par Allowance: $2.71
Limiting Charge: $3.27

Code: J3240
Descriptor: Injection, thyrotropin, up to 10 IU
Par Allowance: $190.18
Non-Par Allowance: $180.67
Limiting Charge: $218.70

Code: J3250
Descriptor: Injection, trimethobenzamide HCI, up to 200 mg
Par Allowance: $2.32
Non-Par Allowance: $2.20
Limiting Charge: $2.66

Code: J3260
Descriptor: Injection, tobramycin sulfate, up to 80 mg
Par Allowance: $7.37
Non-Par Allowance: $7.00
Limiting Charge: $8.47

Code: J3265
Descriptor: Injection, torsemide, 10 mg/ml
Par Allowance: $1.89
Non-Par Allowance: $1.80
Limiting Charge: $2.17

Code: J3270
Descriptor: Injection, imipramine HCI, up to 25 mg
Par Allowance: $2.21
Non-Par Allowance: $2.10
Limiting Charge: $2.54

Code: J3280
Descriptor: Injection, thiethylperazine maleate, up to 10 mg
Par Allowance: $5.01
Non-Par Allowance: $4.76
Limiting Charge: $5.76

Code: J3301
Descriptor: Injection, triamcinolone acetonide, per 10 mg
Par Allowance: $1.43
Non-Par Allowance: $1.36
Limiting Charge: $1.64

Code: J3302
Descriptor: Injection, triamcinolone diacetate, per 5 mg
Par Allowance: $0.71
Non-Par Allowance: $0.67
Limiting Charge: $0.81

Code: J3303
Descriptor: Injection, traimcinolone hexacetonide, per 5 mg
Par Allowance: $2.26
Non-Par Allowance: $2.15
Limiting Charge: $2.59

Code: J3305
Descriptor: Injection, trimetrexate glucoronate, per 25 mg
Par Allowance: $60.19
Non-Par Allowance: $57.18
Limiting Charge: $69.21

Code: J3310
Descriptor: Injection, perphenazine, up to 5 mg
Par Allowance: $5.88

Non-Par Allowance: $5.59
Limiting Charge: $6.76

Code: J3320
Descriptor: Injection, spectinomycin dihydrochloride, up to 2 g
Par Allowance: $19.20
Non-Par Allowance: $18.24
Limiting Charge: $22.08

Code: J3350
Descriptor: Injection, urea, up to 40 g
Par Allowance: $73.58
Non-Par Allowance: $69.90
Limiting Charge: $84.61

Code: J3360
Descriptor: Injection, diazepam, up to 5 mg
Par Allowance: $1.36
Non-Par Allowance: $1.29
Limiting Charge: $1.56

Code: J3364
Descriptor: Injection, urokinase, 5,000 IU vial
Par Allowance: $56.61
Non-Par Allowance: $53.78
Limiting Charge: $65.10

Code: J3365
Descriptor: Injection, IV, irokinase, 250,000 IU vial
Par Allowance: $444.39
Non-Par Allowance: $422.17
Limiting Charge: $511.04

Code: J3370
Descriptor: Injection, vancomycin HCI, up to 500 mg
Par Allowance: $7.03
Non-Par Allowance: $6.68
Limiting Charge: $8.08

Code: J3390
Descriptor: Injection, methoxamine HCI, up to 20 mg
Par Allowance: $23.20
Non-Par Allowance: $22.04
Limiting Charge: $26.68

Code: J3400
Descriptor: Injection, trifluprомazine HCI, up to 20 mg
Par Allowance: $11.85
Non-Par Allowance: $11.26
Limiting Charge: $13.63

Code: J3410
Descriptor: Injection, hydrixyzine HCI, up to 25 mg
Par Allowance: $0.65
Non-Par Allowance: $0.62
Limiting Charge: $0.74

Code: J3420
Descriptor: Injection, vitamin B-12 cyanocobalamin, up to 1,000 mg
Par Allowance: $0.17
Non-Par Allowance: $0.16
Limiting Charge: $0.19

Code: J3430
Descriptor: Injection, phytonadione (vitamin K) per mg1
Par Allowance: $4.15
Non-Par Allowance: $3.94
Limiting Charge: $4.77

Code: J3450
Descriptor: Injection, mephentermine sulfate, up to 30 mg
Par Allowance: $1.85
Non-Par Allowance: $1.76
Limiting Charge: $2.12

Code: J3470
Descriptor: Injection, hyaluronidase, up to 150 units
Par Allowance: $7.47
Non-Par Allowance: $7.10
Limiting Charge: $8.59

Code: J3480
Descriptor: Injection, potassium chloride, per 2 mEq
Par Allowance: $0.11
Non-Par Allowance: $0.10
Limiting Charge: $0.12

Code: J3490
Descriptor: Unclassified drugs
Par Allowance: IC
Non-Par Allowance: IC
Limiting Charge: IC

Code: J3520
Descriptor: Edetate disodium
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J3530
Descriptor: Nasal vaccine inhalation
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J3535
Descriptor: Drug administered through a metered dose inhaler
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J3570
Descriptor: Laetrile, amygdalin, vitamin B-17

Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J6015
Descriptor: Typhus
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J7030
Descriptor: Infusion , normal saline solution, 1, 000 cc
Par Allowance: $10.39
Non-Par Allowance: $9.87
Limiting Charge: $11.94

Code: J7040
Descriptor: Infusion, normal saline solution, sterile (500 ml = 1unit)
Par Allowance: $10.30
Non-Par Allowance: $9.79
Limiting Charge: $11.84

Code: J7042
Descriptor: 5% dextrose/normal saline (500 ml + 1 unit)
Par Allowance: $10.75
Non-Par Allowance: $10.21
Limiting Charge: $12.36

Code: J7050
Descriptor: Infusion, normal saline solution, 250 cc
Par Allowance: $10.90
Non-Par Allowance: $10.36
Limiting Charge: $12.53

Code: J7051
Descriptor: Sterile saline or water, up to 5cc
Par Allowance: $0.94
Non-Par Allowance: $0.89
Limiting Charge: $1.08

Code: J7060
Descriptor: 5% dextrose/water (500 ml + 1 unit)
Par Allowance: $9.73
Non-Par Allowance: $9.24
Limiting Charge: $11.18

Code: J7070
Descriptor: Infusion D-5-W, 1,000 cc
Par Allowance: $10.85
Non-Par Allowance: $10.31
Limiting Charge: $12.47

Code: J7100
Descriptor: Infusion, dextran 40, 500 ml
Par Allowance: $111.64
Non-Par Allowance: $106.06

Limiting Charge: $128.38

Code: J7110
Descriptor: Infusion, dextran 75, 500 ml
Par Allowance: $98.21
Non-Par Allowance: $93.30
Limiting Charge: $112.94

Code: J7120
Descriptor: Ringer's lactate infusion, upto 1,000 cc
Par Allowance: $12.67
Non-Par Allowance: $12.04
Limiting Charge: $14.57

Code: J7130
Descriptor: Hypertonic saline solution, 50 or 100 meq. 20 cc vial
Par Allowance: $4.17
Non-Par Allowance: $3.96
Limiting Charge: $4.78

Code: J7140
Descriptor: Prescription Drug, Oral, Dispensed in Physician's Office
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J7150
Descriptor: Prescription Drug, Oral,Chemotherapy for Malignant Disease
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J7190
Descriptor: Factor VIII (anti-hemophilic factor)(Human) per IU
Par Allowance: $0.88
Non-Par Allowance: $0.84
Limiting Charge: $1.01

Code: J7191
Descriptor: Factor VIII (anti-hemophilic factor)(porcine) per IU
Par Allowance: $2.09
Non-Par Allowance: $1.99
Limiting Charge: $2.40

Code: J7192
Descriptor: Factor VIII (anti-hemophilic factor)(recombinant) per IU
Par Allowance: $1.12
Non-Par Allowance: $1.06
Limiting Charge: $1.28

Code: J7194
Descriptor: Factor IX complex, per IU
Par Allowance: $0.42

Non-Par Allowance: $0.40
Limiting Charge: $0.48

Code: J7196
Descriptor: other hemophilia clotting factors (e.g.anti-inhibitors), per IU
Par Allowance: $1.23
Non-Par Allowance: $1.17
Limiting Charge: $1.41

Code: J7197
Descriptor: Antithrombin III (human) per IU
Par Allowance: $1.00
Non-Par Allowance: $0.95
Limiting Charge: $1.15

Code: J7300
Descriptor: Intrauterine copper contraceptive
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J7310
Descriptor: Ganciclovir, 4.5 mg long-acting implant
Par Allowance: $4,750.00
Non-Par Allowance: $4,512.50
Limiting Charge: $5,462.50

Code: J7500
Descriptor: Azathioprine, oral, tab, 50 mg 100's ea
Par Allowance: $110.79
Non-Par Allowance: $105.25
Limiting Charge: $127.40

Code: J7501
Descriptor: Azathioprine, parenteral, vial, 100 mg 20 ml ea.
Par Allowance: $77.52
Non-Par Allowance: $73.64
Limiting Charge: $89.14

Code: J7502
Descriptor: Cyclosporine-Oral, Sol. 100 mg/ml. 50 ml ea
Par Allowance: deleted
Non-Par Allowance: deleted
Limiting Charge: deleted

Code: J7503
Descriptor: Cyclosporine, parenteral, per 50 mg
Par Allowance: $5.85
Non-Par Allowance: $5.56
Limiting Charge: $6.72

Code: J7504
Descriptor: Lymphocyte immune globulin, anti-thymocyte globulin,parenteral, amp, 50mg/ml 5
Par Allowance: $249.12
Non-Par Allowance: $236.66

Limiting Charge: $286.48

Code: J7505
Descriptor: Monoclonal antibodies - parenteral, 5 mg
Par Allowance: $684.00
Non-Par Allowance: $649.80
Limiting Charge: $786.60

Code: J7506
Descriptor: Prednisione, oral, per 5 mg
Par Allowance: $0.06
Non-Par Allowance: $0.06
Limiting Charge: $0.06

Code: J7507
Descriptor: Tacrolimus, oral, per 1 mg
Par Allowance: IC
Non-Par Allowance: IC
Limiting Charge: IC

Code: J7508
Descriptor: Tacrolimus, oral, per 5 mg
Par Allowance: IC
Non-Par Allowance: IC
Limiting Charge: IC

Code: J7509
Descriptor: Methylprednosolone, oral, per 4mg
Par Allowance: IC
Non-Par Allowance: IC
Limiting Charge: IC

Code: J7510
Descriptor: Prednisolone, oral per 5 mg
Par Allowance: IC
Non-Par Allowance: IC
Limiting Charge: IC

Code: J7599
Descriptor: Immunosuppressive drug, not otherwise clasified
Par Allowance: IC
Non-Par Allowance: IC
Limiting Charge: IC

Code: J7610
Descriptor: Acetylcysteine, 10% per ml, inhalation solution adm thru DME
Par Allowance: $1.29
Non-Par Allowance: $1.23
Limiting Charge: $1.48

Code: J7620
Descriptor: Albuterol sulfate, 0.083% per ml, inhalation solution adm. DME
Par Allowance: $0.39
Non-Par Allowance: $0.37

Limiting Charge: $0.44

Code: J7625
Descriptor: Albuterol sulfate, 0.5% per ml, inhalation solution adm. DME
Par Allowance: $0.69
Non-Par Allowance: $0.66
Limiting Charge: $0.79

Code: J7627
Descriptor: Bitolterol mesylate, 0.2% per 10 ml, inhalation solution adm DME
Par Allowance: $4.80
Non-Par Allowance: $4.56
Limiting Charge: $5.52

Code: J7630
Descriptor: Cromolyn sodium per 20 mg inhalation solution adm thru DME
Par Allowance: $0.33
Non-Par Allowance: $0.31
Limiting Charge: $0.37

Code: J7640
Descriptor: Epinephrie, 2.25% per ml, inhalation solution adm thru DME
Par Allowance: $0.69
Non-Par Allowance: $0.66
Limiting Charge: $0.79

Code: J7645
Descriptor: Ipratropium bromide 0.02% per ml, inhalation sol. adm thru DME
Par Allowance: IC
Non-Par Allowance: IC
Limiting Charge: IC

Code: J7650
Descriptor: Isoetharine HCI, 0.1% per ml, inhalation solution adm thru DME
Par Allowance: $0.37
Non-Par Allowance: $0.35
Limiting Charge: $0.42

Code: J7651
Descriptor: Isoetharine HCI, 0.125% per ml, inhalation solution adm thru DME
Par Allowance: $0.23
Non-Par Allowance: $0.22
Limiting Charge: $0.26

Code: J7652
Descriptor: Isoetharine HCI, 0.167% per ml, inhalation solution adm thru DME
Par Allowance: $0.31
Non-Par Allowance: $0.29
Limiting Charge: $0.35

Code: J7653
Descriptor: Isoetharine HCI, 0.2% per ml, inhalation solution adm thru DME
Par Allowance: $0.37
Non-Par Allowance: $0.35
Limiting Charge: $0.42

Code: J7654
Descriptor: Isoetharine HCI, 0.25% per ml, inhalation solution adm thru DME
Par Allowance: $0.47
Non-Par Allowance: $0.45
Limiting Charge: $0.54

Code: J7655
Descriptor: Isoetharine HCI, 1.0% per ml, inhalation solution adm thru DME
Par Allowance: $0.88
Non-Par Allowance: $0.84
Limiting Charge: $1.01

Code: J7660
Descriptor: Isoproterenol HCI, 0.5 % per ml inhalation solution adm/DME
Par Allowance: $2.35
Non-Par Allowance: $2.23
Limiting Charge: $2.70

Code: J7665
Descriptor: Isoproterenol HCI, 1.0% per ml. inhalation solution adm thru DME
Par Allowance: $2.48
Non-Par Allowance: $2.36
Limiting Charge: $2.85

Code: J7670
Descriptor: Metaproternol sulfate, 0.4% per 2.5 mo inhalation solution adm/DME
Par Allowance: $1.23
Non-Par Allowance: $1.17
Limiting Charge: $1.41

Code: J7672
Descriptor: Metaproternol sulfate, 0.6% per 2.5 mo inhalation solution adm/DME
Par Allowance: $1.23
Non-Par Allowance: $1.17
Limiting Charge: $1.41

Code: J7675
Descriptor: Metaproternol sulfate, 5.0% per 2.5 mo inhalation solution adm/DME
Par Allowance: $1.30
Non-Par Allowance: $1.24
Limiting Charge: $1.49

Code: J7799
Descriptor: NOC drugs, other than inhalation drugs, adm DME
Par Allowance: IC
Non-Par Allowance: IC
Limiting Charge: IC

Code: J8499
Descriptor: Prescription drug, oral, nonchemotherapeutic, not otherwise specified
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: J8530
Descriptor: Cyclophosphamide, oral, 25 mg
Par Allowance: $1.77
Non-Par Allowance: $1.68
Limiting Charge: $2.03

Code: J8560
Descriptor: Etoposide, oral, 50 mg
Par Allowance: $38.42
Non-Par Allowance: $36.50
Limiting Charge: $44.18

Code: J8600
Descriptor: Melphalan, oral 2 mg
Par Allowance: $1.80
Non-Par Allowance: $1.71
Limiting Charge: $2.07

Code: J8610
Descriptor: Methotrexate, oral 2.5 mg
Par Allowance: $3.18
Non-Par Allowance: $3.02
Limiting Charge: $3.65

Code: J8999
Descriptor: Prescription drug, oral, chemotherapeutics, not otherwise specified
Par Allowance: IC
Non-Par Allowance: IC
Limiting Charge: IC

Code: J9000
Descriptor: Doxorubicin HCI, 10 mg
Par Allowance: $46.42
Non-Par Allowance: $44.10
Limiting Charge: $53.38

Code: J9015
Descriptor: Aldesleukin, per single use vial
Par Allowance: $447.21
Non-Par Allowance: $424.85
Limiting Charge: $514.29

Code: J9020

Descriptor: Asparaginase, 10,000 units
Par Allowance: $52.95
Non-Par Allowance: $50.30
Limiting Charge: $60.89

Code: J9040
Descriptor: Bleomycin sulfate, 15 units
Par Allowance: $291.92
Non-Par Allowance: $277.32
Limiting Charge: $335.70

Code: J9045
Descriptor: Carboplatin, 50 mg
Par Allowance: $88.78
Non-Par Allowance: $84.34
Limiting Charge: $102.09

Code: J9050
Descriptor: Carmustine, 100 mg
Par Allowance: $88.29
Non-Par Allowance: $83.88
Limiting Charge: $101.53

Code: J9060
Descriptor: Cisplatin, powder or solution, per 10 mg
Par Allowance: $37.04
Non-Par Allowance: $35.19
Limiting Charge: $42.59

Code: J9062
Descriptor: Cisplatin, 50 mg
Par Allowance: $185.24
Non-Par Allowance: $175.98
$213.02

Code: J9065
Descriptor: Injection, cladribine, per 1 mg
Par Allowance: $47.19
Non-Par Allowance: $44.83
Limiting Charge: $54.26

Code: J9070
Descriptor: Cyclophosphamide 100 mg
Par Allowance: $5.42
Non-Par Allowance: $5.15
Limiting Charge: $6.23

Code: J9080
Descriptor: Cyclophosphamide 200 mg
Par Allowance: $10.30
Non-Par Allowance: $9.79
Limiting Charge: $11.84

Code: J9090
Descriptor: Cyclophosphamide 500 mg
Par Allowance: $21.65
Non-Par Allowance: $20.57

Limiting Charge: $23.65

Code: J9091
Descriptor: Cyclophosphamide, 1 g
Par Allowance: $43.31
Non-Par Allowance: $41.14
Limiting Charge: $49.80

Code: J9092
Descriptor: Cyclophosphamide, 2 g
Par Allowance: $86.60
Non-Par Allowance: $82.27
Limiting Charge: $99.59

Code: J9093
Descriptor: Cyclophosphamide, lyophilized, 100 mg
Par Allowance: $6.12
Non-Par Allowance: $5.81
Limiting Charge: $7.03

Code: J9094
Descriptor: Cyclophosphamide, lyophilized, 200 mg
Par Allowance: $11.63
Non-Par Allowance: $11.05
Limiting Charge: $13.37

Code: J9095
Descriptor: Cyclophosphamide, lyophilized, 500 mg
Par Allowance: $24.42
Non-Par Allowance: $23.20
Limiting Charge: $28.08

Code: J9096
Descriptor: Cyclophosphamide, lyophilized, 1 g
Par Allowance: $48.85
Non-Par Allowance: $46.41
Limiting Charge: $56.17

Code: J9097
Descriptor: Cyclophosphamide, lyophilized, 2 g
Par Allowance: $97.74
Non-Par Allowance: $92.85
Limiting Charge: $112.40

Code: J9100
Descriptor: Cytarabine, 100 mg
Par Allowance: $6.10
Non-Par Allowance: $5.80
Limiting Charge: $7.01

Code: J9110
Descriptor: Cytarabine, 500 mg
Par Allowance: $24.35
Non-Par Allowance: $23.13
Limiting Charge: $28.00

Code: J9120

Descriptor: Dactinomycin, 0.5 mg
Par Allowance: $11.97
Non-Par Allowance: $11.37
Limiting Charge: $13.76

Code: J9130
Descriptor: Dacarbazine, 100 mg
Par Allowance: $10.55
Non-Par Allowance: $10.02
Limiting Charge: $12.13

Code: J9140
Descriptor: Dacarbazine, 200 mg
Par Allowance: $21.11
Non-Par Allowance: $20.05
Limiting Charge: $24.27

Code: J9150
Descriptor: Daunorubicin HCI, 10 mg
Par Allowance: $80.03
Non-Par Allowance: $76.03
Limiting Charge: $92.03

Code: J9165
Descriptor: Diethylstilbestrol diphosphate, 250 mg
Par Allowance: $13.46
Non-Par Allowance: $12.79
Limiting Charge: $15.47

Code: J9170
Descriptor: Docetaxel, 20 mg
Par Allowance: $257.28
Non-Par Allowance: $244.42
Limiting Charge: $295.87

Code: J9181
Descriptor: Etoposide, 10 mg
Par Allowance: $12.93
Non-Par Allowance: $12.28
Limiting Charge: $14.86

Code: J9182
Descriptor: Etoposide, 100 mg
Par Allowance: $129.34
Non-Par Allowance: $122.87
Limiting Charge: $148.74

Code: J9185
Descriptor: Fludarabine phosphate, 50 mg
Par Allowance: $186.67
Non-Par Allowance: $177.34
Limiting Charge: $214.67

Code: J9190
Descriptor: Fluorouracil, 500 mg
Par Allowance: $1.98
Non-Par Allowance: $1.88

Limiting Charge: $2.27

Code: J9200
Descriptor: Floxuridine, 500 mg
Par Allowance: $126.39
Non-Par Allowance: $120.07
Limiting Charge: $145.34

Code: J9201
Descriptor: Gemcitabine HCI, 200 mg
Par Allowance: $75.14
Non-Par Allowance: $71.38
Limiting Charge: $86.41

Code: J9201
Descriptor: Gemzar, 200 mg
Par Allowance: $75.14
Non-Par Allowance: $71.38
Limiting Charge: $82.09

Code: J9202
Descriptor: Goserelin acetate implant, per 3.6 mg
Par Allowance: $417.27
Non-Par Allowance: $396.41
Limiting Charge: $479.86

Code: J9206
Descriptor: Irinotecan 20 mg
Par Allowance: $99.61
Non-Par Allowance: $94.63
Limiting Charge: $114.55

Code: J9208
Descriptor: Ifosfamide, per 1 gm
Par Allowance: $118.97
Non-Par Allowance: $113.02
Limiting Charge: $136.82

Code: J9209
Descriptor: Mesna, 200 mg
Par Allowance: $30.92
Non-Par Allowance: $29.37
Limiting Charge: $35.55

Code: J9211
Descriptor: Idarubicin HCI, 5 mg
Par Allowance: $258.84
Non-Par Allowance: $245.90
Limiting Charge: $297.66

Code: J9213
Descriptor: Interferon alfa-2A, recombinant, 3 million units
Par Allowance: $32.24
Non-Par Allowance: $30.63
Limiting Charge: $37.07

Code: J9214

Descriptor: Interferon alfa-2B, recombinant, 1 million units
Par Allowance: $11.59
Non-Par Allowance: $11.01
Limiting Charge: $13.32

Code: J9215
Descriptor: Interferon alfa-N3, (human keukocyte derived) 250,000 IU
Par Allowance: $7.55
Non-Par Allowance: $7.17
Limiting Charge: $8.68

Code: J9216
Descriptor: Indteferon gamma-1B, 3 million units
Par Allowance: $133.00
Non-Par Allowance: $126.35
Limiting Charge: $152.95

Code: J9217
Descriptor: Leuprolide acetate (for depot suspension), 7.5 mg
Par Allowance: $526.06
Non-Par Allowance: $499.76
Limiting Charge: $604.96

Code: J9218
Descriptor: Leuprolide acetate, per 1 mg
Par Allowance: $64.12
Non-Par Allowance: $60.91
Limiting Charge: $73.74

Code: J9230
Descriptor: Mcechlorethamine HCI, (nitrogen mustard) , 10 mg
Par Allowance: $10.35
Non-Par Allowance: $9.83
Limiting Charge: $11.90

Code: J9245
Descriptor: Injection, melphalan HCI, 50 mg
Par Allowance: $308.77
Non-Par Allowance: $293.33
Limiting Charge: $355.08

Code: J9250
Descriptor: Methotrexate sodium, 5 mg
Par Allowance: $0.40
Non-Par Allowance: $0.38
Limiting Charge: $0.46

Code: J9260
Descriptor: Methotrexate sodium, 50 mg
Par Allowance: $5.52
Non-Par Allowance: $5.24
Limiting Charge: $6.34

Code: J9265
Descriptor: Paclitaxel, 30 mg
Par Allowance: $173.49

Non-Par Allowance: $164.82
Limiting Charge: $199.51

Code: J9268
Descriptor: Pentostatin, per 10 mg
Par Allowance: $1,562.75
Non-Par Allowance: $1,484.61
Limiting Charge: $1,797.16

Code: J9270
Descriptor: Plicamycin, 2,500 mg
Par Allowance: $84.29
Non-Par Allowance: $80.08
Limiting Charge: $96.93

Code: J9280
Descriptor: Mitomycin 5 mg
Par Allowance: $112.53
Non-Par Allowance: $106.90
Limiting Charge: $129.40

Code: J9290
Descriptor: Mitomycin 20 mg
Par Allowance: $413.29
Non-Par Allowance: $392.63
Limiting Charge: $475.28

Code: J9291
Descriptor: Mitomycin 40 mg
Par Allowance: $826.58
Non-Par Allowance: $785.25
Limiting Charge: $950.57

Code: J9293
Descriptor: Injection, mitoxantrone HCI, per 5 mg
Par Allowance: $179.55
Non-Par Allowance: $170.57
Limiting Charge: $206.48

Code: J9320
Descriptor: Stretozocin, 1 gm
Par Allowance: $77.70
Non-Par Allowance: $73.82
Limiting Charge: $89.35

Code: J9340
Descriptor: Thiotepa, 15 mg
Par Allowance: $79.74
Non-Par Allowance: $75.76
Limiting Charge: $91.70

Code: J9350
Descriptor: Topotecan, 4 mg
Par Allowance: $502.83
Non-Par Allowance: $477.69
Limiting Charge: $578.25

Code: J9360
Descriptor: Vinblastine sulfate, 1 mg
Par Allowance: $3.56
Non-Par Allowance: $3.38
Limiting Charge: $4.09

Code: J9370
Descriptor: Vincristine sulfate, 1 mg
Par Allowance: $30.16
Non-Par Allowance: $28.65
Limiting Charge: $34.68

Code: J9375
Descriptor: Vincristine sulfate, 2 mg
Par Allowance: $36.33
Non-Par Allowance: $34.51
Limiting Charge: $41.78

Code: J9380
Descriptor: Vincristine sulfate, 5 mg
Par Allowance: $154.57
Non-Par Allowance: $146.84
Limiting Charge: $177.75

Code: J9390
Descriptor: Vinorelbine tartrate, per 10 mg
Par Allowance: $63.03
Non-Par Allowance: $59.88
Limiting Charge: $72.48

Code: J9600
Descriptor: Porfimer sodium 75 mg
Par Allowance: $2,444.75
Non-Par Allowance: $2,322.51
Limiting Charge: $2,811.46

Code: J9999
Descriptor: Not otherwise classified, antineoplastic drug
Par Allowance: IC
Non-Par Allowance: IC
Limiting Charge: IC

Code: Q0136
Descriptor: Injection Epoetin Alpha, (for non ESRD use), per 100 units
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q0144
Descriptor: Azithromycin Dihydrate, Oral, Capsules/Powder, 1 gram
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: Q0156

Descriptor: Infusion, Albumin (Human), 5%, 500 ml.
Par Allowance: $166.25
Non-Par Allowance: $157.94
Limiting Charge: $181.62

Code: Q0157
Descriptor: Infusion, Albumin (Human), 25%, 50 ml.
Par Allowance: $61.57
Non-Par Allowance: $58.49
Limiting Charge: $70.80

Code: Q0159
Descriptor: Adenoscan 90 mg/30 ml single use vial
Par Allowance: $7.08
Non-Par Allowance: $6.73
Limiting Charge: $8.14

Code: Q9920
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 20 or less
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9921
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 21
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9922
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 22
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9923
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 23
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9924
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 24
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9925
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 25
Par Allowance: $11.20
Non-Par Allowance: $10.64

Limiting Charge: $12.88

Code: Q9926
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 26
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9927
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 27
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9928
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 28
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9929
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 29
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9930
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 30
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9931
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 31
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9932
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 32
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9933
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 33
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9934
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 34
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9935
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 35
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9936
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 36
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9937
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 37
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9938
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 38
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9939
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 39
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: Q9940
Descriptor: Injection of EPO, per 1,000 units, at patient HCT of 40 and/or above
Par Allowance: $11.20
Non-Par Allowance: $10.64
Limiting Charge: $12.88

Code: 90700
Descriptor: Immunization, Active; Diphtheria, Tetanus, Toxoids, and Acellular Pertussis Vaccine(DTaP)
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90701
Descriptor: Immunization, Active, Diphtheria and Tetanus Toxoids and Pertussis Vaccine (DTP)
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90702
Descriptor: Immunization, Active, Diphtheria and Tetanus Toxoids (DT)
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90703
Descriptor: Immunization, Active Tetanus Toxoid
Par Allowance: $2.68
Non-Par Allowance: $2.55
Limiting Charge: $3.08

Code: 90704
Descriptor: Immunization, Active, Mumps Virus Vaccine, Live
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90705
Descriptor: Immunization, Active, Measles Virus Vaccine, Live, Attenuated
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90706
Descriptor: Immunization, Active, Rubella Virus Vaccine, Live
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90707
Descriptor: Immunization, Active, Measles, Mumps, and Rubella Virus Vaccine, Live
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90708
Descriptor: Immunization, Active, Measles and Rubella Virus Vaccine, Live
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90709
Descriptor: Immunization, Active, Rubella and Mumps Virus Vaccine, Live
Par Allowance: NC

Non-Par Allowance: NC
Limiting Charge: NC

Code: 90710
Descriptor: Immunization, Active; Measles, Mumps, Rubella and Varicella Vaccine
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90711
Descriptor: Immunization, Active; Diphtheria, Tetanus, and Pertussis (DTP) and Injectable Poliomyelitis Vaccine
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90712
Descriptor: Immunization, Active, Poliovirus Vaccine, Live, Oral (any Type) Vaccine
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90713
Descriptor: Immunization, Active, Poliomyelitis Vaccine
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90714
Descriptor: Immunization, Active, Typhoid Vaccine
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90716
Descriptor: Immunization, Active; Varicella (Chicken Pox) Vaccine
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90717
Descriptor: Immunization, Active, Yellow Fever Vaccine
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90719
Descriptor: Immunization, Active, Diphtheria Toxoid
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90720

Descriptor: Immunization, Active; Diphtheria, Tetanus Toxoids,and Pertussis (DTP) and Hemophilus Influenza B (Hib) Vaccine
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90721
Descriptor: Immunization, Active; Diphtheria, Tetanus, Toxoids, and Acellular Pertussis Vaccine DTaP 'and Hemophilus Influenza B (Hib) Vaccine
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90724
Descriptor: Immunization, Active, Influenza Virus Vaccine
Par Allowance: $4.74
Non-Par Allowance: $4.50
Limiting Charge: $5.45

Code: 90725
Descriptor: Immunization, Active, Cholera Vaccine
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90726
Descriptor: Immunization, Active, Rabies Vaccine
Par Allowance: $121.93
Non-Par Allowance: $115.83
Limiting Charge: $140.21

Code: 90727
Descriptor: Immunization, Active, Plague Vaccine
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90728
Descriptor: Immunization, Active, BCG Vaccine
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90730
Descriptor: Immunization, Active; Hepatitis A Vaccine
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90732
Descriptor: Immunization, Active, pneumococcal vaccine, polyvalent
Par Allowance: $12.15
Non-Par Allowance: $11.54
Limiting Charge: $13.97

Code: 90733
Descriptor: Immunication, Active, Meningococcal Polysaccharide Vaccine (any group(s))
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90735
Descriptor: Immunization, Active, Encephalitis Virus Vaccine
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90737
Descriptor: Immunization, Active, Hemophilus Influenza B
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90741
Descriptor: Immunization, Passive, Immune Serum Globulin, Human (ISG)
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90742
Descriptor: Immunization, Passive, Specific Hyper-Immune Serum Globulin(e.g. Hepatitis B, Measles) (Pertussis, Rabies, RHO(D), Tetanus, Vaccine, Varicella-Zoster
Par Allowance: IC
Non-Par Allowance: IC
Limiting Charge: IC

Code: 90744
Descriptor: Immunization, Active, Hepatitis B Vaccine; newborn to 11 years
Par Allowance: $22.99
Non-Par Allowance: $21.84
Limiting Charge: $26.43

Code: 90745
Descriptor: Immunization, Active, Hepatitis B Vaccine; 11 - 19 years
Par Allowance: $22.99
Non-Par Allowance: $21.84
Limiting Charge: $26.43

Code: 90746
Descriptor: Immunization, Active, Hepatitis B Vaccine; 20 years and above
Par Allowance: $52.34
Non-Par Allowance: $49.72
Limiting Charge: $60.19

Code: 90747

Descriptor: Immunization, Active, Hepatitis B Vaccine; Dialysis
Par Allowance: $172.33
Non-Par Allowance: $163.71
Limiting Charge: $198.16

Code: 90748
Descriptor: Immunization, active, Hepatitis B and Hemophilus influenza B (HIB) vaccine
Par Allowance: NC
Non-Par Allowance: NC
Limiting Charge: NC

Code: 90749
Descriptor: Unlisted Immunization Procedure
Par Allowance: IC
Non-Par Allowance: IC
Limiting Charge: IC

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Q0163-Q0181: Correction to Covered Diagnoses
Page 34 of the May/June 1998 edition of the Medicare B Update! contained an article about revised guidelines for oral anti-nausea drugs when used as part of a cancer chemotherapeutic regimen. Under the section "Claim Submission/Billing Guidelines," an incorrect diagnosis was given. The following is corrected information:
The oral anti-emetic must be billed with a diagnosis of cancer (ICD-9-CM diagnosis codes 140.0-239.9, or V58.0) in block 24E of the HCFA-1500 claim form, or in FA0 records 14-17 for electronic claims.

Advance Notice Statement
Applies to diagnosis (see page 4)
****
Q0182: Alprostadil Guidelines
Effective for services rendered on or after July 1, 1998, the following temporary procedure code has been established for use when reporting Alprostadil:

Q0182
Alprostadil, urethral suppository, administered under direct physician supervision, excludes self-administration

Medicare Part B will allow payment only for the initial dose when given by the physician. Based on national coverage guidelines, drugs which are self-administered by the patient are not a benefit of Medicare.

Reimbursement
Reimbursement for Q0182 is:
Participating: $20.12
Non-participating: $19.11

Limiting charge: $21.97

Advance Notice Statement
Applies to limitation (see page 4).

****
Diagnostic Tests

76090, 76091: Revision to Screening Mammography Benefit
As a result of a recent change to the screening mammography coverage benefit, if a radiologist finds something suspicious in a beneficiary's screening mammography films, the radiologist may order a diagnostic mammography without having to contact the beneficiary's treating physician and having the beneficiary return to the facility for another mammography. This is only allowable if the radiologist finds something suspicious in the screening mammography films.
This change is effective for claims processed on or after July 1, 1998,

Billing Guidelines
If the radiologist orders a diagnostic mammography as the result of suspicious finding(s) in the screening mammography, the mammography must be billed as diagnostic. The provider cannot bill for the original screening mammography.

The radiologist may bill for the diagnostic mammography using one of the following procedure codes:

76090
Mammography, unilateral

76091
Mammography, bilateral

If the patient has previously undergone a unilateral mastectomy, providers should use procedure code 76090. For other situations, providers may bill procedure code 76091.
Procedure codes 76090 and 76091 are covered only for the following diagnoses:
174.0-174.8
175.0-175.9
198.2
198.81
217
233.0
238.3
610.0-610.8
611.0-611.8
793.8
879.0
879.1
996.54
V10.3
V15.89
V71.1

Advance Notice Statement
Applies to diagnosis (see page 4).

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Roster Billing Guidelines for Influenza and Pneumococcal Pneumonia Vaccines

The Social Security Act, Section 1848 (g)(4) requires that providers bill Medicare for covered Part B services rendered to eligible beneficiaries. Public health clinics, community health clinics, and other entities which have not provided Medicare-covered services to their clients in the past must bill Medicare for the influenza virus vaccine, the pneumococcal pneumonia vaccine (PPV), and the administration of either/both vaccine when the services are provided to Medicare beneficiaries.

To encourage mass immunization of the influenza vaccine and the pneumococcal pneumonia vaccine (PPV), Medicare has:

Established the roster billing method for mass immunizers who agree to accept assignment,

Expanded use of the roster billing method to all providers licensed to render the vaccines and/or their administrations,

Allowed physicians who administer the vaccine in the office setting to use the roster billing method regardless of the number of beneficiaries immunized, provided no other services were rendered to these beneficiaries, and

Now accepts "signature on file" on the roster in lieu of the actual patient's signature where the provider has a signed authorization on file to bill Medicare for services rendered.

Public health clinics and other entities that do not have a provider number and qualify for simplified billing procedures for influenza vaccine or PPV claims should call (904) 634-4994 to obtain the provider/supplier enrollment application form.

What's New for 1998

Effective July 1, 1998, immunization of at least five beneficiaries on the same date is no longer required for any individual or entity to qualify for roster billing. However, the rosters should not be used for single patient bills and the date of service for each vaccination administered must be entered.

Pneumococcal Pneumonia Vaccine

PPV can be billed to Medicare Part B using the simplified roster billing method. Typically, the vaccine is administered once in a lifetime to persons at high risk of pneumococcal disease. Considered at risk are persons age 65 or older; immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks), and individuals with compromised immune systems (e.g., splenic dysfunction or anatomic

asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, HIV infection, nephrotic syndrome, sickle cell disease, or organ transplantation).
Medicare requires for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. However, a physician does not have to be present to meet the physician order requirement if a previously written physician order (standing order) is on hand and it specifies that for any person receiving the vaccine:

The person's age, health, and vaccination status must be determined;

A signed consent must be obtained;

The vaccine may be administered only to persons at high risk of pneumococcal disease who have not been previously vaccinated; and

A record of vaccination must be provided.

Because PPV must be ordered by a physician, the ordering physician's name must be noted in box 17, and the Unique Physician Identification Number (UPIN) must be noted in box 17a of the HCFA-1500 form. If the ordering physician's name or UPIN is missing, the claim will not be processed for payment.

PPV Vaccine Codes
The following HCPCS codes should be used when billing for PPV and its administration. Please note that neither deductible nor coinsurance apply to these codes, and no money may be collected from the beneficiary if the provider is accepting assignment and/or roster billing.

Procedure Code: 90732
Description: Pneumococcal vaccine, polyvalent

Procedure Code: G0009
Description: Administration of pneumococcal vaccine

PPV claims should be submitted using diagnosis code V03.82 (Other specified vaccinations against single bacterial diseases, other specified vaccination).

Advance Notice Requirement for PPV
The PPV vaccine is covered by Medicare Part B when it is furnished within the accepted standards of medical practice. For services which exceed the accepted standards of medical practice, an acceptable advance notice of Medicare's denial of payment must be provided to the patient when the provider does not want to accept financial responsibility for the service.
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Influenza Virus Vaccine
The influenza virus vaccine and its administration are covered by Medicare Part B and may be billed to Medicare Part B using the simplified roster billing method.

Influenza Virus Vaccine Codes

The following HCPCS codes should be used when billing for the influenza virus vaccine and its administration. Please note that neither deductible nor coinsurance apply to these codes, and no money may be collected from the beneficiary if the provider is accepting assignment and/or roster billing.

Procedure Code: 90724
Description: Administration of influenza virus vaccine

Procedure Code: G0008
Description: Immunization, active; influenza virus vaccine

Influenza virus vaccine claims should be submitted using diagnosis code V04.8 (need for prophylactic vaccination and inoculation against certain viral diseases).

Advance Notice Requirement for Influenza Services

The influenza virus vaccine is covered by Medicare Part B when it is furnished within the accepted standards of medical practice. For services which exceed the accepted standards of medical practice, an acceptable advance notice of Medicare's denial of payment must be provided to the patient when the provider does not want to accept financial responsibility for the service.

Benefits of Accepting Assignment

Providers who accept assignment agree to accept the Medicare-approved charge as payment in full for the services rendered. For flu and PPV shots, providers who accept assignment (including those who roster bill for these services) may not collect any money from the beneficiary, as the Medicare-approved charge is paid at 100 percent by Medicare. Nonparticipating providers who submit claims to Medicare for the flu shot or PPV do not have to accept assignment. However, we encourage providers to accept assignment as the out-of-pocket expense burdens some patients to the extent that they will not have these necessary preventative services. Plus, providers who do accept assignment are eligible to submit claims under the simplified billing method for mass immunizations.

Reimbursement for Flu and PPV Claims

The fees for the influenza vaccine, PPV, and their administration are not based on the Physician Fee Schedule; therefore, the limiting charge rules do not apply. Part B reimburses for the influenza vaccine and its administration, and for PPV and its administration, at 100 percent of the Medicare allowed amount. Deductible and coinsurance do not apply, and reimbursement is the same for both participating and nonparticipating providers.
When the claim is nonassigned, the provider may collect payment for the full charges from the beneficiary on the spot. Though the provider cannot roster bill, he/she must complete and submit a claim to Medicare Part B on the patient's behalf.
The Medicare allowed amounts for the influenza vaccine and its administration, and PPV and its administration are outlined below:

Code G0008 (Administration of influenza virus vaccine)

Locality 1	Locality 2	Locality 3	Locality 4
$3.97	$3.97	$4.45	$4.85

Code 90724 (Immunization, active; influenza virus vaccine)

Locality 1	Locality 2	Locality 3	Locality 4
$4.74	$4.74	$4.74	$4.74

Code G0009 (Administration of pneumococcal vaccine)

Locality 1	Locality 2	Locality 3	Locality 4
$3.97	$3.97	$4.45	$4.85

Code 90732 (Pneumococcal vaccine, polyvalent)

Locality 1	Locality 2	Locality 3	Locality 4
$12.15	$12.15	$12.15	$12.15

Both the administration of the vaccines and the vaccines themselves are covered separately when they are rendered with or without other covered physician services. If the sole purpose of the patient encounter is to provide the flu vaccine or PPV, only the administration and vaccine provided should be billed. If a patient receives other services constituting an office visit level of service, the physician may also bill for the visit. Medicare will pay for medically reasonable and necessary visits when rendered with the administration and vaccine.
When other services are rendered to the beneficiary on the same day, claims must be submitted using the standard HCFA-1500 and related filing requirements.

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How To Roster Bill for Influenza and PPV Claims
The following chart outlines the fields on the HCFA-1500 claim form that must be completed for the roster billing of flu and PPV claims. For roster billing of either or both services, use the preprinted HCFA-1500 forms on pages 38 and 40 as cover sheets to the preprinted rosters (pages 39 and 41). (Note: Information in lightly shaded blocks must be added to the HCFA-1500 form by the provider.)

HCFA-1500 Block: Block 1
Influenza Virus Vaccine Claims: Check "Medicare"
Pneumococcal Pneumonia Vaccine Claims: Check "Medicare"

HCFA-1500 Block: Block 2
Influenza Virus Vaccine Claims: See attached roster
Pneumococcal Pneumonia Vaccine Claims: See attached roster

HCFA-1500 Block: Block 11
Influenza Virus Vaccine Claims: None

Pneumococcal Pneumonia Vaccine Claims: None

HCFA-1500 Block: Block 17
Influenza Virus Vaccine Claims: N/A
Pneumococcal Pneumonia Vaccine Claims: Name of ordering physician MUST be entered(One name per claim form)

HCFA-1500 Block: Block 17a
Influenza Virus Vaccine Claims: N/A
Pneumococcal Pneumonia Vaccine Claims: UPIN of ordering physician MUST be entered(One UPIN per claim form)

HCFA-1500 Block: Block 20
Influenza Virus Vaccine Claims: No
Pneumococcal Pneumonia Vaccine Claims: No

HCFA-1500 Block: Block 21
Influenza Virus Vaccine Claims: V04.8
Pneumococcal Pneumonia Vaccine Claims: V03.82

HCFA-1500 Block: Block 24B
Influenza Virus Vaccine Claims: 60-Mass Immunization Center
Pneumococcal Pneumonia Vaccine Claims: 60-Mass Immunization Center

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HCFA-1500 Block: Block 24D (line 1) (line 2)
Influenza Virus Vaccine Claims: (line 1) 90724
(line 2) G0008
Pneumococcal Pneumonia Vaccine Claims: (line 1) 90732

(line 2) G0009

HCFA-1500 Block: Block 24E (lines 1 and 2)
Influenza Virus Vaccine Claims: 1
Pneumococcal Pneumonia Vaccine Claims: 1

HCFA-1500 Block: Block 24F
Influenza Virus Vaccine Claims: Enter the charge for each listed service.
Pneumococcal Pneumonia Vaccine Claims: Enter the charge for each listed service.

HCFA-1500 Block: Block 27
Influenza Virus Vaccine Claims: X in YES block
Pneumococcal Pneumonia Vaccine Claims: X in YES block

HCFA-1500 Block: Block 29
Influenza Virus Vaccine Claims: 0.00
Pneumococcal Pneumonia Vaccine Claims: 0.00

HCFA-1500 Block: Block 31
Influenza Virus Vaccine Claims: Entity's representative must sign
Pneumococcal Pneumonia Vaccine Claims: Entity's representative must sign

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HCFA-1500 Block: Block 32
Influenza Virus Vaccine Claims: N/A
Pneumococcal Pneumonia Vaccine Claims: N/A

HCFA-1500 Block: Block 33
Influenza Virus Vaccine Claims: Enter the entity's billing name, address, ZIP code, and telephone number, and enter the carrier-assigned Provider Identification Number
Pneumococcal Pneumonia Vaccine Claims: Enter the entity's billing name, address, ZIP code, and telephone number, and enter the carrier-assigned Provider Identification Number

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IMPORTANT NOTE: Separate claim forms and rosters must be submitted for influenza vaccines and PPV claims.
All entities that use for the simplified billing process should use place of service 60 (mass immunization center) on any roster claim submitted to Medicare Part B.

How to Complete the Roster
When completing the roster for influenza virus vaccines or for PPV claims, the roster information for each beneficiary must include the following:

Provider name and number

Date of service

Patient's health insurance claim number (copy directly from the patient's red, white, and blue Medicare card)

Patient's name

Patient's address

Date of birth

Sex

Beneficiary's signature, or stamped "Signature on File"

This information must be printed clearly so that we can process these claims in a timely manner. Also, no more than 50 claims (i.e., five rosters per claim form) should be submitted with each claim form.
Finally, if you are only rendering the vaccine or its administration, on the HCFA-1500 claim form mark out the service you are not providing.

Submitting Claims to Medicare Part B of Florida
Roster billings of the PPV and flu vaccine must be mailed to the following address:

Medicare Part B Claims
P.O. Box 45031
Jacksonville, FL 32232-5031

Be sure to include photocopies of the appropriate HCFA-1500 claim form, front and back (see page 42), and a copy of the appropriate vaccine roster.

Filing Electronically
By filing claims electronically, providers can expect to receive payment from Medicare Part B in 14 days as opposed to 27 days for paper claims. Please note, however, the claims cannot be sent electronically in the roster format; each claim must be entered on a per-beneficiary basis.

For more information, contact the PES marketing area at (904)791-8767.

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HCFA-1500 claim form example:
"Influenza Virus Vaccine Claims Only"
"Roster Billing Only"

-- NOT AVAILABLE IN THIS FORMAT --

****
Page 39

"Influenza Virus Vaccine Roster"

-- NOT AVAILABLE IN THIS FORMAT --

****
Page 40

HCFA-1500 claim form example:
"Pneumococcal Pneumonia Virus Vaccine Claims Only"
"Roster Billing Only"

-- NOT AVAILABLE IN THIS FORMAT --

****
Page 41

"Pneumococcal Pneumonia Virus Vaccine Roster"

-- NOT AVAILABLE IN THIS FORMAT --

****
Page 42

Reverse side of HCFA-1500 claim form

-- NOT AVAILABLE IN THIS FORMAT --

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Page 43

90935-9947: Inpatient Dialysis on the same Date as Evaluation and Management Services
Payment for certain evaluation and management services (CPT codes 99231 through 99233, subsequent hospital visits, and CPT codes 99261 through 99263, follow-up inpatient consultations) is considered bundled into the payment for inpatient dialysis (CPT codes 90935 through 90947) when both are performed on the same day by the same physician for the same beneficiary. Payment will not be made for both dialysis and a subsequent hospital visit or a follow-up inpatient consultation on the same date of service. If both are billed, payment will only be made for the dialysis service.
Separate payment may be made for an initial hospital visit (CPT codes 99221 through 99223), an initial inpatient consultation (CPT codes 99251 through 99255), and a hospital discharge service (CPT code 99238 and 99239) when billed for the same date as an inpatient dialysis service. Such services may be billed with modifier 25 provided the service is significant and separately identifiable.
Note: Procedure code modifier 25 should only be used when the patient's condition required a significant, separately identifiable evaluation and management service above and beyond the inpatient dialysis service.
Payment is not allowed for more than one inpatient dialysis service per day.

****
92971: Billing for EECP
Enhanced external counterpulsation (EECP) is a noninvasive treatment that uses timed, sequential inflation of pressure cuffs on the legs which theoretically augments diastolic pressure, decreases left ventricular afterload, and increases venous return. This treatment is being used by some physicians for

patients with chronic angina pectoris and coronary artery disease.
Based on Section 35-74 of the Coverage Issues Manual, External Counterpulsation (ECP) is not covered under Medicare. Even though EECP is a newer technology utilizing air instead of water and utilizing synchronized counterpulsation, it is still classified as ECP, and therefore, is noncovered. EECP should be billed under procedure code 92971 (Cardio-assist method of circulatory assist; external).

Advance Notice Requirement
Applies to the lack of clinical evidence to support the procedure's efficacy (see page 4).

****

92015: Clarification of Determination of Refractive State
An article on page 39 of the March/April 1998 Medicare B Update! discussed Medicare Part B's billing requirements for eye refractions.
Medicare Part B of Florida has been asked to clarify our response to the second question in that article. The following is a clarification of that issue.
Eye refractions are not covered by Medicare. When this procedure code is used on a claim form it will always be denied. When an eye refraction is performed, the charge may not be included in the eye examination or in the evaluation and management procedure code. If an eye refraction is billed, it must be billed using procedure code 92015.
Note that providers are not required to bill the carrier for non-covered services unless the beneficiary requests that they do so. Therefore, a provider is not required to send in a claim for the eye refraction. In addition, a provider is not required to charge a Medicare beneficiary for an eye refraction if he or she does not charge any of his patients for a refraction. However, if it is the customary practice for a provider to include the charge for the refraction with the other services on his or her private pay patients, the provider must back the charge out of the charge to Medicare for the eye exam or evaluation and management service.
A provider's records should support the level of evaluation and management service or eye examination billed without including documentation for refractive services.
If a provider chooses not to bill for a refraction or does not submit a claim for a refraction, the provider's records should document that he or she is in compliance with these Medicare guidelines.

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ELECTRONIC CLAIMS??
Are you still filing paper claims? Call us for information on fees (904)791-8767

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This section of the Medicare B Update! features new and revised medical policies developed as a result of either the Local Medical Review (LMR) or Focused Medical Review 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 August 17, 1998, and after, unless otherwise noted.

Sources of Information
The sources of information used in the development of these policies may be obtained by accessing the Florida 'Medicare Online" Electronic Bulletin Board System (BBS).

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A4644: Low Osmolar Contrast Media (LOCM)

Description
Low osmolar contrast media is used in radiological diagnostic studies where, due to certain medical conditions, the use of other contrast material would be detrimental to a patient's health.

Indications and Limitations of Coverage and/or Medical Necessity

Separate payment may be made for Low Osmolar Contrast Media (LOCM) when furnished "incident to" a physician's service and in the case of intra-arterial and intravenous radiological procedures when it is used for non-hospital patients with one or more of the following characteristics:

- A history of previous adverse reaction to contrast material (with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting);

- A history or condition of asthma or allergy;

- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;

- Generalized severe debilitation; or

Sickle Cell disease
HCPCS Codes
A4644; Supply of low osmolar contrast material (100-199 mgs of iodine)

A4645; Supply of low osmolar contrast material (200-299 mgs of iodine)
A4646; Supply of low osmolar contrast material (300-399 mgs of iodine)

****

ICD-9 Codes That Support Medical Necessity

203.00 203.01 250.00-250.93 282.4 282.60 282.61
282.62 282.63 282.69 402.00 402.01 402.10
402.11 402.90 402.91 404.00 404.01 404.02
404.03 404.10 404.11 404.12 404.13 404.90
404.91 404.92 404.93 410.00-410.02 410.10-410.12
410.20-410.22 410.30-410.32 410.40-410.42 410.50-410.52
410.60-410.62 410.70-410.72 410.80-410.82 410.90-410.92
411.1 415.0 416.0 416.1 416.8 416.9 420.0
420.90 420.91 420.99 424.90 424.91 424.99 427.0
427.1 427.2 427.31 427.32 427.41 427.42 427.5
427.60 427.61 427.69 427.81 427.89 427.9 428.0
428.1 428.9 429.0 429.1 429.2 429.3 429.4
429.5 429.6 429.71 429.79 429.81 429.82 429.89
429.9 493.00 493.01 493.10 493.11 493.20 493.21
493.90 493.91 495.0 495.1 495.2 495.3 495.4
495.5 495.6 495.7 495.8 495.9 518.81 585
586 785.50 785.51 785.59 799.3 799.4 995.0
995.1 995.2 995.3 E947.8 V07.1 V14.0 V14.1
V14.2 V14.3 V14.4 V14.5 V14.6 V14.7 V14.8
V14.9 V15.0 V46.1

Reasons for Denial
Low osmolar contrast media utilized for conditions other than those listed as covered in this policy will be denied as not medically necessary.

Noncovered ICD-9 Code(s)
Any ICD-9 diagnosis code not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.

Coding Guidelines
The radiological diagnostic procedure performed with the low osmolar contrast media should be listed separately.
The amount of contrast media used should be billed using the appropriate procedure code.
If the beneficiary does not meet any of the criteria for coverage, the contrast is considered to be bundled into the TC of the procedure, and the beneficiary may not be billed for LOCM.

Documentation Requirements
Medical record documentation maintained by the ordering/referring physician or attending radiologist must clearly document the medical need for using low osmolar contrast media.
This information is usually found in the history and physical, office/progress notes, or radiological diagnostic procedure notes.

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A9270: Noncoverage Coding Guidelines
On pages 41-43 of the May/June 1998 Medicare B Update!, the Noncoverage Coding Guidelines were published. Since that time there have been two additions to the noncoverage list. The following were added to the Local Noncoverage Decisions list:

A9270; Neuronal Thread Protein (NTP) and
A9270; Epiduroscopy/Myeloscopy

In addition, A9270-Pelvic floor stimulator has been moved from the Local Noncoverage to the National Noncoverage Decisions list based on the Coverage Issues Manual (CIM 65-9).

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J3490: Clarification to Viscosupplementation for Osteoarthritis of the Knee
Medicare Part B of Florida's medical policy for viscosupplementation for osteoarthritis of the knee (billed using procedure code J3490) was published on page 44 of the May/June 1998 issue of the Medicare B Update! Documentation requirements (i.e. what the Medicare medical reviewer would expect to see in the documentation of medical necessity for the drug/procedure) were outlined in that article. This documentation information is generally found in the office notes, a recent history and physical, progress notes, and/or procedure note.
Also, to avoid unnecessary denials, the intra-articular injection (procedure code 20610) should be billed on the same claim as the drug used for viscosupplementation (procedure code J3490) and

should be submitted with the documentation to support medical necessity. The documentation to support medical necessity only needs to be submitted with the initial claim for one course of treatment. For example, Hyalgan (sodium hyaluronate) is administered in one injection per week for five weeks. Synvisc (hylan G-F 20) is administered in one injection per week for three weeks. Therefore, a course of treatment for Hyalgan is five injections and a course of treatment for Synvisc is three injections.

If the initial injection is determined to be medically necessary, then the remaining doses of one course of treatment would not require that documentation be submitted with the subsequent claims. However, for every claim submitted for viscosupplementation of the knee, the drug and the dosage of the drug must be indicated on the claim. When billing on the HCFA-1500 claim form, put this information in block 19. Electronic billers should put this information in the HA0 narrative record.

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J9999 Off-Label Use of Chemotherapy Drugs

Description

According to Medicare guidelines, certain medical services which are deemed reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are covered services. FDA approval is often one of the main criteria of Medicare's coverage guidelines for drugs and biologicals. However, in the case of chemotherapeutic agents, FDA approval does not always keep pace with clinically indicated efficacy. Therefore, the need exists to address off-label chemotherapy drug uses which have been validated by clinical trials.

The purpose of this policy is to establish the circumstances under which Medicare will consider off-label uses for chemotherapy drugs to be medically reasonable and necessary, and to specify those drugs and their off-label uses as they become available. This policy does not restrict what providers can provide nor what beneficiaries receive. It simply defines what can be covered by Medicare in order to avoid or reduce denials for unapproved treatment.

Indications and Limitations of Coverage and/or Medical Necessity

Effective January 1, 1994, unlabeled uses of FDA approved drugs and biologicals used singly or in an anti-cancer regimen for a medically accepted indication are evaluated under the conditions described in the following paragraphs. A regimen is a combination of anti-cancer agents which have been clinically recognized for the treatment of a specific type of cancer. An example of a drug regimen is: Cyclophosphamide + vincristine + prednisone (CPV) for non-Hodgkin's lymphoma. There may be different regimens or combinations which are used at different phases of the cancer's history (induction, prophylaxis of CNS involvement, post remission, and relapsed or refractory disease). A protocol may specify the combination of drugs, doses, and schedules for administration of the drugs. For purposes of this provision, a cancer treatment regimen includes drugs used to treat toxicities or side effects of the treatment regimen when the drugs are administered incident to a chemotherapy treatment.

In order for Medicare Part B of Florida to evaluate the off-label uses of chemotherapeutic agents for coverage, the uses must not be listed as "not indicated" by HCFA, the FDA, or the compendia. Justification for approval of off-label uses must be based upon data from clinical trials in which there was a defined combination and dosage schedule, an appropriate study design, an adequate number of trial subjects, and evidence of significant increase in survival rate or life expectancy or an objective and significant decrease in tumor size or reduction in tumor-related symptoms. (Stabilization is not considered a response to therapy.) The unlabeled uses of a chemotherapy drug must be supported by one of the following:

The compendia. (If an unlabeled use does not appear in the compendia or is listed there as insufficient data or investigational, the compendia will be contacted to determine whether a report is forthcoming. If a report is forthcoming, the information in that report will be used as a basis for decision making. The compendium process for making decisions regarding unlabeled uses is very thorough and continually updated.)
Phase III clinical trials.

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Clinical research that appears in peer reviewed medical literature. This includes scientific, medical, and pharmaceutical publications in which original manuscripts are published, only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This does not include in-house publications of pharmaceutical manufacturing companies or abstracts (including meeting abstracts).

Use peer reviewed medical literature appearing in the following publications:

-American Journal of Medicine;
-Annals of Internal Medicine;
-The Journal of the American Medical Association;
-Journal of Clinical Oncology;
-Blood;
-Journal of the National Cancer Institute;
-The New England Journal of Medicine;
-British Journal of Cancer;
-British Journal of Hematology;
-British Medical Journal;
-Cancer;
-Drugs;
-European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology);
-Lancet; or
-Leukemia.

Physicians seeking to establish Medicare coverage for specific off-label uses of chemotherapeutic drugs must submit documentation from any of the above publications supporting the

efficacy of each of the off-label uses to the Medicare Medical Policy and Procedures Department.

Following are chemotherapy drugs and their off-label uses for which Medicare Part B considers coverage to be medically reasonable and necessary:

Gemcitabine (Gemzar(r))
Gemcitabine is a deoxycytidine analogue antimetabolite which is structurally related to cytarabine. In contrast to cytarabine it has greater membrane permeability and enzyme affinity, as well as prolonged intracellular retention. The compound acts as an inhibitor of DNA synthesis, and its mechanism of action appears to be cell-cycle specific.
Gemzar is for intravenous use only. It is supplied as 200 mg of powder to be reconstituted, and should be administered by intravenous infusion at a dose of 1000 mg/m2 over 30 minutes once weekly for up to 7 weeks, (or until toxicity necessitates reducing or holding a dose), followed by a week of rest from treatment. Subsequent cycles should consist of infusions once weekly for 3 consecutive weeks out of every 4 weeks. Dosage adjustment is based upon the degree of hematologic toxicity experienced by the patient.
Gemzar is FDA approved for first-line treatment of patients with advanced or metastatic adenocarcinoma of the pancreas. Clinical trials have also demonstrated the efficacy of Gemzar in the treatment of additional carcinomas. Medicare Part B will now cover Gemzar for its FDA approved use, as well as for treatment of the following neoplasms:

- Non-small cell lung carcinoma
- Bladder carcinoma

HCPCS Codes
J9201 - Gemcitabine HCl, 200 mg.

ICD-9 Codes That Support Medical Necessity
157.0-157.9
162.2-162.9
188.0-188.9

Docetaxel (Taxotere(r))
Docetaxel, an antineoplastic agent belonging to the taxoid family, acts by disrupting cell replication. It is a derivative of 10-deacetylbaccatin 111, a compound extracted from the needles of the European yew tree. Docetaxel acts by disrupting the microtubular network in cells, an essential component of vital mitotic and interphase cellular functions.
Taxotere is supplied as either 20 mg or 80 mg Concentrate for Infusion. The recommended dose is 60-100 mg/m2 administered intravenously over one hour every three weeks.
Taxotere is FDA approved as a front-line agent in the treatment of metastatic breast cancer when anthracycline-based therapy and other agents have failed. It is also FDA approved as a second-line treatment of AIDS-related Kaposi's sarcoma. Clinical trials have demonstrated the efficacy of Taxotere in the treatment of several additional carcinomas, as well. Medicare Part B will now

cover Taxotere for its FDA approved uses, as well as for the treatment of the following neoplasms:

- Non-small cell and small cell carcinoma of the lung
- Squamous cell carcinoma of the head and neck
- Ovarian carcinoma
- Gastric carcinoma
- Melanoma

HCPCS Codes
J9170 - Docetaxel, 20 mg.

ICD-9 Codes That Support Medical Necessity
151.0-151.9
162.2-162.9
172.0-172.9
174.0-174.9
175.0-175.9
176.0-176.9
183.0
195.0

****

Topotecan Hydrochloride (Hycamtin(r))
Topotecan Hydrochloride is a semi-synthetic derivative of camptothecin and is an anti-tumor drug with topoisomerase I-inhibitory activity. Hycamtin for injection is supplied in a single dose vial containing topotecan hydrochloride equivalent to 4 mg. of topotecan as free base. The reconstituted solution is intended for administration by intravenous infusion.
The cytotoxicity of topotecan is thought to be due to double strand DNA damage produced during DNA synthesis when replication enzymes interact with the ternary complex formed by topotecan, topoisomerase I, and DNA. Mammalian cells cannot efficiently repair these double strand breaks.
Hycamtin is FDA approved for treatment of metastatic carcinoma of the ovary. Clinical trials have also demonstrated the efficacy of Hycamtin in the treatment of an additional carcinoma. Medicare Part B of Florida will now cover Hycamtin for its FDA approved use, as well as for treatment of the following neoplasm:

- Small cell lung carcinoma

HCPCS Codes
J9350 Topotecan, 4 mg.

ICD-9 Codes That Support Medical Necessity
162.2-162.9
183.0

Reasons for Denial
The use of Gemzar, Taxotere or Hycamtin for any clinical indication 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 ICD-9 diagnosis code not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.

Coding Guidelines
When billing for Gemcitabine 200 mg, use HCPCS code J9201 and the appropriate ICD-9 diagnosis code which indicates the medical condition being treated.
When billing for either Taxotere 80 mg or Taxotere 20 mg, use HCPCS code J9170 and include both the drug strength and the appropriate ICD-9 diagnosis code which indicates the medical condition being treated.
When billing for Topotecan 4 mg., use HCPCS code J9350 and the appropriate ICD-9 diagnosis code which indicates the medical condition being treated.

****
35201-35226: Billing of Blood Vessel Repairs
It has been brought to our attention that providers are billing separately for the closure of the skin/artery when a patient is undergoing cardiac catheterizations. For example, items such as Angioseal and the Prostar Percutaneous Vascular Surgical System are being used to facilitate arterial closure following cardiac catheterization and these items have been billed with procedure code 35226. Blood vessel repair codes (procedure codes 35201-35226) should only be billed when the repair procedure is the primary procedure performed. These codes should not be used in conjunction with any catheterization procedure performed for diagnostic or therapeutic purposes.
****
44388-44394: Colonoscopy
In the November/December 1997 Medicare B Update!, the coverage for colonoscopies was published. Since that time an evaluation of the policy was performed resulting in the following changes:
The HCPCS codes section was expanded to include procedure codes 44388-44394. These procedure codes are covered only for the diagnosis listed on pages 28-29 of the November/December 1997 Medicare B Update!
The indication, " Evaluation of a patient presenting with signs/symptoms (i.e., rectal bleeding, abdominal pain) of a disorder that appears to be related to the colon" was added to the circumstances in which a colonoscopy can be performed. Applicable diagnoses for this indication were published in the November/December 1997 Update! article.
The statement regarding the noncoverage of screening colonoscopies was deleted with reference made to Florida's Medicare medical policy on Colorectal Cancer Screening.

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52282: Urethral Stents
Urethral obstruction in the male may result from benign prostatic hyperplasia (BPH), prostatic carcinoma, chronic prostatitis with fibrosis, a foreign body, contracture of the vesical neck, or congenital urethral valves. Urethral strictures and meatal

stenosis may be acquired or congenital. Urethral obstruction is the second most common cause of established incontinence in older men. It can present as dribbling incontinence after voiding; urge incontinence due to detrusor over activity, which co-exists in approximately two-thirds of cases; or overflow incontinence due to urinary retention. Treatment consists of elimination of the obstruction by medical, surgical, or instrumentation techniques. This policy addresses one treatment option for urethral obstruction which is urethral stent(s).

Indications and Limitations of Coverage and/or Medical Necessity
Currently, the UroLume Endoprosthesis, which is a urethral stent, has been FDA approved for the indications and limitations listed in this policy. These indications and limitations should be applicable to other devices that are FDA approved for the treatment of relieving urethral obstruction by using urethral stent(s).
Urethral stent(s) is an implantable device intended for use in men as a treatment to relieve urinary obstruction secondary to recurrent bulbar urethral strictures and prostatic obstruction secondary to benign prostatic hyperplasia (BPH).
The stent is made of corrosion resistant superalloy wire, the woven mesh cylinder is designed to expand inside the urethra and create an open lumen by pressing against the urethral wall with radial force. As urothelial tissue grows over the prosthesis, the mesh becomes incorporated within the urethral wall, providing a flexible and open urethral lumen.
Testing prior to insertion of the urethral stent may consist of performing a urethroscopy or urethrography for visualization of the bladder and urethra to demonstrate the site, length, and number of urethral strictures and urine flow parameters. The stent is implanted endoscopically after internal urethrotomy or sequential dilation of the stricture. One to three stents can be inserted; however, usually only one is required. The stent may migrate and/or shorten resulting in incomplete coverage of the stricture. If this occurs, additional stent(s) may be placed or the prosthesis' position may be adjusted to assure complete stricture coverage.
This procedure is most appropriate when performed in an outpatient setting or inpatient hospital because of the need for anesthesia. The placement procedure can be performed under general or local anesthesia.
Treatment of urethral obstruction with urethral stent(s) is indicated and covered when the treatment is performed using an FDA device approved for these specific indications and the patient meets the following criteria:

For the use in men to relieve urinary obstruction secondary to recurrent benign bulbar urethral strictures less than 3.0 cm in length located distal to the external sphincter and proximal to the bulbar scrotal junction. The urethral stent is not intended as an initial treatment for bulbar urethral strictures nor for the treatment of strictures outside the bulbar urethra. The stent is an alternative treatment for the patient in whom previous treatment methods (dilation, urethrotomy or urethroplasty) have been unsuccessful (i.e., treatment was not effective initially in

relieving stricture disease or there has been recurrence of stricture formation necessitating further treatment).

Contraindications for this indication would include:

1. Stricture involving the external sphincter;
2. Presence of fistula at the proposed prosthesis location;
3. Urethral squamous cell carcinoma;
4. Perineal urethrostomy;
5. Patients with other urethral conditions requiring transurethral manipulations within eight weeks of urethral stent placement;
6. Infected, suppurating strictures;
7. Meatal or urethral strictures which cannot be opened to 26 Fr. by dilation, urethrotomy or meatotomy; and/or
8. Patients with active urinary tract infection.

For the use in men to relieve prostatic obstruction secondary to BPH in men at least 60 years of age, or men under 60 years of age who are poor surgical candidates, and whose prostates are at least 2.5 cm in length.

Contraindications for this indication would include:

1. Meatal or urethral strictures which cannot be opened to 26Fr.
2. Patients with an active urinary tract infection.
3. Patients with other urethral conditions requiring transurethral manipulations within eight weeks of potential urethral stent placement.
4. Patients with known or suspected treatable prostate cancer.
5. Patients with urethral squamous cell carcinoma.
6. Patients with transitional cell carcinoma of the bladder.
7. Patients with previous surgical procedures to alleviate symptoms of BPH.
8. Patients with median prostatic lobe involvement.

****

9. Patients with a prostatic urethra less than 2.5 cm in length.
10. Patients with current bladder stones or neurogenic bladder.

HCPCS Codes

52282 Cystourethroscopy, with insertion of urethral stent

ICD-9 Codes That Support Medical Necessity

598.00
598.01
598.1
598.2
598.8
598.9
600

Reasons for Denial

When performed on patients who have one or more of the contraindications and patients who do not meet the indications for coverage criteria as in listed in the "Indication and Limitation of Coverage and/or Medical Necessity" section of this policy.
When performed with devices that have not been FDA approved for the specific indications listed in the "Indication and Limitations of coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9 Code(s)
All ICD-9 Codes not listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

Documentation Requirements
Medical record documentation maintained by the physician must indicate the medical necessity for performing this procedure. All coverage criteria listed in the "Indications and Limitation of Coverage and/or Medical Necessity" section must be documented in the patient's medical record, as well as the operative report documenting the urethral stent was performed and made available to Medicare upon request. This information is usually found in the history and physical and/or office/progress notes and operative report.

Advance Notice Requirements
Advance notice applies to diagnosis requirements and medical necessity (see page 4).

****
54235: Injection of Corpora Cavernosa
On page 35 of the March/April 1998 Medicare B Update!, the coverage for the drugs used with the injection of corpora cavernosa was published. It stated that payment will be allowed one time for the following drugs: J0270, J2440, and J2760. However, it appears that clarification regarding this statement is needed. It is expected that procedure code 54235 or the appropriate "J" code would be billed when the initial injection is performed by the provider. It is not appropriate to bill both 54235 and the "J" code since procedure code 54235 includes the pharmacological agent.

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58400: Uterine Suspension
Effective for claims processed on or after May 11, 1998, documentation is no longer required when submitting claims for uterine suspension, with or without shortening of round ligaments, with or without shortening of sacroutine ligaments; (separate procedure) (procedure code 58400).
Claims for this procedure may now be submitted electronically.

Note: Supporting documentation for the procedure must be maintained in the provider's records.

****
66821: Neodymium:Yag (Nd:YAG) Laser Capsulotomy

The neodymium:YAG (Nd:Yag) laser is used to create posterior capsulotomies for posterior capsule opacification. Posterior capsule opacification generally occurs following cataract surgery. Desired outcomes of use of the Nd:Yag laser are an increase in visual acuity and/or improvement in glare and contrast sensitivity.
Medicare will consider the Nd:Yag laser capsulotomy medically necessary and reasonable if the following criteria are met:

1. The patient complains of symptoms such as blurred vision, visual distortion and/or glare resulting in reduced ability or inability to carry out activities of daily living due to decreased visual acuity or an increase in glare, particularly under bright light conditions, and/or conditions of night driving.

2. The eye examination confirms the diagnosis of posterior capsular opacification and excludes other ocular causes of functional impairment by one of the following methods.

The eye examination should demonstrate decreased light transmission (visual acuity 20/30 or 20/25 if the procedure is performed to assist in the diagnosis and treatment of retinal detachment) after other causes of loss of acuity have been ruled out, or

Additional testing must demonstrate 1) contrast sensitivity testing resulting in a decreased visual acuity by two (2) lines or 2) a decrease of two (2) lines of visual acuity in the glare tester, and
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3. This procedure should not be routinely scheduled after cataract surgery and rarely would it be expected to see this procedure performed within four months following cataract surgery.

4. Occasionally, a Yag laser capsulotomy may also be performed to assist in the diagnosis and treatment of retinal detachment; to assist in the diagnosis and treatment of macular disease; to assist in the diagnosis and treatment of diabetic retinopathy; to evaluate the optic nerve head; or to diagnose posterior pole tumors.

Generally, the Yag laser capsulotomy is expected to be performed only once per eye per lifetime of a beneficiary.

HCPCS Codes
66821 Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid; laser surgery (e.g., YAG laser) (one or more stages)

ICD-9 Codes That Support Medical Necessity
366.50
366.51

366.53

Reasons for Denial
- If the diagnosis does not support medical necessity the claim will be denied.

- If the number of capsulotomies performed exceeds that which is considered medically appropriate, the claim may be denied unless documentation stating the medical necessity of the frequency is submitted with the claim .

- When performed as a routine procedure, i.e., as a preventative measure, following cataract surgery, the claim will be denied.

Noncovered ICD-9 Code(s)
Those which are not listed as covered.

Coding Guidelines
- Report procedure code 66821 with the -50 modifier if the procedure is done bilaterally.

- Report procedure code 66821 with a -LT or -RT modifier if performed on one eye only.

- Report procedure code 66821 with a -78 modifier if performed within three months of cataract surgery.

- If procedure code 66821 is billed within four months of cataract surgery, documentation must be submitted with the claim to determine medical necessity.

- As always, the procedure must be documented in the patient's medical record and the documentation must clearly demonstrate the medical necessity of the procedure.

- When a series of procedures is planned for the removal of a posterior dense fibrotic capsule, it will be covered as a single procedure.

- If the procedure is performed on the same patient, on the same eye and is not part of a series of posterior capsule removal, documentation must be submitted to determine the medical necessity of the subsequent procedure(s).

Documentation Requirements
Documentation, such as the patient's medical record, should demonstrate very clearly why Yag laser capsulotomy was performed. This should include the results of a visual acuity test and/or a glare test. If this procedure is performed for one of the indications listed as occasional in the policy under the "Indications and Limitations" section, the documentation should clearly demonstrate why the procedure was performed.
Generally, it is not expected that the Yag laser capsulotomy will be performed more than once per eye. If the Yag capsulotomy is performed more often than one time per eye, documentation must be submitted which supports medical necessity.

This policy was developed to outline the indications and limitations associated with the performance of nd:YAG laser posterior capsulotomy and proper coding instructions. In addition, it specifically lists the ICD-9 codes for which Medicare will consider medically necessary and reasonable.

Advance Notice Requirement
Advance notice applies to diagnosis requirements and medical necessity (see page 4).

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Page 52

66930, L7501, L8614, L8619, 92510: Coverage of Cochlear Implantation
Recently, Section 65-14 of the Coverage Issues Manual was revised to clarify the coverage requirements for Cochlear Implantation. Since the coverage requirements have not been published in a few years, the policy is being published in its entirety.
A cochlear implant device is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn or carried by the individual to capture and amplify sound. Cochlear implant devices are available in single channel and multi-channel models. The purpose of implanting the device is to provide an awareness and identification of sounds and to facilitate communication for persons who are profoundly hearing impaired. This change is effective for services rendered on or after May 1, 1998.

Indications and Limitations of Coverage and/or Medical Necessity
Cochlear implant devices and the resultant services are indicated in adults and children who have no contraindications to the implant.
Implantation of the cochlear device (69930) and its associated aural rehabilitation services (92510) are covered services under the Medicare program, provided the following conditions exist:

General
- Diagnosis of bilateral severe to profound sensorineural hearing impairment with limited benefit from appropriate hearing (or vibrotactile) aids;

- Cognitive ability to use auditory clues and a willingness to undergo extended program of rehabilitation;

- Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system;

- No contraindications to surgery; and

- The device must be used in accordance with the FDA approved labeling.

Adults

- Cochlear implants may be covered for adults (over age 18) for prelinguistically, perlinguistically and post linguistically deafened adults. Post linguistically deafened adults must demonstrate test scores of 30 percent or less on sentence recognition scores from tape recorded tests in the patient's best listening condition.

Children
- Cochlear implants may be covered for prelinguistically and post linguistically deafened children aged 2 through 17. Bilateral profound sensorineural deafness must be demonstrated by the inability to improve on age appropriate closed - set word identification tasks with amplification.

Hearing/speech therapy following cochlear device implantation (92510) is a covered service when performed by a physician (M.D. or D.O.), or by a licensed audiologist under the supervision of a physician, and may include programming the threshold, comfort level and pitch ranking onto an erasable memory chip in the patient's speech processor (this is referred to as MAP); informal testing of MAP using live voice presentations; introduction to sound sensations generated by the patient's own voice; retesting of electrodes for consistency of effective dynamic ranges; loudness balancing of electrodes; vowel/consonant testing; and speech tracking.

HCPCS Codes
69930 Cochlear device implantation, with or without mastoidectomy
L7510 Repair prosthetic device, repair or replace minor parts (excludes repair of oral or laryngeal prosthesis or artificial larynx)
L8614 Cochlear device/system
L8619 Cochlear implant external speech processor, replacement
92510 Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming

Reasons for Denial
Cochlear device implantation performed for any other indication other than those listed as covered in this policy, will be denied as not medically necessary by Medicare.
Services related to or required as a result of services which are not covered or are excluded from coverage are also not covered under Medicare. Services "not related to" noncovered services are covered under Medicare.
CPT code 69710 is a noncovered service, therefore code L8614 would be denied if billed with this procedure.

Coding Guidelines
The cochlear implant device (L8614) is reimbursed separately when performed in an ASC.
If the device is implanted during a procedure that is performed in an ASC, and the Medicare coverage requirements are met, the cochlear implant device should be billed separately from the procedure.

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Effective January 1, 1996, and after, upgrades to the speech processor (external device) for cochlear implants are a covered service of Medicare B and should be billed by the supplier who repairs or replaces the item, using code L7510. These services are to be billed to Medicare Part B of Florida.
The replacement of the cochlear implant external speech processor is billed using HCPCS Level II code L8619. This will be billed to the carrier when provided in an ASC.

Documentation Requirements
Medical record documentation must indicate the medical necessity for performing this procedure.
Medical record documentation (i.e., operative report, history and physical, progress notes: audiological rehabilitation services) should be maintained in the patient's medical record and made available to the Carrier in the event a medical review is required.

Advance Notice Statement
Applies to medical necessity (see page 4).

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80091-80092, 84436-84439, 84443, 84479-84482: Correction to Thyroid Panels and Tests
On page 28 of the July/August 1997 Medicare B Update!, a list of covered diagnoses was published for thyroid function tests and panels (procedure codes 80091-80092, 84436-84439, 84443, 84479-84482). The diagnosis for Mixed hyperlipidemia was incorrectly listed as 273.2. The correct diagnosis should be 272.2.

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82330: Coverage for Ionized Calcium
The bulk of body calcium (98%-99%) is stored in the skeleton and teeth, which act as huge reservoirs for maintaining the blood levels of calcium. Ionized calcium is a cation that circulates freely in the bloodstream and comprises 46-50% of all circulating calcium. Only the ionized calcium can be used by the body in such vital processes as muscular contraction, cardiac function, transmission of nerve impulses, and blood clotting. Ionized calcium is considered a more sensitive and accurate indicator for many operative procedures and disease processes. A normal serum ionized calcium for an adult is 4.65 - 5.28 mg/dl.
Medicare will consider an Ionized Calcium test (procedure code 82330) medically necessary under any of the following circumstances:

- Evaluation of patients with clinical signs and symptoms of hyperparathyroidism such as weakness, fatigue, bone pain, confusion, depression, nausea, vomiting, polyuria, etc. in which parathyroid disease is suspected;
- Evaluation of patients with clinical signs and symptoms of hypoparathyroidism such as Chvostek's sign, Trousseau's sign,

dysphagia, tetany, increased deep tendon reflexes, etc. in which parathyroid disease is suspected;
- Evaluation of a patient with an abnormal total calcium level;
- Monitoring of a patient with renal disease, renal transplantation, or hemodialysis;
- Patients with previously diagnosed hyper or hypoparathyroidism;
- Patients with pancreatitis as characterized by symptoms such as epigastric abdominal pain, nausea and/or vomiting, fever, hypotension, mild jaundice, umbilical discoloration (Cullen's sign), etc.;

- Patients with a magnesium deficiency and/or excessive Vitamin D;
- Patients with sepsis as characterized by symptoms such as hypotension, tachycardia, tachypnea, change in mental status, etc.; and

- Patients with ectopic parathyroid hormone producing neoplasms.

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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
588.8
733.90
780.7
781.0
781.7
787.01-787.03
787.2
788.42
996.81

Testing for ionized calcium is not covered when performed as a screening test, billed without a covered diagnosis, or when the physician's documentation does not support medical necessity. A calculated ionized calcium, which is an indirect method for calculating the amount of ionized calcium based on serum protein levels, is not reimbursable by Medicare.

Documentation Requirements
The medical records maintained in the patient's file must document the medical necessity of the test including the test

results. This information is usually found in the office/progress notes, hospital notes, and/or laboratory results.

Advance Notice Statement
Applies to medical necessity (see page 4).

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94010-94200, 94360 and 94375: Coverage for Spirometry

Since the local medical review policy for Spirometry was published in the July/August 1996 Medicare B Update!, a few additions and/or clarifications have been performed, with publication in subsequent articles. Therefore, the complete policy is being republished in its entirety.

Spirometry, a component of pulmonary function tests (PFT's) consists of the performance of a set of maneuvers to detect and quantitate disorders of pulmonary ventilation and gas exchange. PFT's are interpreted with respect to predicted values for normal individuals. Predicted values are based on standard linear regression equations that use age, height, and weight in calculating normal values. Typically, a percent of predicted greater than 80% is considered to be within normal limits. However, a change from a patient's base-line value is more likely to indicate pulmonary injury than is the traditional comparison of values measured in the patient with reference values obtained from population studies.

Spirometry involves the use of an instrument, a spirometer, to measure and record the changes in the gas volume in the lungs with time and thus ventilatory capacity and flow rate. The commonly obtained lung volumes and capacities as seen on a spirogram are: tidal volume, inspiratory reserve volume, expiratory reserve volume, residual volume, inspiratory capacity, and vital capacity.

Pulmonary Function Tests are performed to detect abnormalities in respiratory function and to determine the extent of any pulmonary abnormalities. The PFT will be considered medically necessary for the following conditions:

- Preoperative evaluation of the lungs and pulmonary reserve when:

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

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

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

- Initial diagnostic work-up for the purpose of differentiating between obstructive and restrictive forms of chronic pulmonary disease. Obstructive defects (e.g., emphysema, bronchitis, asthma) occur when ventilation is disturbed by an increase in airway resistance. Expiration is primarily affected. Restrictive

defects (e.g., pulmonary fibrosis, tumors, chest wall trauma) occur when ventilation is disturbed by a limitation in chest expansion. Inspiration is primarily affected.

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

- Evaluate patient's response to a newly established bronchodilator anti-inflammatory therapy.

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

- Evaluate patients who continue to exhibit increasing shortness of breath after initiation of bronchodilator anti-inflammatory therapy.

- Initial evaluation for a patient that presents with new onset (within 1 month) of one or more of the following symptoms: shortness of breath, cough, dyspnea, wheezing, orthopnea, or chest pain.

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

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

****

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

It is expected that procedure code 94070 will only be performed to make an initial diagnosis of asthma.
Also, it is expected that procedure code 94060 be utilized during the initial diagnostic evaluation of a patient. Once it has been determined that a patient is sensitive to bronchodilators, repeat bronchospasm evaluation is usually not medically necessary, unless one of the following circumstances exist: (1) a patient is exhibiting an acute exacerbation and a bronchospasm evaluation is being performed to determine if the patient will respond to bronchodilators; (2) the initial bronchospasm evaluation was negative for bronchodilator sensivity and the patient presents with new symptoms which suggest the patient has a disease process which may respond to bronchodilators; or (3) the initial bronchospasm evaluation was not diagnostic due to lack of patient effort. Repeat spirometries performed to evaluate patients' response to newly established treatments, monitor the course of

asthma/COPD, or evaluate patients continuing with symptomatology after initiation of treatment should be utilizing procedure code 94010.
In addition, it is not expected that a pulse oximetry (procedure code 94760 or 94761) for oxygen saturation would routinely be performed with a spirometry. Pulse oximetry is considered medically necessary when the patient has a condition resulting in hypoxemia and there is a need to assess the status of a chronic respiratory condition, supplemental oxygen and/or a therapeutic regimen (i.e., acute symptoms).
Usually during an initial evaluation, there is no reason to obtain a spirometry after the administration of bronchodilators in patients who have normal spirometry, normal flow volume loop and normal airway resistance unless there is reason to believe (i.e., symptoms, exam) that a patient has underlying lung disease.
The residual volume (RV) cannot be measured by spirometry because this includes air that cannot be expelled from the lungs, and, therefore is determined by subtracting the expiratory reserve volume (ERV) from the functional residual capacity (FRC). The FRC cannot be measured by simple spirometry either, therefore, procedure code 94240 will be performed when the RV and FRC need to be determined.
The Maximum Voluntary Ventilation (MVV; procedure code 94200) is a determination of the liters of air that a person can breathe per minute by a maximum voluntary effort. This test measures several physiologic phenomena occurring at the same time. The results and success of this test are effort dependent, therefore routine performance of this test is not recommended, except in cases such as: pre-operative evaluation, neuromuscular weakness, upper airway obstruction, or suspicion of Chest Bellows disease.
The Respiratory Flow Volume Loop (procedure code 94375) is used to evaluate the dynamics of both large and medium size airways. This test is more useful than the conventional spirogram. The procedure is the same for spirometry except for the addition of a maximal forced inspiration at the end of the force expiratory measures.

To ensure that services are medically necessity, Spirometry (procedure codes 94010, 94060, 94070, 94150, 94200, 94360, and 94375) are only covered for the following diagnoses:
135
162.0-162.9
197.0
197.3
212.2
212.3
231.2
415.0
415.11-415.19
446.20
466.0-466.19
486
490
491.0-491.9
492.0-492.8
493.00-493.91

494
495.0-495.9
496
508.0-508.9
515
517.1-517.8
518.0-518.89
519.1
519.4
519.8
780.51
780.53
780.57
786.02
786.09
786.2
786.3
793.1
799.1
V72.82

Coding Guidelines
When a physician who is in attendance for a pulmonary function study, obtains a limited history, and performs a limited examination referable specifically to the pulmonary function testing, separately coding for an evaluation and management service is not appropriate. If a significant, separately identifiable service is performed unrelated to the technical performance of the pulmonary function test, an evaluation and management service may be billed.
When multiple spirometric determinations are necessary (e.g., CPT code 94070) to complete the service described in the CPT code, only one unit of service is billed.

Documentation Requirements
Medical record documentation must indicate the medical necessity for performing the test. In addition, documentation that the service was performed including the results of the Spirometry should be available. This information is normally found in the office notes, progress notes, history and physical, and/or hard copy of the test results.
If the provider of the service is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physicians order for the studies. The physician must state the clinical indication/medical necessity for the study in his order for the test.

Advance Notice Requirement
Applies to diagnosis requirements (see page 4).

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92499: Computerized Corneal Topography

The following ICD-9-CM diagnosis code has been updated to the highest level of specificity for Computerized Corneal Topography (procedure code 92499). As a reminder, providers must code ICD-9-CM codes to the highest level of specificity.

Not to highest level: V45.6
To highest level: V45.61, V45.69

Refer to the latest edition of the ICD-9-CM for descriptions of the diagnosis codes listed above.

Advance Notice Statement
Applies to diagnosis (see page 4).

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93508: Cardiac Catheterization
Procedure code 93508 (Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization) was a new code beginning 1/1/98. There have been some questions regarding the use of this code. Procedure code 93508 should be billed when a cardiac catheterization involves the viewing of coronary artery(s), bypass grafts or arterial conduits, without the performance of a left ventriculogram. For example, it would be appropriate to bill for procedure code 93508 when a post Percutaneous Transluminal Coronary Angioplasty (PTCA) patient presents with symptoms suggestive of a reocclusion of that artery and the catheterization is done only to view the artery to determine whether reocclusion has occured.

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93990: Billing for Duplex Scan of Hemodialysis Access
In the November/December 1997 Medicare B Update! on page 22, we provided billing instructions for entities who perform duplex scanning for end stage renal dialysis beneficiaries as a means of monitoring a hemodialysis access site. These instructions were published to you based upon HCFA direction to ensure your awareness of its December 1, 1997 effective date. Since that publication, HCFA has delayed the implementation of this reimbursement policy while they continue to meet with representatives from the renal industry. In the interim, we are to continue our usual payment policy which is to consider payment to the performing entity for medically reasonable and necessary duplex scans of hemodialysis access sites. Please see page 37 of the September/ October 1997 issue of the Medicare B Update! for information on this local medical review policy describing the indications and limitations for duplex scans of hemodialysis access sites.

****

94240: Coverage for Functional Residual Capacity or Residual Volume
The Functional Residual Capacity (FRC) and Residual Volume (RV) (procedure code 94240) are pulmonary tests that cannot be measured directly using spirometry because these volumes and capacities include air that cannot be expelled from the lungs. However, a change from a patient's base-line value is more likely

to indicate pulmonary injury than is the traditional comparison of values measured in the patient with reference values obtained from population studies.
Pulmonary Function Tests (PFT's) are performed to detect abnormalities in respiratory function and to determine the extent of any pulmonary abnormalities. The PFT will be considered medically necessary for the following conditions:

- Preoperative evaluation of the lungs and pulmonary reserve when:
thoracic surgery will result in loss of functional pulmonary tissue (i.e.,lobectomy) or
patients are undergoing major abdominal surgery; and the physician has some reason to believe the patient may have a pre-existing pulmonary limitation (e.g., long history of smoking) or,

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

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

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

- Evaluate patient's response to a newly established bronchodilator anti-inflammatory therapy.

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

- Evaluate patients who continue to exhibit increasing shortness of breath after initiation of bronchodilator anti-inflammatory therapy.

****

- Initial evaluation for a patient that presents with new onset (within 1 month) of one or more of the following symptoms: shortness of breath, cough, dyspnea, wheezing, orthopnea, or chest pain.

- Initial diagnostic work-up for a patient whose physical exam revealed one of the following: over inflation, expiratory slowing, cyanosis, chest deformity, wheezing, or unexplained crackles.

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

- Initial diagnostic work-up for a patient with chronic cough. It is not expected that a patient has a repeat spirometry without new symptomology.

The FRC is most frequently measured by one of the four different methods:

- Closed circuit helium equilibration.
- Open circuit nitrogen washout, or
- Whole body plethysmograph
- Radiologic techniques

The Residual Volume can be determined by subtracting the expiratory reserve volume (obtained during simple spirometry) from the FRC.

To ensure that services are medically necessary, Functional Residual Capacity (FRC) and Residual Volume (RV) (procedure code 94240) are only covered for the following diagnoses:

135
162.0-162.9
197.0
197.3
212.2
212.3
231.2
415.0
415.11-415.19
446.20
466.0-466.19
486
490
491.0-491.9
492.0-492.8
493.00-493.91
494
495.0-495.9
496
508.0-508.9
515
517.1-517.8
518.0-518.89
519.1
519.4
519.8
780.51
780.53
780.57
786.02
786.09
786.2

786.3
793.1
799.1
V72.82

Documentation Requirements
Medical record documentation must indicate the medical necessity for performing the test. In addition, documentation that the service was performed including the results of the Spirometry should be available. This information is normally found in the office notes, progress notes, history and physical, and/or hard copy of the test results.
If the provider of the service is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physicians order for the studies. The physician must state the clinical indication/medical necessity for the study in his order for the test.

Advance Notice Requirement
Applies to diagnosis (see page 4).
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94620: Coverage for Pulmonary Stress Testing
Exercise testing consists of physiological measurements of maximum oxygen uptake (VO2 max), CO2 output, heart rate, endurance, and arterial blood gas composition during exercise. Blood pressure (BP) readings, electrocardiogram (ECG) analysis, and ventilation readings are made during incremental cycle ergometer or treadmill. Incrementation of workload is estimated to yield 8-12 minutes of exercise and is based on the patient's history of activities which cause breathlessness and/or fatigue. Exercise continues until the patient is exhausted or for other medical reasons (e.g., ischemic changes, severe cardiac arrhythmias, etc.)
The pulmonary stress testing procedures range from simple to complex. The simple procedure (Stage 1) consists of BP, ECG, and ventilation measurements at timed increments during exercise. The O2 uptake and CO2 output are measured, if possible. The complex procedure includes Stage 2 and Stage 3. Stage 2 involves all of Stage 1 measurements in addition to the mixed venous CO2 tension by means of re-breathing technique. Stage 3 requires the following: (a) blood gas sampling and analysis, (b) an indwelling catheter is inserted into the brachial or radial artery, and (c) in addition to Stage 2 tests, measurements for cardiac output, alveolar ventilation, ratio of dead space to tidal volume, alveolar-arterial O2 tension difference, venous admixture ratio and lactate levels are determined.
Exercise testing is done to evaluate functional capacity and to assess the severity and type of impairment of existing as well as undiagnosed conditions. The Pulmonary Stress Test (procedure code 94620) will be considered medically necessary for the following conditions:

- To determine whether the patient's exercise intolerance is related to pulmonary disease, cardiac disease, or due to lack of conditioning or poor effort.

- Initial diagnostic work-up when symptoms (generally dyspnea) are out of proportion to findings on tatic function (spirometry, lung volume, diffusion capacity.)

****

- Detection of interstitial lung disease (fibrosis) or exercise-induced broncho-spasm which are only manifested by exercise.

- Evaluate patient's response to a newly established pulmonary treatment regimen

The majority of clinical problems can be assessed during the simple procedures included in Stage 1, and should be completed before more complex tests are performed. Abnormal results indicate that more precise information is required through more complex Stage 2 protocols. If Stage 3 protocols are implemented, arterial blood analysis is necessary. In 75% of patients, Stage 1 is sufficient. Oxygen titration can be done during graded exercise to determine the oxygen needs for improving exercise tolerance and increased functional capacity.
Absolute contraindications to exercise testing include:

- Acute febrile illness
- Pulmonary edema
- Systolic BP 250 mm Hg
- Diastolic BP 120 mm Hg
- Acute asthma attack
- Unstable angina
- Acute Myocarditis

ICD-9 Codes That Support Medical Necessity

135
162.0-162.9
197.0
197.3
212.2
212.3
231.2
415.0
415.11-415.19
446.20
466.0-466.19
486
490
491.0-491.9
492.0-492.8
493.00-493.91
494
495.0-495.9
496
508.0-508.9
515
517.1-517.8

518.0-518.89
519.1
519.4
519.8
780.51
780.53
780.57
786.02
786.09
786.2
786.3
793.1
799.1
V72.82

Coding Guidelines
If using a standard exercise protocol, serial electrocardiograms are obtained, and a separate report describing a cardiac stress test (professional component) is included in the medical record, and both a cardiac and pulmonary stress test may be billed. In addition, if both tests are billed, both tests must meet medical necessity requirements.
When a physician who is in attendance for a pulmonary function study obtains a limited history and performs a limited examination referable specifically to the pulmonary function testing, separately coding for an evaluation and management service is not appropriate. If a significant, separately identifiable service is performed, unrelated to the technical performance of the pulmonary function test, an evaluation and management service may be billed.

Based on a review of this service, it has been determined that this procedure requires constant supervision, monitoring, and emergency backup equipment. Therefore, this service is not allowed in the following location:

12 Home

33 Custodial Care Facility

Documentation Requirements
Medical record documentation must indicate the medical necessity for performing the test. In addition, documentation that the service was performed including the results of the Spirometry should be available. This information is normally found in the office notes, progress notes, history and physical, and/or hard copy of the test results.
If the provider of the service is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies. 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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94799: Pulmonary Rehabilitation Services Policy Revision
The ICD-9 code list has been revised to reflect the highest level of specificity for the following codes:
277.0 to 277.00-277.01

493.0-493.9 to 493.00, 493.10, 493.20, and 493.90

495 to 495.0-495.9

See page 51 of the March/April 1998 Medicare B Update! for complete medical policy information.

Advance Notice Requirement
Applies to diagnosis (see page 4).

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95805-95811, 95822: Coverage for Sleep Testing

The Medicare Carriers Manual, Section 2055 provides coverage for sleep testing for certain conditions. Some comments regarding the medical review decisions for diagnostic testing performed in a sleep disorder clinic revealed that further medical information was needed to enhance the covered indications as listed in the Medicare Carriers Manual. As a result, this policy was developed to clearly define the indications of diagnostic testing for sleep disorders.
Normal nocturnal sleep in adults displays a consistent organization from night to night. Sleep consists of two(2) distinct states: rapid eye movement (REM), also called dream sleep; and non-rapid eye movement (NREM), which is divided into four (4) stages. Stages 1 and 2 are referred to as light sleep and stages 3 and 4 as deep or slow-wave sleep. Dreaming occurs mostly in REM and to a lesser extent in NREM sleep.
Sleep is a cyclic phenomenon, with four or five REM periods during the night accounting for about one-fourth of the total night's sleep (1 1/2 - 2 hours). The first REM period occurs about 80

- 120 minutes after onset of sleep and lasts about 10 minutes. Later REM periods are longer and occur mostly in the last several hours of sleep. Most stage 4 (deepest) sleep occurs during the first part of the night.
When abnormal sleep patterns are not easily explainable and further evaluation is necessary, sleep studies may be needed. Sleep studies and polysomnography refer to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for 6 or more hours with physician review, interpretation, and report. The studies are performed to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as nasal continuous positive airway pressure (NCPAP).

Polysomnography is distinguished from sleep studies by the inclusion of sleep staging which involves the use of a 1-4 lead electroencephalogram (EEG), an electro-oculogram (EOG), and a submental electromyogram (EMG). In addition to the three electrophysiologic variables used to define sleep states and stages, other measures used in polysomnography may include: electrocardiogram (ECG); airflow; ventilation and respiratory effort; gas exchange by oximetry, transcutaneous monitoring or end tidal gas analysis; extremity muscle activity, motor activity-movement; extended EEG monitoring; penile tumescence; gastroesophageal reflux; continuous blood pressure monitoring; snoring; body positions, etc.
Normally, sleep studies are performed in a sleep disorder clinic. Sleep disorder clinics are facilities in which certain conditions are diagnosed through the study of sleep. Such clinics are for diagnosis, therapy, and research. Sleep disorder clinics may provide some diagnostic or therapeutic services which may be covered under Medicare. These clinics may either be affiliated with a hospital or operate as a freestanding facility.

Indications and Limitations of Coverage and/or Medical Necessity
Medicare will consider Sleep Studies (procedure codes 95805, 95806 [noncovered], 95807, 95808, 95810, 95811, and 95822) reasonable and necessary when performed for the medical conditions listed in this section and when the following criteria are met:

The clinic is either affiliated with a hospital or is under the direction and control of physicians. Diagnostic testing routinely performed in sleep disorder clinics may be covered even in the absence of direct supervision by a physician.

Patients are referred to the sleep disorder clinic by their attending physicians, and the clinic maintains a record of the attending physician's order.

The need for diagnostic testing is confirmed by medical evidence, e.g., physician examinations and laboratory tests.

Diagnostic testing is covered when a patient has the symptoms or complaints of one of the following conditions:

A. Narcolepsy - Narcolepsy is a neurologic disorder of unknown etiology characterized predominantly by abnormalities of REM, some abnormalities of NREM sleep and the presence of excessive daytime sleepiness often with involuntary daytime sleep episodes (e.g., while driving, in the middle of a meal, amnesiac episodes). Other associated symptoms of narcolepsy include cataplexy and other REM sleep phenomena, such as sleep paralysis and hypnogogic hallucinations.
The diagnosis of narcolepsy is usually confirmed by an overnight sleep study (Polysomnography) followed by a multiple sleep latency test (MSLT). The following measurements are normally required to diagnose narcolepsy: (1) Polysomnographic assessment of the quality and quantity of nighttime sleep; (2) determination of the latency to the first REM episode; (3) MSLT; and (4) the presence of REM-sleep episodes. The minimum electrophysiological

channels that are required for this diagnosis include EEG, EOG, and chin EMG.
Initial polysomnography and multiple sleep latency testing occasionally fail to identify narcolepsy. Repeat testing is necessary when the initial results are negative or ambiguous and the clinical history strongly indicates a diagnosis of narcolepsy.
The diagnosis of narcolepsy requires documentation of the absence of other untreated significant disorders that cause excessive daytime sleepiness (i.e., sleep apnea, mental depression, insomnia, etc.).

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Treatment for narcolepsy is usually focused around the symptom of sleepiness and primarily consists of prescribing and taking of stimulant medication.

B. Sleep Apnea - sleep apnea is a respiratory dysfunction resulting in cessation or near cessation of respiration for a minimum of 10 seconds. These cessations of breathing may be due to either an occlusion of the airway (obstructive sleep apnea), absence of respiratory effort (central sleep apnea), or a combination of these factors (mixed sleep apnea). Central sleep apnea is a relatively rare entity. Obstructive sleep apnea is caused by one of the following: (1) reduced upper airway caliber due to obesity, adenotonsillar hypertrophy, mandibular deficiency, macroglossia, or upper airway tumor; (2) excessive pressure across the collapsible segment of the upper airway; or (3) activity of the muscles of the upper airway insufficient to maintain patency.
The most common nocturnal (during sleep) symptoms of sleep apnea are snoring, abnormal motor activity (i.e., patients flail out and throw the bedcovers off and may sit up or get out of bed), and nocturia. Diurnal (during wakefulness) symptoms associated with sleep apnea are excessive daytime sleepiness due to sleep disruption from hypoxemia and cognitive impairment, including poor memory, and personality changes.
Polysomnography is the test of choice and is diagnostic if more than 5 observed apneas or hypopneas occur per hour of sleep during at least 6 hours of nocturnal sleep. Normally, the polysomnography measurements used to diagnose sleep apnea are: the electrophysiologic indices of sleep staging (EEG, EOG, EMG); electromechanical indices contrasting respiratory effort with actual ventilation (chest and/or abdomen movement; airflow at the nose and mouth); and consequences of apneic events, including electrocardiograms and pulse oximetry.
Treatment for sleep apnea is generally recommended for any patient with an apnea index (number of apneas per hour of sleep) greater than 20 or if patients with fewer apneic episodes are symptomatic (excessive daytime sleepiness, snoring, etc.). The most frequent and satisfying treatment used for these patients is nasal CPAP. Other possible treatment options include oral appliances, a variety of surgical procedures, medications that

suppress REM sleep, weight reduction, and sleep position training.
Polysomnography with CPAP titration is appropriate for patients with any of the following polysomnographic results:

An apnea index (AI) of at least 20 per hour or an apnea-hypopnea index (AHI) of at least 30 per hour, regardless of the patient's symptoms;

AHI of at least 10 per hour in a patient with excessive daytime sleepiness; or

A respiratory arousal index of at least 10 per hour in a patient with excessive daytime sleepiness.

For CPAP titration, a split-night study (initial diagnostic polysomnogram followed by CPAP titration during polysomnography on the same night) is an alternative to one full night of diagnostic polysomnography followed by a second night of titration if the following criteria are met:

An AHI of at least 40 is documented during a minimum of 2 hours of diagnostic polysomnography;

CPAP titration is carried out for more than 3 hours;

Polysomnography documents that CPAP eliminates or nearly eliminates the respiratory events during REM and NREM sleep.

Follow up polysomnography or a cardiorespiratory sleep study is indicated for the following conditions: to evaluate the response to treatment (CPAP, oral appliances, surgical intervention); after substantial weight loss has occurred in patients on CPAP for treatment of sleep-related breathing disorders to ascertain whether CPAP is still needed at the previously titrated pressure; after substantial weight gain has occurred in patients previously treated with CPAP successfully, who are again symptomatic despite the continued use of CPAP, to ascertain whether pressure adjustments are needed; or when clinical response is insufficient or when symptoms return despite a good initial response to treatment with CPAP.

C. Parasomnias - Parasomnias are a group of behavioral disorders during sleep that are associated with brief or partial arousals but not with marked sleep disruption or impaired daytime alertness. The presenting complaint is usually related to the behavior itself. Most parasomnias are more common in children, but may persist into adulthood when their occurrence may have more pathologic significance.
Parasomnias include the following conditions: sleepwalking (Somnambulism), sleep terrors, REM sleep behavior disorder, sleep bruxism, sleep enuresis, and miscellaneous (nocturnal headbanging, sleep talking, and nocturnal leg cramps).
Normally, a clinical history, neurologic exam and routine EEG obtained while the patient is awake and asleep are often sufficient to establish the diagnosis and permit the appropriate treatment of sleep related epilepsy. In addition, common,

uncomplicated, noninjurious parasomnias, such as typical disorders of arousal, nightmares, enuresis, somniloquy, and bruxism can usually be diagnosed by clinical evaluation alone. Polysomnography is indicated to provide a diagnostic classification or prognosis when both of the following exists: when the clinical evaluation and results of standard EEG have ruled out a seizure disorder; and in cases that present a history of repeated violent or injurious episodes during sleep. Normally when polysomnography is performed for the diagnosis of parasomnias the following measurements are obtained: sleep-scoring channels (EEG, EOG, chin EMG): EEG using an expanded bilateral montage; EMG for body movements; and audiovisual recording and documented technologist observations.

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D. Impotence - Impotence is the inability of the male to achieve or maintain an erection. Diagnostic nocturnal penile tumescence testing may be covered to determine whether erectile impotence is organic or psychogenic. Although impotence is not a sleep disorder, the nature of the testing requires that it be performed during sleep. Refer to the Local Medical Review Policy (54250) regarding this service.

Reasons for Denial
Diagnostic testing that is duplicative of previous sleep testing done by the attending physician to the extent the results are still pertinent is not covered because it is not reasonable and necessary.
Polysomnography, cardiorespiratory sleep study or a MSLT is not covered in the following situations:

- For the diagnosis of patients with chronic insomnia;

- To preoperatively evaluate a patient undergoing a laser assisted uvulopalatopharyngoplasty without clinical evidence that obstructive sleep apnea is suspected;

- To diagnose chronic lung disease. Nocturnal hypoxemia in patients with chronic, obstructive, restrictive, or reactive lung disease is usually adequately evaluated by oximetry. However, if the patient's symptoms suggest a diagnosis of obstructive sleep apnea, polysomnography is considered medically necessary.

- In cases where seizure disorders have not been ruled out;

- In cases of typical, uncomplicated, and noninjurious parasomnias when the diagnosis is clearly delineated;

- For patients with epilepsy who have no specific complaints consistent with a sleep disorder;

- For patients with symptoms suggestive of the periodic limb movement disorder unless symptoms are suspected to be related to a covered indication;

- For diagnosing to guide treatment of restless legs syndrome;

- For the diagnosis of insomnia related to depression;

- For the diagnosis of circadian rhythm sleep disorders (i.e., rapid time-zone change [jet-lag], shift-work sleep disorder, delayed sleep phase syndrome, advanced sleep phase syndrome, and non 24-hour sleep wake disorder).

The following diagnoses are not covered when performed for sleep testing:

307.3
307.41
307.42
307.43
307.44
307.45
307.47
333.99
492.0-496

Coding Guidelines
A polysomnography normally includes sleep staging which uses a 1-4 lead EEG, therefore separate billing of a sleep only EEG is not appropriate.

Documentation Requirements
Documentation submitted with the claim must support that the patient has been referred to the clinic by their attending physician, has signs/symptoms of a covered medical condition as listed in this policy and the sleep testing is being performed to diagnose or rule out a condition. In addition, when repeat sleep testing is performed, documentation must support the medical necessity of this test which may include reasons such as: to evaluate the response to treatment, after substantial weight gain/loss, symptomatic even after therapeutic intervention, etc.

Also, in addition to documentation supporting medically necessity, documentation must support that the procedure billed was actually performed.

The above information is normally found in a clinical evaluation such as an history and physical and test resusts.

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95860, 95861, 95863, 95864: Electromyography
On page 34 of the November/December 1997 Medicare B Update!, the "Indications and Limitations of Coverage and/or Medical Necessity" for Electromyograpy (95860, 95861, 95863, and 95864) were published. Since the publication of the article, the following indication has been added to the list of "Indications and Limitations of Coverage and/or Medical Necessity:"

- other myopathies (e.g., mitochondrial myopathies, desmin myopathy)

Advance Notice Requirement
Applies to medical necessity (see page 4).

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PHPPROG Psychiatric Partial Hospitalization Program

Description
Individuals requiring psychiatric care generally receive services along a continuum of care which involves three levels - inpatient, partial hospitalization, and outpatient.
Psychiatric partial hospitalization is a distinct, organized, time-limited, ambulatory, and intensive psychiatric outpatient treatment of less than 24 hours of daily care. It is designed to provide patients with profound or disabling mental health conditions an individualized, intensive, comprehensive, and multi-disciplinary treatment program not provided in a regular outpatient setting. Partial hospitalization services are furnished by a hospital or community mental health center (CMHC) to patients with acute mental illness in order to avoid inpatient care. Patients are generally directly admitted (transitioned) to a partial hospitalization program (PHP) from an inpatient psychiatric stay or from a failed attempt at being managed as an outpatient.
Partial Hospitalization requires admission and certification of need by a physician (M.D./D.O.) trained in the diagnosis and treatment of psychiatric illness. PHPs differ from inpatient hospitalization and outpatient management in day programs in 1) the intensity of the treatment programs and frequency of participation by the patient and 2) the comprehensive structured program of services provided that are specified in an individualized treatment plan, formulated by a physician and the multi-disciplinary team, with the patient's involvement.

Indications and Limitations of Coverage and/or Medical Necessity
Eligibility Requirements
Facilities eligible for reimbursement for partial hospitalization services and the associated physician supervision requirements of each:

- Outpatient hospital - Partial hospitalization services rendered within a hospital outpatient department are considered "incident to" a physician (MD/DO) services and require physician supervision. The physician supervision requirement is presumed to be met when services are performed on hospital premises (i.e., certified as part of the hospital). If a hospital outpatient department operates a PHP offsite, the services must be rendered under the direct personal supervision of a physician (MD/DO). Direct supervision means that the physician must be physically present in the same office suite and immediately available to provide assistance and direction throughout the time the employee is performing the service.

- Community mental health center (CMHC) - The CMHC must meet applicable certification or licensure requirements of the state in which they operate, and additionally be certified by Medicare.

A CMHC is a Medicare provider of services only with respect to the furnishing of partial hospitalization services under Section 1866(e)(2) of the Act. HCFA'S definition of a CMHC is based on Section 1916 (c)(4) of the Public Health Service (PHS) Act. The PHS definition of a CMHC is cross referenced in Section 1861(ff) of the Act.

Partial hospitalization services provided in a CMHC require general supervision and oversight of the program by a physician (MD/DO). General supervision means the physician must at least be available by telephone.

Patients eligible for Medicare reimbursement for PHP services are:
- Those patients who are directly discharged or transitioned from an inpatient hospital treatment program, and the PHP admission is in lieu of continued inpatient treatment.

- Those patients who, in the absence of the partial hospitalization, would require inpatient hospitalization. **There must be documented evidence of failure at or inability to benefit from a less intensive outpatient program.

The following eligibility requirements must also be met:
- The services must be reasonable and necessary for the diagnosis or active treatment of the individual's condition.
- The patient must be under the care of a licensed psychiatric physician, who is knowledgeable about the patient and certifies the need for partial hospitalization.
- The patient or legal guardian must provide written informed consent for partial hospitalization treatment.
- The patient must require comprehensive, multi-modal treatment requiring medical supervision and coordination because of a mental disorder which severely interferes with multiple areas of daily life including social, vocational, and/or educational functioning. **Such dysfunction must be of an acute nature and not a chronic circumstance.**
- The patient must have the capacity for active participation in all phases of the multi-disciplinary and multi-modal program (e.g., the patient is medically stable and not limited by another serious medical condition, the patient demonstrates an appropriate level of cognition).
- There must be reasonable expectation of improvement in the patient's disorder and level of functioning, which would be evident within two weeks of admission, as a result of the active treatment provided by the PHP.

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- The active treatment must directly address the presenting problems necessitating admission to the PHP. Active treatment consists of clinically recognized therapeutic interventions including individual, group, and family psychotherapies, occupational, activity, and psychoeducational groups pertinent to the patient's current illness. Medical and psychiatric diagnostic evaluation and medical management are also integral to active

treatment. Evidence of active monitoring of the patient's physical status which could impact the patient's psychiatric condition is required.
- The individualized treatment plan is developed by a physician and the multi-disciplinary team, with the patient's involvement.
- A physician must provide supervision and evaluation of the patient's treatment and the extent to which the therapeutic goals are being met.
- The program must be prepared to appropriately treat the co-morbid substance abuse disorder when it exists (dual diagnosis patients). Dual diagnosed individuals suffer from concomitant mental illness and chemical dependency. Sobriety, as an initial clinical goal, is essential for further differential diagnosis and clinical decisions about appropriate treatment. **It is not generally expected that a patient who is actively using a chemical substance be admitted to or engaged in a partial hospitalization program, as a patient under the influence of a chemical substance would not be capable of actively participating in his/her psychiatric treatment program.

Admission Criteria (Intensity of Service)
In general, patients should be treated in the least intensive and restrictive setting which meets the needs of their illness.

Patients admitted to a PHP must:

- Not require a 24 hour a day level of care as provided in an inpatient setting. **Therefore, it is not expected for the patient to be an inpatient of, nor living at, the location in which the partial hospitalization services are rendered.

- Have an adequate support system to sustain/maintain themselves outside the partial program. **The patient is not expected to be homeless and/or have no identifiable significant support system while he/she is not actively engaged in the program (i.e., in the evening, on the weekend, or anytime the PHP services are not available).

- Require PHP services at a level of intensity and frequency comparable to patients in an inpatient setting for similar psychiatric illnesses.

Admission Criteria (Severity of Illness)
Patients admitted to a PHP must:

- Have an acute onset or decompensation of a covered Axis I mental disorder, as defined by the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) published by the American Psychiatric Association (1994), which severely interferes with multiple areas of daily life.

- Demonstrate a degree of impairment severe enough that without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself and such neglect or refusal poses a real and present threat of substantial harm to his or her well being. This degree of impairment requires a multi-disciplinary structured program, but is not so severe that the

patient is incapable of participating in and benefiting from an active treatment program and be maintained outside the program.

- Not be an immediate/imminent danger to self, others, or property. **There may be a recent history of self mutilation, serious risk taking, or other self-endangering behavior. Evidence of appropriate safety measures must be in place to accommodate at-risk patients (i.e., a no harm contract with a specified emergency plan signed by the patient upon admission and re-affirmed upon the end of each treatment day.)

Discharge Criteria (Intensity of Service):
Patients are appropriate for discharge from a partial hospitalization program, based on intensity of service, when:

The patient requires stepping up to an inpatient level of care. The inpatient psychiatric admission (24 hour supervision) becomes necessary when the probability for self harm, or harm to others exists.

- The patient requires stepping down to a less intensive level of outpatient care. Stepping down to a less intensive level of service than a partial hospitalization would be considered when the patient no longer requires the multi-disciplinary or multi-modal program. These patients must be transitioned to the outpatient setting.

Although patients entering the PHP may require active treatment services at a level of intensity and frequency comparable to patients in an inpatient setting, it is not expected that the patient will require that same level of intensity and frequency of active treatment during the transition phase. Transitioning must be documented with a decrease in frequency and intensity of services.

The length of time necessary for transition to a less intensive outpatient setting is not expected to exceed two weeks, as it is the treatment team's responsibility to determine that the patient is now appropriate for transition and failure to transition to a less intensive level is unlikely.

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In the rare circumstance of inability or failure to transition to a less intensive level, medical records must substantiate the need for a continuation in the PHP . **PARTIAL HOSPITALIZATION PROGRAM SERVICES ARE INTENDED TO BE TIME-LIMITED AND GENERALLY SHOULD NOT EXCEED 45 CALENDAR DAYS (30 TREATMENT DAYS).

Discharge Criteria (Severity of Illness):
Patients are appropriate for discharge from a PHP, based on severity of illness, when:

- The patient's clinical condition declines and the individual requires inpatient psychiatric care (24-hour supervision).

- The patient's clinical condition improves or stabilizes and the individual no longer benefits from or requires the intensive, multi-modal treatment of the PHP. This would be evidenced by a reduced impairment in daily functioning, symptom reduction, improved capacity to access community supports, accomplishment of treatment goals to extent possible, and ability to return to increased levels of independence in day-to-day activities.

- The patient is unwilling or unable to participate in the active treatment of their condition. **If little or no participation is evidenced for three or more consecutive treatment days, discharge criteria are met.

- The patient has not demonstrated improvement in their disorder and level of functioning within two weeks of admission.

Covered Services:
- Medically necessary diagnostic services related to mental illness.

Individual or group psychotherapy rendered by physicians (MD/DO), psychologists, or other mental health professionals licensed or authorized by Florida State law. ** Professional services furnished by physicians, physician assistants, nurse practitioners, and clinical psychologists to patients in PHPs must be billed to the carrier. There must not be more than 8 patients participating in each group psychotherapy session.

- Occupational therapy, requiring the skills of an occupational therapist (OT), which is a component of the physician's treatment plan for the patient. The occupational therapy services must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals. The physician's treatment plan must clearly justify the need for each occupational therapy service modality utilized, and explain how it fits into the treatment of the patient's mental illness and functional deficits. **Providers must not bill occupational therapy services as individual or group psychotherapy services.

- Services of other staff trained to work with psychiatric patients.

- Drugs and biologicals that cannot be self administered and are furnished for psychotherapeutic purposes. **The medication must be safe and effective, and approved by the Food and Drug Administration. It cannot be experimental or administered under investigational protocol.

- Individualized activity therapy that is not primarily recreational or diversionary. The activity therapy group must be individualized and essential for the treatment of the patient's diagnosed psychiatric condition and for progress toward treatment goals. The physician's treatment plan must clearly justify the need for each activity therapy modality utilized and explain how it fits into the treatment of the patient's illness and functional deficits.** Providers must not bill activity therapies as individual or group psychotherapy services.

- Family counseling services for which the primary purpose is the treatment of the patient's condition. Such services include the need to observe the patient's interaction with the family for diagnostic purposes, or to assess the capability of and assist the family members in aiding in the management of the patient.

- Patient training and education, when the training and educational sessions are closely and clearly related to the individual's care and treatment of their diagnosed psychiatric condition. **Providers must also not bill for general education (e.g., providing information in a group setting regarding a medication the patient is not receiving, information regarding the PHP's schedule, policies, changes in personnel, etc.).

HCPCS Codes

The following HCPCS are applicable for billing Part B professional services:

90801	90802	90816	90817	90818	90819	90821	90822	90823
90824	90826	90827	90828	90829	90846	90847	90849	90853
90857	90862	90865	90875	90876	90880			

** There are HCPCS codes on this list that may not be reimbursable through Medicare due to existing national or local medical review policies. Please refer to the applicable Medicare manuals and local medical review policies for coverage criteria information regarding each service.

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ICD-9 Codes That Support Medical Necessity
A diagnosis that falls within the range of ICD-9 codes for mental illness (290-319). ** The diagnosis itself is not the sole determining factor for coverage.

Reasons for Denial
- Services furnished by a facility other than an outpatient hospital or a community mental health center (CMHC);
- The treatment of chronic conditions without acute exacerbation;
- Individual or group psychotherapy rendered by someone who is not licensed or authorized by Florida State Law;
- Professional services of physicians, physician assistants, nurse practitioners, and clinical psychologists billed to the Intermediary;
- More than 8 patients participating in a group psychotherapy session;
- Occupational therapy services related primarily to specific employment opportunities, work skills, or work settings;
- Activity therapy that is primarily recreational or diversionary;
- Any service that does not have a specific treatment goal;
- Daycare programs, which provide primarily social, recreational, or diversional activities, custodial or respite care;
- Psychosocial programs attempting to maintain psychiatric wellness (e.g., daycare programs for the chronically mentally ill

which provide only a structured environment, socialization, and/or vocational rehabilitation);
- Services to a skilled nursing facility or nursing home resident that should be expected to provided by the nursing facility staff (e.g., adjustment difficulties related to their placement in the skilled nursing facility or nursing home);
- Services to hospital inpatients;
- Meals;
- Transportation;
- Self-administered medications;
- Vocational training;
- General education (e.g., information provided about the partial hospitalization program's schedule, policies, changes in staffing, etc.);
- Biofeedback therapy for ordinary muscle tension or psychosomatic conditions;
- Transcendental meditation; and
- Electroconvulsive therapy (ECT).

- Beneficiaries Ineligible for Partial Hospitalization Services:
- Patients who do not meet admission criteria for partial hospitalization services;
- Patients who cannot or refuse to participate (due to their behavioral, cognitive or emotional status) with the active treatment of their mental disorder, or who cannot tolerate the intensity of a partial hospitalization program;
- Patients who require 24 hour supervision inpatient hospitalization because of the severity of their mental disorder or their safety or security risk;
- Patients who require primarily social, recreational, custodial, or respite care;
- Patients with multiple unexcused absences or who are persistently non-compliant;
- Individuals with an organic brain disorder(i.e., Dementia, Delirium, Alzheimer's), or other psychiatric or neurologic conditions (Severe Head Trauma) which have produced a severe enough cognitive deficit to prevent establishment of a relationship with the therapist or other group members, or participation in insight oriented processes;
- Patients who have met the criteria for discharge from the partial hospitalization program to a less intensive level of outpatient care.

Noncovered ICD-9 Code(s)
Any diagnosis that does not fall within the range of ICD-9 codes for mental illness (290-319).

Coding Guidelines
- Professional services furnished by physicians, physician assistants, nurse practitioners, and clinical psychologists to patients in PHP must be billed to the carrier. The claim would show place of service code 52 (psychiatric facility partial hospitalization) for hospital outpatient programs, or 53 for CMHC programs.

- Claims for the professional services of physicians, nurse practitioners, and clinical psychologists may be billed by the

practitioner directly to the carrier, or the facility may bill the carrier on behalf of the practitioner. Claims for the professional services of physician assistants can be submitted to the carrier only by the actual employer of the PA. All of these professional services are potentially subject to the outpatient mental health treatment limitation.

- Procedure codes 90817, 90819, 90822, 90824, 90827, and 90829 include medical evaluation and management (E/M) services which include continuing medical diagnostic evaluation as well as pharmacologic management. Therefore, pharmacologic management (90862) and E/M service codes may not be billed separately on the same day as a psychotherapy service by the same physician.

- Clinical psychologists are not permitted to bill for the psychotherapy codes that include the medical evaluation and management component .

Documentation Requirements
The following documentation must be maintained in the patient's medical record:
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PHYSICIAN CERTIFICATION- A physician trained in the diagnosis and treatment of psychiatric illness must certify that the patient being admitted to the partial hospitalization program would require inpatient psychiatric hospitalization if the partial hospitalization services are not provided. The certification must also include an attestation that the services will be furnished while the individual is under the care of a physician, and that the services will be furnished under a written plan of care. **The certification must be completed within 24 hours of THE PATIENT'S ADMISSION to the partial hospitalization program.**

PHYSICIAN RECERTIFICATION- Periodic recertification by the physician who is directing or regularly involved in the care of the patient is required at least every 31 days. Recertification should be based on a thorough re-evaluation of the treatment plan in relation to the reason for admission and the progress of the patient.
** A psychologist is not considered a physician for the purpose of establishing a certification or recertification.

INITIAL PSYCHIATRIC EVALUATION- The initial psychiatric evaluation with medical history and physical examination must be performed by the physician and placed in the chart within 24 hours of admission in order to establish the medical necessity for partial hospitalization services. If the patient is being directly discharged from an inpatient psychiatric admission to a partial hospitalization program, an appropriate update to the inpatient psychiatric evaluation and medical history and physical is acceptable, as long as it is reflective of the patient's condition upon admission to the PHP.

The initial evaluation must include the following documentation to support the medical necessity of the admission:

- Referral source;
- Patient's chief complaint;
- Description of the precipitating event and date of onset of the acute illness or exacerbation of chronic illness requiring admission, including whether the patient is being admitted directly from a psychiatric inpatient hospitalization or has experienced a failed attempt at or inability to benefit from less intensive outpatient services;
- Description of the failed attempt at or inability to be managed in the outpatient setting. The description must include the length of time patient has received outpatient services, the outpatient regime, and duration of symptomatology indicating a worsening in the patient's conditions;
- Current medical history, including medications and their dosage, frequency, and level of compliance;
- Past psychiatric and medical history;
- History of substance abuse including the type of substance used, frequency amount and duration as well as symptoms of withdrawal or other complications (e.g., hepatitis or AIDS resulting from the use of contaminated needles);
- Family, vocational, and social history, including documentation of an adequate support system to sustain/maintain the patient outside the partial hospitalization program;
- Mental status examination, including general appearance and behavior, orientation, affect, motor activity, thought content, long and short term memory, estimate of intelligence, capacity for self harm or harm to others, insight, judgment, and capacity for activities of daily living (ADLs) with examples of specifics in each category and the method of elicitation when applicable;
- Physical examination (if not done within the past 30 days and available for inclusion in the medical record);
- Formulation of the patient's status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms, as a result of the active treatment provided by the partial hospitalization program;
- ICD-9/DSM-IV diagnoses, including all five axes of the multi-axial assessment as described in DSM-IV, to assist in establishing the patient's baseline functioning;
- An initial treatment plan, including long and short term goals related to the active treatment of the reason for admission and the specific types, amount, duration, and frequency of therapy services required to address the goals; and
- Certification by the physician that the course of the patient's current episode of illness would result in psychiatric inpatient hospitalization if the partial hospitalization services are not initiated at this time.

TREATMENT PLAN- An individualized formal treatment plan must be signed and dated by a physician and established within 7 days of admission to the program. **NO STAMPED SIGNATURES WILL BE ACCEPTED.

The treatment plan must include the following:

- Physician's diagnosis;

- Specific problems to be addressed which are pertinent to the crisis/precipitators to admission. The problem list should identify current functional deficits and the cause of each (e.g., cognitive,
communication, emotional, psychosocail, behavioral);
- Type, amount, frequency and duration of each active treatment modality to be rendered (e.g., individual psychotherapy 3 days per week for 2 weeks, occupational therapy 2 days per week for 2 weeks, etc.). **The name of the specific psychotherapy group, educational group, etc. as it would appear on an itemized statement must also be listed in the treatment plan;
- The interventions or what the staff will do to assist the patient in meeting specific functional outcomes that are directly related to the reason for admission;

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- Short and long term goals for each service provided that is directly related to an expected functional outcome. The treatment goals are the basis for evaluating the patient's response to treatment. **The treatment goals must be measurable, functional, time-framed, and directly related to the reason for admission;
- Psychotherapeutic medications the patient is receiving concurrent with therapy services (including dosages, negative and/or positive effects); and
- A proposed discharge plan which is initiated at the time of admission, describes the transition to a less intensive level of care, and is addressed throughout treatment.

The frequency of treatment plan updates is always contingent upon an individual patient's needs, but must occur no less frequently than once a week. The treatment planning updates must be based on the physician's periodic consultation with therapists and staff, review of medical records, and patient interviews.

PROGRESS NOTES- A separate progress note must be written for each HCPCS or revenue code billed. The progress note should be legible, dated and signed, and include the credentials of the rendering provider.

The progress note must be written by the team member rendering the service and must include the following:

- The type of service rendered (name of the specific psychotherapy group, educational group, etc. if applicable);
- The problem/functional deficit to be addressed during the session, and how it relates to the patient's current condition, diagnosis, and problem/deficit identified in the treatment plan;
- The content of the therapeutic session, as well as a clear description of the intervention used to assist the patient in reaching the related treatment goal;
- The patient's status (behavior, verbalizations, mental status) during the session; and
- The patient's response to the therapeutic intervention including benefit from the session and how it relates to progress made toward the short/long term goal in measurable and functional

terms. **Functional improvement is considered to be the patient's increasing ability to perform activities of daily living outside of the direction or support of a therapist and/or therapeutic environment.

PHYSICIAN SUPERVISION AND EVALUATION - Evidence in the medical record that physician has conducted a patient interview and evaluated the patient at least weekly, provided supervision and direction to the therapist(s) and staff, reviewed the medical record, and determined the extent to which the therapeutic goals are being met.

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WHAT'S NEW FOR EMC?

MEDFACS Migration Assistance
To make your MEDFACS Migration to PC-ACE easier, you may fax the New Installation and Software License Agreement for PC-ACE to (904) 791-6692. These forms were mailed with the October 1996 release of MEDFACS.
If you cannot locate these forms, please contact the PES Marketing Department at (904) 791-8767.
You may contact the the PC-ACE Support Line for assistance with MEDFACS migration by calling (904) 355-0313. Note that we must receive the Software License Agreement before we contact you regarding assisatnce with MEDFACS. When we receive the agreement, we will contact you and complete the New Installation for PC-ACE with you.

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GENERAL EMC INFORMATION

What Can Prevent Claim Rejects?
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; this causes no payment on your Medicare claims. The top three high volume errors for May 1998 and how to prevent these errors is outlined in the table below. Do not transmit any claims until these errors are resolved.

Error Message: Inv / Miss CLIA

Location Record & Field/HCFA 1500 Form:
  NSF FA0 - 34, Position - 164-178
  1500 claim form Block 24K

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 retransmit the entire claim. Talk with your vendor to have edits

placed in your system to prevent this error from occuring. If you do not have a CLIA number call the Healthcare Agency at 850/487-3063

Error Message: Prv Not In Group

Location Record & Field/HCFA 1500 Form:
  NSF FA0 - 23
  1500 claim form Block 33

Explanation: You have entered a performing provider number that is not a part of the PA group billing for 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

Location Record & Field/HCFA 1500 Form:
  NSF 1.04 BA0 - 02
  NSF 2.0, BA0 - 09
  1500 claim formBlock 33

Explanation: 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.

Preventive Action: Verify the number you have entered as the billing provider. Make correction and retransmit the entire claim. If you are sure you have keyed the correct number, then contact the customer service area at 904/634-4994.

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More PC-ACE(tm) Training Available
PC-ACE(tm) has completed the first two free in-house training sessions in Jacksonville, and continues to receive requests for additional sessions. As a result, more new sessions will occur! Each training session lasts approximately four hours and is conducted in a hands-on environment.
If you are interested in attending a training session, please fax the form below to (904) 791-6692. You will be contacted regarding available dates.

****
*   (Form Retreived from BBS - July/August UPDATE!)
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*

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*  PC-ACE(tm) In-House Training
*
*                                                                  *
*  Sender Number(s):  _____________________________________        *
*                                                                  *
*
**  Location Name:   _____________________________________
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*                                                                  *
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**  Address:  _____________________________________________
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**  Phone Number:  _____________________________
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**  Fax Number:    _____________________________
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**  Attendee Name(s):  _____________________________________
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*
*  Attendee Name(s):  _____________________________________        *
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**
**  Medicare Part B (HCFA-1500):  _____________________________
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*                                                                  *
*
**  Medicare Part A (UB92):  _________________________________
*
*                                                                  *
*
**  If you have questions, please call the PC-ACE(tm) Support
Line  *
*  at (904) 355-0313.                                              *
*********************************************************************
*      (Form Retreived from BBS - July/August UPDATE!)
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Another Ounce of Prevention

The May/June 1998 Medicare B Update! included an article titled "Be Aware of Fraud: A Lesson From Ben." That article highlighted just one of the fraud and abuse prevention measures that Medicare of Florida uses in its day-to-day operations. Prevention of

fraud, waste and abuse is not only the responsibility of Medicare contractors; all health care providers must share responsibility in this role. Providers should note that although they may be legitimate, there may be instances where they may fall victim to fraudulent schemes and, consequently, they may subject themselves to possible scrutiny from the Medicare contractor as well as law enforcement. Therefore, this article outlines some of the prevention measures that health care providers may use in protecting themselves from possible fraud and abuse.

Obtaining a Medicare Billing Number

To bill Medicare directly, providers must first obtain a provider identification number (PIN). These numbers are issued for your use in billing Medicare for services rendered. Protect it like a credit card number. Ensure that others don't use this number to bill Medicare without your knowledge.

Authorizing Another Entity to Bill Medicare and Receive Payments on Your Behalf

Generally speaking, Medicare pays the provider that performed the service. In limited situations, however, Medicare may allow the performing provider to reassign Medicare payments to another entity. This is called "reassignment of benefits" and requires that various forms be completed, signed and returned to the Medicare Registration Department. A fully executed "reassignment of benefits" form is powerful because it allows another person or entity to bill Medicare on the provider's behalf and receive payments that otherwise would have been sent directly to the provider. Have you authorized someone else to bill and be paid by Medicare for services that you or your organization render? If so, you must be certain to ensure that such billings are appropriate and reflect services you actually performed.

Changing Your Billing Arrangements

Providers and suppliers may formally revoke the "reassignment" agreement by writing directly to the Medicare Registration Department. Failure to revoke outdated agreements allows that entity to continue to bill Medicare. Be certain that you have notified Medicare if your reassignment agreements are outdated or no longer valid.

Hiring Someone to Prepare Your Claims

Some physicians and hospitals find it helpful to engage the services of a billing service or consultant to submit their Medicare claims. While such entities can provide valuable services, they should be engaged with caution. Delegating your entire claims preparation process does not protect you from being held responsible for the Medicare payments that are generated from the claims they file on your behalf. Before hiring a service or consultant, be certain to carefully check references and ensure that they:

- Provide you with periodic reports of claims it has billed on your behalf and, if the billing service receives your Medicare payments, how much Medicare paid;

- Protect your provider number and any other information used to act on your behalf;

- Do not change procedure codes, diagnostic codes or other such information furnished by you or your organization without your knowledge and consent; and

- Keep you informed of all correspondence received from Medicare.

Review these reports regularly to ensure consistency with your records. Also, keep complete administrative records for the claims that the billing service files on your behalf for seven years.

Hiring New Employees
Recent estimates for employee theft in the U.S. are approximately $50 billion each year. This fact combined with the provider's responsibility for the actions of their billing staff makes it critically important that your organization hires competent and ethical employees. Screen applicants carefully and develop internal controls within your organization in order to minimize risk. Install checks and balances in your organization's procedures to ensure the appropriateness of your interactions with Medicare. In addition, conduct periodic quality checks of sensitive processes such as the posting of account receivables.

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Lost or Stolen Medicare Cards
Did you know that Medicare receives thousands of calls and letters from beneficiaries stating their Medicare cards have been lost or stolen and used by others?
Beneficiary impersonators are becoming more common as the cost of health care rises and people feel forced to resort to other measures to obtain necessary health care. As a result, HCFA is requesting that providers take action to avoid becoming victims. One suggestion is to make a copy of each beneficiary's driver's license or some other form of valid identification and keep it on file. By doing so, office staff can quickly look at the picture on record to ensure that the patient receiving the service is actually the beneficiary named on the Medicare card.
Providers should beware of receiving false, fake, and fabricated Medicare cards as well as receiving false address and telephone information from their patients.
Remember it is the provider who is ultimately responsible for the verification of the identity of each patient receiving services from them. If services are rendered to a beneficiary impersonator, providers may be liable for an overpayment.

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

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

Period: July 19, 1996 - October 23, 1996

Interest Rate: 13.50%

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%

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Important Information on Medicare Registration Applications

The Medicare Registration area wants to assist you in submitting requests for General Enrollment and changes to the Medicare program. Your application must be completed correctly and in its entirety to ensure your application is processed quickly and correctly on the initial submission. This article outlines the most frequent items that have been identified as missing or incomplete on an application.

General Hints

Please enclose a letter with each application explaining what type of request or changes you are making. This will assist the

registration area in processing your application quickly and correctly.
When you are completing an application, please read the instructions printed in the front section of the application. Use the information in "Medicare Registration's Top 10" (later in this article) to make sure you have not overlooked important information required to process your application. If you have questions while completing the application, please call the Provider Customer Service department for assistance at 904-634-4994.
Completed applications should be mailed to:

Medicare Registration
P O Box 44021
Jacksonville, Fl 32231-4021

Medicare Registration's Top 10
The following are the items most frequently omitted or incomplete on an application.

General Enrollment Application (HCFA 855)
- Include a current copy of the applicant's occupational license as required by the city and/or county. A license is needed for each practice location. The addresses indicated in the practice locations should match the addresses on the occupational licenses.

- A current copy of the applicant's Professional License is needed.

- Submit a copy of the applicant's IRS form, W9, CP575, or 8109 Tax coupon. The EIN (Employer Identification Number) or SSN (Social Security Number) on the tax form should match the name to whom the payment will be generated.

- Managing/Directing employees section of the application should be completed as outlined in the instructions. List the required information on the Managing/Directing employees for each location. If the applicant is the managing directing employee, the applicant should complete with information relevant to themselves.

- Ownership Information Section should always be completed. Each owner of the business must fill out this information (make additional copies if needed). If the applicant is the sole owner, the owner should check the applicable box in the Ownership Information Section on the application and include a copy of the IRS W9 form, CP575 or tax coupon. See the Ownership Information Section on the application for more details.

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- Certification Statement Section of the application must be completed. The applicant must sign agreeing to the Medicare Regulations. The signature must be an original. Copied or stamped facsimiles are not acceptable. We prefer signatures to be in blue

ink instead of black. It is difficult to distinguish a signature in black ink from a copy.

- Billing Agency/Management Service Organization Section of the application should be completed. The information concerning the billing agency must be completed in full. A copy of the billing agreement must be submitted with the application. If a Billing Agency/Management Service will not be utilized indicate that this section does not apply in the appropriate box.

- Contact Person Section of the application should always include a contact person with a valid daytime telephone number. If additional information is needed we may try to contact the individual indicated to obtain the information rather than returning the application.

Individual Group Member Enrollment Application
- Group Practice Locations Section of the application. Please list all group practice locations where members will render services. If the practice location has never been enrolled please have the group's authorized representative complete the Group Practice Location section of the General Enrollment Application form for each practice location. A copy of the occupational license for each practice location should also be included. This information is stored in our files and will eliminate the need to return future Group Enrollment applications even if that practice has not been enumerated .

- Certification Statement Section of the application must be signed by both the authorized representative and the applicant. The applicant should not sign in both areas unless he is an owner or partner. An authorized representative should be an officer, chief executive officer or general business partner. All signatures must be originals. Copies or stamped signatures are not acceptable. We prefer signatures to be in blue ink instead of black. It is difficult to distinguish a signature in black ink from a copy.

Reassigning Benefits
Physicians or other health care providers need to use caution when reassigning benefits. They should read thoroughly the reassignment of benefits rules and guidelines. They should ask questions, read the paperwork, and perhaps consult an attorney before agreeing to reassign benefits or allow the use of their number by a third party. Physicians and other health care providers have an obligation to keep control over the use of the provider number issued to them by the Medicare Registration Department. Any changes to status should be reported immediately to:

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

A few simple rules physicians and other health care providers should follow when reassigning benefits:

- If you reassign benefits to a group, insist on meeting the other health care providers participating in the group.

- You are responsible for all claims for services filed on your behalf. Therefore, insist on reviewing a summary of all claims filed to Medicare under your provider number or suffix.

- You should have unfettered access to any entity to which you have reassigned benefits.

- You should never reassign benefits to an entity or clinic that you have never visited or inspected.

- Physicians and other health care providers are responsible for reviewing the credentials and background of the company or individuals to whom they are reassigning benefits.

- Treat your provider number as you would a credit card, and guard it judiciously.

Keep in mind, physicians or other health care providers who reassign benefits are allowing their number to be used to file claims with the Medicare Program. They may be held accountable for the unauthorized use of their Medicare provider number. The filing of claims for false or unnecessary services is a crime and a very serious offense. These activities cost everyone and cause an unnecessary burden on the Medicare trust fund. Misuse of the Individual Reassignment of Benefits Application (HCFA 855G) to gain access to the Medicare program could subject the physician or other health care provider and the perpetrator to fines/imprisonment or both and/or exclusion from the Medicare program.

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Top Three Additional Development Requests for First Quarter of FY 1998

Are you receiving requests from Medicare Part B for additional information? If your answer is yes, this article was written with you in mind.

Requests for additional information is causing the Medicare program millions of dollars. During the first quarter of fiscal year 1998, the Florida Medicare Part B carrier identified the top additional development requests (ADR's). Outlined below are the top three ADR's and tips on how to avoid receiving them.

ADR: The procedure submitted does not correspond with the place of service (POS) indicated on your claim.

TIP TO AVOID: T o ensure that the appropriate POS is billed, definitions were published on page 18 of the September/October 1997 issue of the Medicare Part B Update! For example, if you billed an office visit (CPT procedure code 99215), the two digit POS code should be 11 for office, not 21 for hospital.

ADR: Please verify the date of death. Social Security records indicate the beneficiary was deceased on the date the service was rendered.

TIP TO AVOID: See article below for information.

ADR: Please verify the date of death. Social Security records indicate the beneficiary was deceased on the date the service was rendered.

TIP TO AVOID: I f the billing provider is a PA group, the performing provider who is a member of the group must be indicated in the appropriated EMC field of block 24K of the HCFA 1500 claim form. Please ensure that the correct suffix is included with the provider's identification number. Failure to correctly identify the provider will cause a denial or an ADR.

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Medicare Does Not Pay for the Interpretation of Tests After a Patient's Date of Death

To help providers understand Medicare Part B's policy regarding the coding and payment of claims for deceased patients, the following information has been provided.

Question: What date of service should be billed if the technical component of a chest X-ray was performed on January 19, 1998, the patient died on January 20, 1998, and the interpretation for the X-ray was performed on January 21, 1998?

Answer: The technical component should be billed with date of service January 19, 1998 and consideration for payment will be made. The professional component (if billed) should be billed with date of service January 21, 1998, and no payment will be made.

Rationale: Medicare will not allow any service that was performed after the patient's death.

Remember, this rule applies to global billing situations and purchased test arrangements. For example, under global billing, the physician may perform the technical and professional component on the same day or different days, but would normally bill globally using the date the technical portion of the service was performed. As stated above, when the patient is deceased, it is not appropriate to bill globally when any portion of your service is performed after the patient's death. In fact, you would need to separate the billing so that only the portion you performed before the patient's demise is performed (ex., the technical). This same logic applies to the purchased test arrangement. If you have purchased a test or performed a purchased test for someone else, you must notify Medicare that services were performed after the patient's date of death.

Question: If I determine I have been paid for services performed after the patient is deceased, how should I handle the overpayment?

Answer: Billing as stated above will prevent any overpayment from occurring. However, should you detect an overpayment you will need to notify Medicare in writing about the error and include a voluntary refund check for the overpaid amount. The refund and letter of explanation should be mailed directly to:

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

Although some facilities routinely perform the professional component of tests given to patients who have died (for liability reasons, for example), Medicare Part B will not reimburse for these services.

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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 Department
Blue 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 BCompliance 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:

Computer
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.

TECHNICAL SUPPORT (BBS HELP LINE):
Questions, comments and concerns: (904)791-8384

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Windows 95 Access to the "Medicare Online BBS"
Using HyperTerminal:
Windows 95 includes a communications program called HyperTerminal which will allow you to connect to the Medicare Online BBS without exiting to the DOS prompt. The program includes a simple setup wizard used to establish your connections.

Step 1:
To access HyperTerminal program; from the Start menu, click Programs, click Accessories, click HyperTerminal.

Step 2:
Look for the icon labeled "Hypertrm", or "HYPER.TRM". Double-click this icon to start the setup wizard.

Step 3:
The setup wizard will ask you to name the connection and select an icon. Name the connection B-Line BBS, select the icon you want to use by clicking on it, and click OK.

Step 4:
The setup wizard will ask you for the phone number to dial. All users have access to the toll free number (800)838-8859. Jacksonville, FL users should dial 791-6991. Click OK.

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Step 5:
The setup wizard allows you to revise dialing properties in order to make your connection. Click on Dialing Properties. Revise settings appropriately under "How I dial from this location": how your location accesses an outside line (i.e., "9" for an outside line), long distance access (i.e., "1" for long distance), and disabling call waiting (click on selections available and choose appropriately: i.e., "*70"). When complete, click OK.

Step 6:
The setup wizard will ask you to make the connection (call). At this time choose Dial to call the Medicare Online BBS.

Signing On To The BBS - If you are a new user to the BBS, type "new" when the system asks for your User ID. You will then complete a brief questionnaire (registration) about your practice/office. Please be sure to indicate your provider number. That's it - when you sign off the BBS and then exit HyperTerminal, be sure to save this new connection. The next time you open HyperTerminal, you will have an icon in this group titled "Medicare Online BBS". Simply double-click on this icon to connect in the future.

Need Help?
If you have any questions or problems with the B-Line BBS, contact our Technical Support BBS Help Line at (904)791-8384. We will respond to you within 48 hours. In leaving your message, please speak slowly and clearly when leaving your company name, contact name and telephone number.
If you are unable to access HyperTerminal, contact us at the above help number and we will provide you with a free communication software program which will enable you to access the Medicare Online BBS.

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ORDER FORM - 1998 PART B MATERIALS

--- Form not available in this format. ---

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ORDER FORM - 1998. MEDIFEST AND SPECIALTY SEMINAR BOOKS

--- Form not available in this format ---

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PHONE NUMBERS

PROVIDERS
Express Line/ARU
Status Inquiries:
904-353-3205

Specialty Customer Service Reps and EMC Billing
Problems/Guidelines:
904-634-4994

Medicare Online Bulletin Board System (BBS)
Access:
1-800-838-8859 All other users
1-904-791-6991 Jacksonville FL users
Technical Problems:

BBS Help Line
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:
904-791-6878

PC-ACE Support:
904-355-0313

Testing:
904-354-5977

Help Desk (Confirmation/Transmission):
904-791-9880

OCR
Printer Specifications/Test Claims:
904-791-6911

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(end of file)